The International Emergency Management Society
9th Annual Conference Proceedings
University of Waterloo, Canada, May 14-17, 2002

BIOTERRORISM PLANNING: SAN ANTONIO LESSONS FOR SUCCESS

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Abstract

Although planning for bioterrorism has gone on in many US communities for several years, it has been hindered by obstacles including jurisdictional isolation, inertia, lack of funds and lack of standards. The terrorist attacks of 9-11 and anthrax cases of October 2001 demonstrated the urgency of this planning despite all barriers. San Antonio, TX, succeeded in putting together an achievable plan using existing resources in less than 60 days. Its process included defined lines of authority, broad inclusiveness, triage of goals and breaking up tasks. With elements of a comprehensive plan in place, it is now possible to go back and solidify it, adding resources as funds become available. Key points of the process included gap analysis, regional approach and modularity of equipment packages for standardization and economy. The San Antonio experience outlines pitfalls and opportunities for medical leaders in communities preparing for biological emergencies.

Disclaimer

This presentation describes medical planning in a community in which a significant part of both the population and the medical infrastructure happen to be military. The principles described are community-focused and could have been derived anywhere. Military assistance to a community in a homeland emergency is a separate subject, governed by the Federal Response Plan.

Bioterrorism Planning in San Antonio

That bioterrorism is a threat to the United States is no longer in doubt after the anthrax incidents of October 2001. There is broad consensus that the medical community is not adequately prepared to deal with bioterrorism, or with any of the weapons of mass destruction that may be used by terrorists. But what does that statement mean? Is it a lack of material resources, of the right people, the right plans, the right connections or the right knowledge? The medical community of San Antonio came together in October, in a way that has attracted national attention, and asserted that the answer is "All of the above". The result: in a survey of bioterrorism preparedness in the 30 largest US cities, San Antonio rated second, after New York City, despite having some of the lowest indicators of per capita resources. One of the most significant contributors to that high rating was medical preparedness.

This presentation will give a short overview of what San Antonio did and highlight some of the features of this approach which can be applied anywhere.

Our starting position was that in the face of active terrorism, we had to have a plan that was as good as we could get without additional resources. Our experience leads us to say, "You can't buy readiness." However, thorough planning provides the basis for intelligent decisions about what gaps exist, what resources must be found to fill them, and how to spend those resources for the greatest effectiveness.

San Antonio and Bexar County have a long-standing, high-quality emergency preparedness program. San Antonio was the sixth city in the US to receive Weapons of Mass Destruction (WMD) training from the Department of Justice in 1997, and several city-wide exercises sponsored by the City, Local Emergency Planning Committee, National Disaster Medical System (NDMS) and the Texas Guard in conjunction with the City addressed chemical and biological terrorism issues in the years since then. However, as is typical of most cities, these exercises focused on first responders and did not task hospitals, physicians or other parts of the medical community. Also, South Texas has a good background in regional coordination in emergency management among governments and some agencies. For medical issues, the Regional Advisory Committees for Trauma (RACs) and regional organization of the Texas Department of Health provided some foundations for regional emergency planning, but this concept was not well developed in other aspects of health care.

There are a number of significant barriers to medical play in disaster preparedness, including lack of funds, the need to continue to provide uninterrupted real-world care, lack of a central authority or common forum under which the medical community could participate, and unwillingness to reveal proprietary information to competitors. All of these factors were operative in San Antonio as they are elsewhere.

However, thanks to the leadership of a number of dedicated individuals, we did succeed in building a core group of people who understood the need for better cooperation. Thus, on 9-11, the Greater San Antonio Area Hospital Council (GSAHC) was able to convene representatives of the key organizations for a number of meetings, first physically and then by teleconference, to coordinate resources. After the anthrax incidents of October 2001, this group organized itself as the Regional Emergency Medical Preparedness Steering Committee (REMPSC). The goal of REMPSC was to produce a workable, integrated, regional plan for bioterrorism response using existing resources before the Christmas holidays, an interval of 60 days. That plan was delivered and validated 18 December.

The REMPSC actually delivered a package of products in addition to updating the city and county medical plans. Even before this group was formally chartered, several of its members engaged in a physician education program sponsored by the Bexar County Medical Society. This education effort evolved into a Speakers' Bureau and package of educational materials for physicians as well as a collection of reference materials for the media and to be released to the public in the event of a local bio event.

A second critical achievement was the formation of a regional Medical Operations Center, or MOC, to back up the solitary medical representative at the City's Emergency Operations Center. The MOC provides a way to quickly identify resources and move them to where they are most needed, from and to anywhere in the region. It consists of upper-middle management personnel from all the hospital systems and other key agencies. They do not control their agencies resources themselves, but they have the ears of those who do. While a fully-equipped command post is in the works for the MOC, it currently meets in borrowed space and is able to assemble on short notice today.

Third, REMPSC devised one of the first comprehensive regional plans in the country for reception and distribution of the National Pharmaceutical Stockpile. This is a huge amount of materiel that arrives in 747s with a small core of advisors from the CDC. All unloading, transshipment,

breakdown to individual dose packs and distribution is the responsibility of the receiving community. We identified a menu of options including primary and alternate landing sites, freight handlers, wholesale pharmacies to break down the bulk medications, storage and distribution sites, record keeping and staffing. This process engaged a number of groups that were very eager to be included but had been overlooked as resources, including retail pharmacies, dentists and churches.

Other working groups addressed hospital security issues, personnel, infection control and hospital-based patient decontamination. The latter two issues were particularly interesting because the only existing national standards are unachievable on a large scale with any realistic current or future resources. We did the best we could with what we could get our hands on, and have a common local standard that is pretty good, even if it is not ideal.

The process has been very rewarding. A network of robust new friendships and collaborations has grown out of REMPSC activities. Knowing that there is a lot we can do with what we already have has been reassuring to those to whom we are responsible and empowering to us. We have also built a fact base that can lead to a rational approach to future planning priorities and looking for additional resources.

From what we have learned, here is what we can offer to other communities:

1. Authority. Somebody needs to own the medical preparedness for the area. That responsibility is usually already assigned in the Emergency Plan, and is probably the local public health authority. However, first, public health agencies have a notorious history of being overworked and underfunded, and may not have the time or personnel to fully address this huge task. Second, medical preparedness is a complex, multidimensional problem, and includes stakeholders from government, hospitals, physician organizations, laboratories, support services, suppliers and a variety of others. Thus, the responsible authority should consider assigning operational responsibility for developing and implementing the plan to a workgroup, preferably based on existing organizational lines, with subcommittees from all interested constituencies.

2. Inclusiveness. Our workgroup had several hundred participants in multiple teams. We included City and County elected officials and Emergency Management Offices, the Alamo Area Council of Governments, local and state Health Departments, the Hospital Council and Medical Society, one civilian and two military Trauma Centers as well as about 20 other hospitals, a medical school, AirLife, San Antonio EMS and private ambulance companies, retail and wholesale pharmacies, a local grocery chain, shipping firms, churches and assorted other players. Anybody who griped about being left out was given a subcommittee to chair. The resulting community buy-in was spectacular.

3. Gap analysis. You can't know what you don't have until you know what you do have and what you might need. Right now a lot of money is being thrown around for terrorism response, but there are no data on where the needs are, what capabilities a facility should be expected to have, or what works. If the people with the responsibility do not get involved in answering these questions, people with other agendas and probably a lot less insight into critical issues will answer them.

4. Prioritization. Ours was quick and dirty—we knew what frightened us the most about our preparedness in October, and that's where we plugged deficiencies first. We were worried about education, patient decontamination at hospitals, and distribution of prophylaxis to tens or hundreds of thousands of people in a short time. Now we have those issues under control, and we are reassessing what our next priorities will be.

5. Division of labor. Nobody can do it all, and there's a lot of talent out there. We found ourselves all trying to do the same few things at first. Knowing that each issue had trustworthy people taking care of it freed each of us to concentrate on our own parts of the task.

6. Urgency. We set ourselves a brutal time line because we fully believed that it was our responsibility to ourselves and our community to have a comprehensive plan ready before the Christmas holidays. Since there have been no more anthrax cases for several months, the flame is flickering even in our community. However, the complexity of the job, as well as the length of funding cycles for supplies, training and exercises, requires a stern discipline about setting time goals. It also helps to build in some rewards along the way—internal recognition among the workgroup members, exercises designed to highlight successes, maybe even a party.

7. Civil-military integration. This falls into two categories.

   a. Communities that have embedded or nearby military installations have both an asset and a challenge. Installations are an asset in that they often have resources that can support a local community in an emergency. However, that support works best if detailed arrangement are made ahead of time and there are no unrealistic expectation. The other side of the coin is that installations may depend on the communities around them for a variety of services, including food supply, telecommunications, utilities, support personnel in base jobs, possibly even fire, police and medical services. These critical resources may find themselves double-tasked. This enmeshed relationship need not be a problem for either side, but it will require unprecedented levels of cooperation.

   b. All communities, with or without local installations, may expect to call for federal support in an overwhelming event, and some of that support is likely to be military. This presents opportunities for culture clashes and operational glitches. Get to know what help may be available, how to ask for it, and how to work with your uniformed colleagues. Especially, work with your state National Guard and Joint Forces Command to understand command and control issues and ensure that you can communicate over your radios.

8. Regional approach. The radiological, biological or chemical agent that will respect jurisdictional boundaries has yet to be identified. Small communities will be dependent on their larger neighbors for support, and may be able to reciprocate by offering personnel, hospital beds and other resources to hard-hit cities. Building in regional interoperability will be a challenge in the absence of umbrella organizations, but the time to start is now.

9. Modularity. We designed equipment packages that could be used in multiples—one for a small hospital, three or more for a large one—so that we could purchase, train and share regionally for efficiency and cost savings.

10. Exercises. It doesn't work until you've proved it works. These are hard to do on a grand scale. Start with "open book" discussions, tabletop exercises and tests of small pieces of the larger plan. Build components of medical response onto existing exercises with your fire and police departments or military neighbors. But don't give up on doing a big-picture functional exercise. Nothing else will test all the interrelationships. Just remember that these take a year or two to fund and plan.

What does it take to succeed? The requirements are simple in concept. First, you need the blessing of your senior Health Authority, Emergency Manager and elected officials. Second, you need a "sheepdog" to get and keep key players moving together in the right direction. Third, you need a few credible, knowledgeable champions from key participant groups to set that direction. Fourth, each key organization needs an enthusiast to drive and shape its participation. Finally, there needs to be a mentor to provide meeting space, administrative support and food. We found that good food was sometimes the only bait that brought tired, stressed people to meetings.

In summary, the medical community of San Antonio has done remarkably effective work in bioterrorism response for little cost other than the good will, energy and time of a lot of dedicated people. Much remains to be done in preparedness, both for our community and for the nation. We

have outlined some of the processes that have been effective in our area and that we believe are broadly applicable, and we will be very interested in other communities' success stories. This is a job we must all make up as we go along. I would like to close with an anonymous quotation much favored by Lt Gen Paul Carlton, the visionary Surgeon General of the Air Force, who has encouraged members of the Medical Service to share with our civilian partners for mutual benefit: "The future is not some place we are going, but one we are creating. The paths are not to be found, but made, and the activity of making them changes both the maker and the destination."