



## Executive Summary — USMI Roundtable Discussion

### *Improving Bio-Preparedness in the National Capital Region*

Washington, D.C.    April 7, 2006

Preparing for a biological event — whether man-induced or natural — remains a concern among communities, governments and healthcare organizations across the United States. This imperative takes on special significance in the National Capital Region (NCR), because the NCR's role as the seat of federal government makes it a prominent target for potential bio-terrorist activity. In a pandemic, the National Capital Region would be seen as an example for other parts of the country in such aspects as mass vaccination, surge capacity and care of the afflicted.

How much progress has been made in the NCR toward mounting a coordinated, effective response to a terrorist incident or pandemic threat? What lessons have been learned, and how much remains to be accomplished? To gauge the status of bio-preparedness in the NCR, the nonprofit **U.S. Medicine Institute for Health Studies**, in partnership with the Director of the District of Columbia Department of Health and the Commander of Walter Reed Army Medical Center, held a roundtable discussion involving key federal, regional, local and private-sector officials.

The issue permeating the group's deliberations was one of authority, given the multiple county, state (Virginia and Maryland), and federal entities in the NCR: *Who is in charge, who determines when action must be taken, and who directs those activities?* There was concern that planning has become too bureaucratic and complex, and that there should be greater focus on simple, standardized plans that can be joined across jurisdictional lines. The group urged improved training for healthcare personnel, engagement of private-sector resources, and stable, increased funding for bio-preparedness — along with a heightened sense of urgency (“less talk and more action”) in resolving such issues as the need for greater surge capacity, the reliability of the medical supply line and the ability to continue essential business and government functions in the face of a massive disease outbreak.

At the same time, the group emphasized that “the trend is toward improvement,” with the NCR much better prepared to face a biologic threat than it was at the time of the anthrax attack on Capitol Hill in late 2001. More than 1,000 surge-capacity beds have been added to the region, two regional hospital consortia have developed plans that can be used as templates, and a mutual-aid radio system under the auspices of the D.C. Hospital Association allows daily assessment of the status of bed capacity as well as rapid communication among involved parties.

### **Summary of discussion and recommendations**

Roundtable participants pointed out that although surge capacity has increased over the past five years in the NCR, the economic pressures facing hospitals cause them to operate at capacity, meaning there is “much less excess capacity” at facilities on a day-to-day basis. Further, since hospitals and pharmacies now use just-in-time supply systems, there are insufficient stored supplies for an emergency situation, and it is doubtful that a supplier serving numerous hospitals could suddenly provide needed supplies to all of them at once.

The group urged greater sharing of information and plans across jurisdictional lines. This could be accomplished, it was suggested, by creating a core group of personnel from each jurisdiction dedicated to bio-preparedness planning. This group would coordinate with each jurisdiction and ensure that plans are compatible across the NCR. Developing a project time-line was suggested as a way to assess progress — and to make sure that it occurs.

“Much of what is planned on paper is fallacy in reality,” one participant cautioned, pointing out that having enough staff for an emergency situation is problematic. Staff might want to stay home with family members rather than risk bringing disease to them. Providing prophylaxis for staff thus is essential, but an exercise in how this might be accomplished conducted at the National Institutes of Health has shown this to be very expensive. While some essential medical staff and government

personnel might be able to work at home via the Internet, it is uncertain whether ISPs would remain in operation during an emergency.

Resources are a vital issue, participants agreed, noting that it's hard to operate across jurisdictions, or even across offices within jurisdictions, when computer systems are not compatible or software is not up-to-date. The group lamented the general lack of focus and funding — at all levels of government — on public health generally.

*Other points made during the roundtable discussion:*

- Someone needs to be in charge, to decide when emergency plans should be activated, where patients should be treated — or if they should be advised to remain at home — and what assets need to be mobilized. Currently, there are “islands” of planning among the various entities in the NCR; these need to be coordinated and standardized, and it likely will take a cross-jurisdictional entity to accomplish this. At the same time, planning can become so complicated that it ties things in knots.

An essential ingredient in being able to deal with a biologic threat is communication, especially the ability to pick up the phone and reach key personnel. A list of key individuals, with nighttime phone numbers, is being assembled and will be kept current. “We can plan all we want, but when the crunch hits, we'll fly by the seat of our pants” and need to remain in communication — and to share information. Too frequently, information is not shared across jurisdictional lines.

- Innovative approaches to training are being considered across the NCR. One suggestion is to use medical and nursing students to supplement staff in hospitals and makeshift clinics during an emergency. Another step might be to ask medical personnel to check a box when they renew their licenses indicating they are willing to serve during an emergency. The Public Health Service is contemplating creation of an auxiliary corps, based on the current civilian reserve corps, that would train regularly in how to deal with emergencies.

The Center for Disaster and Humanitarian Assistance at the Uniformed Services University of the Health Sciences offers on-line distance learning at [opep.usuhs.edu](http://opep.usuhs.edu).

- Mass vaccination or administration of medications might be accomplished by establishing hub distribution sites. One way to accomplish might be to use existing drive-through pharmacies across the region.
- Security remains an issue. Should large crowds descend on hospitals for care, hospital security personnel quickly would be overwhelmed. The Department of Homeland Security currently is working to secure stockpiles of vaccines and other supplies.
- Reaching minorities and the disadvantaged will be difficult in an emergency. Informational material should be developed that has a simple, repetitive message; it should be distributed in numerous languages. The media should be engaged and given a single, coordinated message.

*Participants in this roundtable: John T. Babb of the U.S. Department of Health and Human Services; Cynthia Bascetta of the Government Accountability Office; Clark Beil of the Virginia Department of Health; Scott Burgoon of the Washington, D.C., VA Medical Center; Douglas Ehrhardt of the Center for Disaster and Humanitarian Assistance, USUHS; John Eisold, attending physician to the U.S. Congress; Jeffrey Elting of the D.C. Hospital Association; Kenneth Farmer of Walter Reed Army Medical Center; Thomas Fitzpatrick of Walter Reed Army Medical Center; Christopher Gillette of the National Naval Medical Center; Renata Greenspan of the Armed Forces Institute of Pathology; Fred Hannett of the Virginia State Board of Health; Til Jolly of the Department of Homeland Security; Lisa Kaplowitz of the Commonwealth of Virginia; Donald Karcher of George Washington University Medical Center; Charles Konigsberg Jr. of the Alexandria (Va.) Health Department; Thomas Lockwood of the Department of Homeland Security; Dan Lucey of the D.C. Hospital Association; Matthew Minson of the State of Maryland; Pierre Noel of the National Institutes of Health; Arnauld Nicogossian of George Mason University; Janis Orłowski of the Washington Hospital Center; Gregg Pane of the D.C. Department of Health; Beverly Pritchett of Joint Forces Headquarters for the NCR; Zeenath Rehana of Prince William County (Va.) Department of Health; Charles W. Rice of USUHS; Kevin Riley of the Center for Disaster and Humanitarian Assistance, USUHS; Fred Sanford; Donald Shell of Prince George's County (Md.); Peach Taylor of the U.S. Air Force; Ulder Tillman of Montgomery County (Md.); Charlotte Tsoucalas of Defense Health Advisors; Ava Walker of Joint Forces Headquarters for the NCR; Margan Zajdowicz of the National Naval Medical Center. The roundtable was moderated John S. Parker of SAIC. USMI Managing Director is Nancy Tomich [[www.usminstitute.org](http://www.usminstitute.org)].*