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**NATIONAL
HEALTH
POLICY
FORUM**

Preparing for
a Bioterrorist Incident:
Linking the Public
Health and Medical
Communities

October 4-5, 1999
Baltimore & Fort Detrick, Maryland

The
George
Washington
University
WASHINGTON DC

■
SITE VISIT REPORT

*As Thucydides pointed out, hope is an expensive commodity.
It makes better sense to be prepared.*

—Richard Preston, *The Cobra Event*



Contents

Acknowledgments	iii
Executive Summary	iv
Background	1
Objectives	1
Program	1
Impressions	3
Issues for Further Consideration	4
Agenda	5
Federal Participants	7
Biographical Sketches—	
Baltimore and Fort Detrick Participants	9

Executive Summary

As follow-up to the National Health Policy Forum's February 1999 session entitled "Biological Terrorism: Is the Health Care Community Prepared?" (Issue Brief 731), the Forum organized a site visit on October 4 and 5, 1999, to Baltimore and Fort Detrick, Maryland. The site visit, "Preparing for a Bioterrorist Incident: Linking the Public Health and Medical Communities," provided federal congressional and agency staff with the opportunity to learn first-hand how one local area is preparing for the possibility of a bioterrorist incident.

Several themes were stressed throughout the two days, including the following:

- Distinguishing bioterrorism from chemical terrorism.
- Understanding the relationships between various agencies and institutions and their related funding streams.
- Determining how the federal government can be most effective and efficient in assisting those at the local level.
- Identifying preparedness gaps and barriers to change.
- Suggesting areas where the public health and medical communities—the nations's first lines of defense in the event of a bioterrorist incident—can come together to enhance their preparedness efforts.

The consensus from both the group of participants as well as from the panelists was that, although numerous efforts are under way, the United States is ill-prepared to handle casualties from a weapons-of-mass-destruction scenario. Part of the reason lies in the fact that bioterrorism is a relatively nascent public health threat in the United States and presents a significant learning curve. It is clear from NHPF's site visit that a great deal of work remains to be done. The benefits of this work will be far-reaching: not only will the U.S. community be better prepared, but the basic public health infrastructure, which has deteriorated over the years and which forms the foundation of bioterrorism preparedness, will be given a much-needed boost.

Preparing for a Bioterrorist Incident: Linking the Public Health & Medical Communities

BACKGROUND

The nature of terrorism is changing. At the request of Capitol Hill staff, the Forum held a meeting in February 1999 entitled “Biological Terrorism: Is the Health Care Community Prepared?” That session used the Institute of Medicine’s 1999 report “Chemical and Biological Terrorism: Research and Development to Improve Civilian Medical Response” as a springboard for understanding the role the health care community must play in the event of a domestic biological terrorist attack. Speakers—focusing primarily on bioterrorism, as opposed to chemical or radiologic terrorism—highlighted the issue of threat assessment and discussed ways to improve the current level of preparedness as well as steps needed to convert the public health system into the nation’s best form of civil defense.

Several meeting attendees requested that the Forum arrange a follow-up site visit to see first-hand what was happening at the local level. The Baltimore area was selected because of its proximity to Fort Detrick’s U.S. Army Medical Research Institute for Infectious Diseases (USAMRIID) and because of its work on bioterrorism at the local and state levels. In addition to visiting Baltimore, the Forum wanted to highlight the work that is under way at the Department of Veterans Affairs and its regional links to local (Washington, D.C.) hospitals and Metropolitan Medical Strike Teams.

OBJECTIVES

Forum staff structured the site visit around the following themes:

- Distinguishing bioterrorism from chemical terrorism.
- Understanding the relationships between various agencies and institutions and their related funding streams.
- Determining how the federal government can be most effective and efficient in assisting those at the local level.
- Identifying preparedness gaps and barriers to change.
- Suggesting areas where the public health and medical communities—the nation’s first lines of defense in the event of a bioterrorist incident—can come together to enhance their preparedness efforts.

PROGRAM

As the bus departed from Union Station in Washington, D.C., participants were reminded of the difference between chemical and bioterrorism agents and incidents, the variations in incident response plans, and the difficulties inherent in answering questions such as: Who is in charge when an incident occurs? Who is in charge of deciding who is in charge? It quickly became clear from the briefing and the questions that followed that confusion surrounds the chain-of-command issue. It was pointed out, however, that this should not necessarily be surprising, given that large-scale U.S. bioterrorism scenarios are still theoretical.

Baltimore City Health Department: Shoring Up the Public Health Infrastructure

In Baltimore, the site visit opened with a conversation involving the staff of the 200-year-old Baltimore City Health Department regarding the adequacy of the existing public health infrastructure, including surveillance and laboratory capabilities, emergency medical services and communication technologies, the adequacy of mental health services, and training and education programs.

It was explained that the health department’s role in preparing for and responding to a bioterrorist incident is that of the lead agency, a herculean task by any standard. In the event of an incident, health department officials would be called upon to determine how to verify the biologic agent used, who is to be notified, and how they are to be notified, as well as to track patients, establish treatment sites, disperse pharmaceuticals and vaccines, dispose of medical waste, provide public information, coordinate treatment of the sick and worried well, and care for the deceased. Additionally, the health department would be responsible for the long-term tracking of survivors to address medical and mental health needs.

U.S. Army Medical Research Institute for Infectious Diseases

The next stop was Fort Detrick, Maryland. Over lunch, participants were briefed on the work under way at USAMRIID. USAMRIID, which is part of the army’s Medical Research and Materiel Command, is the lead medical research laboratory for the U.S. Biological

Defense Research Program. USAMRIID conducts research to develop strategies, vaccines, drugs and diagnostics, information, procedures, and training programs for medical defense against biological warfare threats and infectious diseases.

A very important component of USAMRIID is its world-renowned reference laboratory, which is designated by the CDC as a reference laboratory for anthrax as well as by the World Health Organization as a reference laboratory for hemorrhagic fevers and arboviruses requiring high levels of biological containment. Among its unique facilities, USAMRIID contains 50,000 square feet of Biosafety Level 3 (containment) laboratory space and 10,000 square feet of Biosafety Level 4 (maximum containment) laboratory space. Arrangements were made for site visit participants to tour the facility and its laboratories.

Weapons of Mass Destruction: A Case Study

To explore interactions and links between local and state health departments and between the departments and the Centers for Disease Control and Prevention, the second day of the site visit opened with a briefing by Maryland Secretary of Health and Mental Hygiene Georges C. Benjamin on weapons of mass destruction. In his remarks, he reiterated that bioterrorism is not new and can present as an overt event, a covert release, or as threats and hoaxes. In any of these circumstances, public health surveillance and reporting are key. The ability to identify sentinel events is crucial, as was made clear during the summer 1999 outbreak of West Nile-Like Viral Encephalitis in New York State. As part of the briefing, this outbreak was presented as a case study:

- August 23: An infectious disease physician reports to the New York City Department of Health (NYCDOH) two human encephalitis cases.
- Upon investigation, NYCDOH initially identifies a cluster of six cases.
- August 30: Active surveillance by NYCDOH shows more cases (eight in a two-square-mile area).
- September 3: Active surveillance expands to Westchester and Nassau Counties.
- Before and concurrent with this outbreak, local health officials observe increased fatalities among New York City birds, especially crows.
- September 7–9: Exotic birds die at the Bronx Zoo.
- Necropsy of birds shows encephalitis and myocarditis.
- Initial diagnosis of St. Louis Encephalitis.
- Actually the first U.S. cases of West Nile Encephalitis—surprise link to bird deaths.

- Spread by common mosquito.
- Disease now of epidemic proportions.
- Threatens to move south through the U.S. as birds migrate.
- Media frenzy ensues.
- Was this bioterrorism?

What was learned was disturbing. According to the experts, although the West Nile incident was tiny, relative to what is contemplated in a weapons-of-mass-destruction scenario, it completely overwhelmed the public health capacity in New York City, a city considered by many as a model of bioterrorism preparedness.

Maryland Institute for Emergency Medical Services Systems and University of Maryland R Adams Cowley Shock Trauma Center

A portion of the second day was devoted to the communications and the emergency medical services coordination that would be necessary in the event of either a bioterrorist or chemical attack. The sophisticated communications systems that would be employed are currently used by first responders—such as emergency medical services and hazardous material (HAZMAT) personnel—in emergency medical situations and chemical incidents.

Participants toured both the Maryland Institute for Emergency Medical Services System (MIEMSS) and the University of Maryland’s R Adams Cowley Shock Trauma Center and had an opportunity to see first-hand how critical it is to have strong ties between emergency medical services (EMS)—whose personnel are the first responders—and health care facilities. As the lead emergency medical services agency, MIEMSS provides state of the art “leadership, direction, expertise, and coordination of resources to continuously improve the efficient and effective provision of EMS throughout the state of Maryland.” Participants came away very impressed with the level of sophistication and the extensive planning that the MIEMSS staff have orchestrated. The consensus among participants was that this is a model to be emulated by other regions.

The Role of the Hospital: Johns Hopkins

A working lunch at the Johns Hopkins Hospital focused on the role and readiness of a health care facility in the midst of a bioterrorist event. The panel discussion covered the waterfront of issues, which included the medical management of over 100,000 patients, vaccination and prophylaxis policy, the potential lack of adequate resources—both supplies and personnel—and the need for better coordination both inside and outside the hospital. Throughout the site visit, almost all the speakers, including

the hospital panel, stressed that physicians today are not trained to look for or think of diseases such as anthrax, smallpox, or viral hemorrhagic fevers, thus making containment much more difficult.

The hospital panelists made it clear that, in addition to the daunting medical challenges that would present, should a bioterrorist attack occur, there would also be significant media, crowd control, health care worker protection, and financial challenges facing hospital personnel.

Regional Links and the Role of the VA

The site visit concluded with a tour of the Veterans Administration (VA) Medical Center in Washington, D.C., including its decontamination unit. After the tour, a panel discussion included presentations highlighting the contributions the VA could make (for example, bed capacity, vaccine stockpiles, medication caches, decontamination, quarantine, and the use of the facility as a secured staging area); the purpose, organization, and funding of Metropolitan Medical Strike Teams (MMST); and the relationship between the VA, MMST, and area hospitals.

It was pointed out that the VA—with its workforce of 15,600 physicians, 1,100 dentists, 58,000 nurses, and 134,000 other staff and its 22,000 acres of land and 4,300 structures at nearly 1,000 locations—is what former Under Secretary for Health Kenneth W. Kizer has called “the best kept secret in American healthcare.” Panelists highlighted that the VA serves as the primary contingency backup to the Department of Defense medical care system and assists the Public Health Service and the National Disaster Medical System in providing emergency medical care to victims of disaster. The devolution of the military health care system will likely make this assistance an even higher priority in the future, because the VA provides many of the physical resources needed to make federal disaster plans work.

IMPRESSIONS

At a post-site visit debriefing held in Washington, D.C., federal participants had the opportunity to reflect on what they learned. Their observations and impressions are summarized below.



The United States is not prepared for a large-scale bioterrorist incident.

The U.S. civilian health care community—medical and public health—will be woefully unprepared to handle all aspects of a weapons of mass destruction scenario:

Pre-event. Surveillance, physician and laboratory expertise and facilities capable of identifying rare and exotic

agents, vaccine and other pharmaceutical/supply stockpiles, information sharing, and training are currently inadequate.

During the event. The chain of command is currently unclear, and treatment capabilities, prophylaxis, disaster management, media management, health care facility capacity, and the ability to handle the worried well are inadequate.

Post-event. Methods and resources for disposing of the deceased (physically and with respect to religious and cultural sensitivities) and meeting mental health needs of civilians, including health care and first responder personnel, are currently inadequate.

Reaction to a bioterrorist threat would be very different from that required by a chemical attack or major accident. Nevertheless, responders would need to draw on existing expertise, relationships, and infrastructure. Most of these, however, are underfunded, understaffed, and ill-equipped to handle the day-to-day activities on a routine basis.

Compounding the problem is the cultural and communication gap and lack of coordination between the medical community and public health community, not just in preparing for bioterrorism but in day to day reporting, surveillance, and diagnosis. For example, some of the speakers underscored the lack of knowledge on required reporting to the local health department and to internal infection control programs on the part of emergency department personnel, private practitioners (hospital and non-hospital based), and attending physicians. Likewise, there exists an insufficient reporting system from hospitals to local health departments. In Baltimore, the current practice involves waiting for lab referrals for reportable diseases or reliance on a physician with third-world biological disease knowledge to establish a diagnosis and report it to the local health department.

Challenges exist within individual health care facilities as well. It became clear that, although internal hospital committees have been formed and that staff take the possibility of a bioterrorist incident seriously, *current* hospital disaster plans make insufficient allowance for the likely tremendous patient (and worried well) volume as well as inadequate preparation for the unique aspects of such a disaster. Several panelists throughout the two days mentioned that more education and closer working relationships between the public health and medical communities would go a long way toward minimizing some of these inadequacies. For example, a number of participants repeatedly emphasized the need within the medical community for extensive training in the issues surrounding chemical and biological agents, including reporting requirements, where to call for assistance, and what to expect within the first 24, 48, and 72 hours from local and state health departments.

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Efforts to identify best solutions and appropriate players need to intensify.

Based upon what was learned during the site visit, it became clear that the number of technical and political problems to overcome is staggering. For example, the preparedness efforts to date tend to be nonintegrated piecemeal approaches or fixes. No systematic plan for preparedness exists. Everywhere, participants found a need for improvement of coordination at and among all three levels of government—local, state and federal—as well as among and between the public and the private sectors. In addition, health planning will need to be superimposed over a market-based system, and provisions for access to the health care system (despite the limits of insurance) will be paramount.

Responding to such challenges, many hardworking, dedicated people have committed themselves to preparing for a bioterrorist attack. The site visit highlighted several steps, some already under way, that hold promise. These include the following:

- Defining the base capability necessary.
- Agreeing upon uniform standards and case definitions. Developing standardized fact sheets for use by health care personnel as well as the media. Developing a national Web site listing best practices.
- Constructing one standardized disaster plan that allows for local flexibility (rather than each agency and professional association developing separate ones), addressing issues such as who is to receive prophylaxis and when, what to do and who is in charge during the first hours until help arrives, and how to deal with crowd control.
- Articulating the role of the federal government in knowledge development and transfer.
- Overcoming turf problems and clarifying the roles of all players. Figuring out now, in advance of an incident, the legal authority determining who is in charge under different scenarios.
- Reforming public health laws to address bioterrorism concerns.
- Working out a shared financing strategy for all levels of government, as well as the private sector.
- Building upon and improving resource platforms that currently exist, such as USAMRIID, the VA's national database of specific experts, the National Disaster Medical System, and CDC's databases and laboratories.
- Improving the efficiency and logistics of moving large quantities of reagents, medicines, and vaccines quickly and safely.

- Closing the gaps that exist between the medical and public health communities. Encouraging the American Medical Association and the American Hospital Association to take a greater leadership position.
- Improving public health linkages with intelligence agencies, poison control centers, veterinarians, first responders, mental health care workers, clergy, and national experts and resources. (Establishing toll-free numbers with a single point of entry has been found to be extremely helpful.)
- Improving reporting speed and accuracy of communicable diseases and cluster outbreaks to public health departments.
- Planning, communication, training (for all personnel—from mail room staff to hospital volunteers, clerks, and health care personnel), and often repeated testing.

ISSUES FOR FURTHER CONSIDERATION

As part of their evaluation of the site visit, federal participants were asked what questions were raised during the two days that they would like the Forum to pursue. These were their replies:

- Where do we go from here?
- What is the responsibility of providers to protect the public health in the event of a catastrophe: Who will be the “smallpox hospital”?
- How do other states and regions compare in readiness to Baltimore?
- What are the roles and responsibilities of the federal, state, and local governments, given the diminished capability of public health over the past 15 years?
- Who is in charge? How are the various federal agencies coordinated, including nonhealth agencies such as the Department of Justice, the Department of Energy, the Department of Transportation, the Federal Bureau of Investigation, the Central Intelligence Agency, the Federal Emergency Management Agency, the State Department, the National Security Council, the military, and the White House? How are they coordinated with state and local officials?

Agenda

Monday, October 4, 1999

- 8:15 am Board bus at Union Station, Washington, D.C. (box breakfast provided)
- 8:30 am Departure for Baltimore (briefing en route)
- OVERVIEW: THE DIFFERENCE BETWEEN CHEMICAL AND BIOTERRORISM AGENTS AND INCIDENTS; DIFFERENT TYPES OF INCIDENT RESPONSE PLANS; WHO'S IN CHARGE? WHO'S IN CHARGE OF DECIDING WHO'S IN CHARGE?
- Frederick J. Manning, Ph.D.**, *Senior Program Officer*, Health Science Policy Program, Institute of Medicine, National Academy of Sciences
- 10:00 am Presentation and discussion [*Maxi Collier Conference Room, Baltimore City Health Department*]
- SHORING UP THE PUBLIC HEALTH INFRASTRUCTURE
- Peter Beilenson, M.D., M.P.H.**, *Commissioner of Health*, Baltimore City Health Department
Irene Lumpkins, *Director*, Field Health Services, and *Chair*, Health and Safety Remediation Committee for the Domestic Preparedness Program
- 11:00 am Coffee break
- 11:30 am Question and answer session
- Noon Departure for Fort Detrick, Maryland
- 1:30 pm Working lunch and briefing [*Dalrymple Conference Room, Building 1425, U.S. Army Medical Research Institute for Infectious Diseases (USAMRIID)*]
- USAMRIID: A UNIQUE NATIONAL RESOURCE
- Lt. Col. George W. Korch, Jr., Ph.D.**, *Deputy Commander*, USAMRIID
Comdr. Randall C. Culpepper, U.S. Navy Medical Corps, *Assistant Chief*, Operational Medicine Division, USAMRIID
Lt. Col. Erik A. Henchal, Ph.D., *Chief*, Diagnostic Systems Division, USAMRIID
- 2:15 pm Tour of USAMRIID facility and labs
- 3:00 pm Departure for headquarters hotel
- 4:30 pm Check-in, Admiral Fell Inn, Fells Point, Baltimore
- 6:00 pm Reception [*Rooftop Terrace, Admiral Fell Inn*]
- 7:00 pm Dinner [*Captain's Room, Admiral Fell Inn*]

Tuesday, October 5, 1999

- 7:30 am Breakfast [*Mitchell/Moran Room, Admiral Fell Inn*] and checkout
- 8:30 am Bus departure for Maryland Institute for Emergency Medical Services Systems (MIEMSS)

- 9:00 am Briefing [*Room 212, Conference Center, MIEMSS*]
 WEAPONS OF MASS DESTRUCTION
Georges C. Benjamin, M.D., *Secretary*, Maryland Department of Health and Mental Hygiene
- 9:30 am Question and answer session
- 9:45 am Tour of MIEMSS facility
Richard L. Alcorta, M.D., *EMS Medical Director*, State of Maryland
- 10:45 am Coffee break
- 11:00 am Tour of University of Maryland Trauma Center
Thomas M. Scalea, M.D., *Chief of Trauma and Critical Care*, and *Physician in Chief*, R Adams Cowley Shock Trauma Center, University of Maryland Medical System
Carnell Cooper, M.D., *Assistant Professor*, General Surgery, University of Maryland School of Medicine, and *Trauma Surgeon*, R Adams Cowley Shock Trauma Center, University of Maryland Medical System
- 12:30 pm Departure for Johns Hopkins University Hospital
- 1:00 pm Working lunch and panel discussion [*Smith Room (212), Billings Administration Building*]
 THE ROLE OF THE HOSPITAL
John G. Bartlett, M.D., *Chief*, Division of Infectious Diseases, Johns Hopkins University Hospital, and *Co-Director*, Johns Hopkins Center for Civilian Biodefense Studies
Trish Perl, M.D., M.Sc., *Assistant Professor*, Division of Infectious Diseases, and *Hospital Epidemiologist*, Johns Hopkins University Hospital
Christina L. Catlett, M.D., *Assistant Chief of Service*, Department of Emergency Medicine, Johns Hopkins University Hospital
Gary M. Stephenson, M.S., *Associate Director for Media Relations*, Johns Hopkins University Hospital
- 2:00 pm Question and answer session
- 2:30 pm Departure for Veterans Administration Medical Center, Washington, D.C.
- 4:00 pm Tour of Decontamination Unit [*Veterans Administration Medical Center*]
Philip A. Forbes, *Lead Area Emergency Manager*, Washington, D.C., Department of Veterans Affairs
Kenneth A. Steadman, M.D., *Emergency Physician*, Veterans Administration Medical Center, and *Chair*, Emergency Preparedness Committee, Washington Veterans Administration Hospital
- 5:00 pm Panel discussion [*Room 4A138, Abraham Lincoln Auditorium, Veterans Administration Medical Center*]
 REGIONAL LINKAGE AND THE ROLE OF THE VA
Kristi L. Koenig, M.D., *Director*, Emergency Management Strategic Healthcare Group, and *Principal Advisor on Emergency Management and Disaster Medicine*, Department of Veterans Affairs
Joseph A. Barbera, M.D., *Director of Disaster Medicine*, George Washington University Hospital
William M. Moultrie, *Captain*, Arlington County Fire Department, and *Program Manager*, Metropolitan Medical Strike Team
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- Frederick J. Manning, Ph.D.**, *Senior Program Officer*, Health Science Policy Program, Institute of Medicine, National Academy of Sciences
- 10:00 am Presentation and discussion [*Maxi Collier Conference Room, Baltimore City Health Department*]
- SHORING UP THE PUBLIC HEALTH INFRASTRUCTURE
- Peter Beilenson, M.D., M.P.H.**, *Commissioner of Health*, Baltimore City Health Department
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Federal Participants

Cindy Bascetta

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Maternal and Child Health Bureau
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U.S. Congressional Budget Office

Amy McMillen

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Ellen Morrison

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Subcommittee on National Security,
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House Committee on Government Reform
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U.S. House of Representatives

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Director, Washington Office
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Wendy Taylor

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Malcolm Williams

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Judith Miller Jones

Director

Robin Strongin

Senior Research Associate

(Site Visit Director)

Dagny Wolf

Program Coordinator

(Site Visit Arrangements Coordinator)

Biographical Sketches— Speakers and Panelists

Richard L. Alcorta, M.D., is medical director for Maryland Emergency Medical Services as well as an emergency specialist/physician paramedic liaison at Suburban Hospital in Bethesda. A fellow of the American College of Emergency Physicians, Dr. Alcorta received his M.D. degree from the Howard University School of Medicine in Washington, D.C. He is certified as a Maryland State EMT paramedic instructor, a hospital hazardous material instructor, and an advanced trauma life support instructor. He has received numerous awards, including the Governor's Salute to Excellence from Gov. William D. Schaefer.

Joseph A. Barbera, M.D., is director of disaster medicine at George Washington University Hospital, where he also serves as a member of the Medical Faculty Associates Productivity Committee. In his additional capacity as an assistant professor at the university's School of Medicine, Dr. Barbera provides the Emergency Medicine Morning Conference Lecture Series and serves as guest lecturer for the Disaster Response Planning and Management Conference. He also served as the primary author of "Urban Search and Rescue Medical Team Training Course," the "gold standard" four-day curriculum taught to all physicians and paramedics participating in the Federal Emergency Management Administration National Urban Search and Rescue System, and established the National Capital EMS and Disaster Medicine Fellowship. Dr. Barbera's current appointments include medical officer, Office of U.S. Foreign Disaster Assistance, Agency for International Development, International Search and Rescue Team, and advisor, Office of the Attending Physician, United States Capitol. Dr. Barbera's community service includes being medical team manager for the Fairfax County Urban Search and Rescue Task Force and chair of the Emergency Preparedness Committee of the District of Columbia Hospital Association.

John G. Bartlett, M.D., is chief of the Division of Infectious Diseases and director of the AIDS Care Program at Johns Hopkins Hospital. In addition, Dr. Bartlett serves as co-director of the Johns Hopkins Center for Civilian Biodefense Studies. After graduating from Dartmouth and receiving his M.D. degree from Upstate Medical Center in Syracuse, New York, Dr. Bartlett served on a fever ward in Vietnam. He completed his infectious disease training at Brigham Hospital in Boston and at UCLA and later moved to the Boston Veterans' Administration Hospital.

Peter Beilenson, M.D., M.P.H., was appointed commissioner of Health for Baltimore City by Mayor Kurt L. Schmoke in 1992. He is responsible for health policy for the city and for the management of a \$160 million budget and 1,300 employees. In 1996 Dr. Beilenson was recognized nationally by his peers as the first-ever recipient of the Milton and Ruth Roemer Award for creativity by a local health official. In 1998, he received the Laughlin Distinguished Public Officer Award from the Medical and Chirurgical Faculty of Maryland, the state medical society. Dr. Beilenson graduated cum laude from Harvard College and earned his medical degree from Emory University. He received his M.P.H. degree from Johns Hopkins in 1990 while completing his residency in preventive medicine.

Georges C. Benjamin, M.D., was appointed secretary of Health and Mental Hygiene by Gov. Parris N. Glendening, effective May 1, 1999. He oversees an agency with more than 10,000 employees and a \$3.7 billion budget. Dr. Benjamin is a graduate of the Illinois Institute of Technology and the University of Illinois College of Medicine. He is board certified in internal medicine and is a fellow of the American College of Physicians. His early career experience includes serving in administrative positions as chief of the Acute Illness Clinic at Madigan Army Medical Center, chief of Emergency Medicine at Walter Reed Army Medical Center, chairman of the Department of Community Health and Ambulatory Care at the District of Columbia General Hospital, and health commissioner for the District of Columbia. Dr. Benjamin leads the state's public health efforts to combat biological and chemical terrorism and was a member of the Institutes of Medicine's committee on Research and Development Needs for Improving Civilian Medical Response to Chemical and Biological Terrorism Incidents.

Christina L. Catlett, M.D., is assistant chief of service in the Department of Emergency Medicine at Johns Hopkins Hospital. While infectious disease specialists would deal with the early stages of a biological attack, emergency physicians would be called to triage and treat patients if an outbreak spreads. Dr. Catlett is an emergency medicine specialist who spends time thinking about and planning for such a scenario. She has published articles and made presentations on the topic and has taken part in a U.S. Army hospital training program for biological, chemical, and nuclear warfare. She serves on the Hopkins Bioterror-

ism Response Task Force, charged with planning for such an attack, and is a consultant to the Johns Hopkins Center for Civilian Biodefense Studies. Dr. Catlett received her M.D. degree from the University of North Carolina.

Comdr. Randall C. Culpepper, U.S. Navy Medical Corps, is currently stationed at the U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID) at Fort Detrick, Maryland. USAMRIID conducts research to develop vaccines, drugs, and diagnostics to protect U.S. service members from biological warfare threats and endemic infectious diseases. Comdr. Culpepper serves as assistant chief of USAMRIID's Operational Medicine Division and heads the institute's education and training programs, lecturing and consulting extensively on the medical management of biological warfare and terrorism casualties. Commander Culpepper graduated from the University of Colorado School of Medicine in 1984. Following his internship at Naval Hospital Jacksonville, he completed flight surgeon training at the Naval Aerospace Medical Institute at Naval Air Station (NAS) Pensacola and a tour with Patrol Squadron Twenty-Four at NAS Jacksonville. He completed his residency in general preventive medicine and public health at the University of Washington in Seattle while also earning a master's degree in public health. His previous duty assignments include head of occupational health/preventive medicine, Naval Hospital Great Lakes; officer in charge, Navy Environmental and Preventive Medicine Unit 7 in Italy, and head of quality management, Naval Hospital Sigonella.

Philip A. Forbes is the Department of Veterans' Affairs (DVA) area emergency manager for Washington, D.C., and is responsible for a wide spectrum of emergency management issues. Mr. Forbes serves on several committees and task forces and in October 1998 was appointed to serve on the mayor's District of Columbia Emergency Medical Services Advisory Committee. Mr. Forbes is a 1999 graduate of the U.S. Army Chemical Warfare School. Prior to his work at the DVA, Mr. Forbes served as a contractor to the U.S. Customs Service where he was the senior management analyst and project leader for the Aerostat Joint Program Office. The Aerostat Program consisted of high-altitude surveillance by balloon to aid law enforcement officials in drug interdiction efforts along the southwest border of the United States. Mr. Forbes served from 1960 to 1984 in the U.S. Marine Corps and had several overseas tours: two in Vietnam and one each in Santa Domingo, Cuba, and Okinawa. He is the recipient of eight awards for valor, including two Purple Hearts.

Kristi L. Koenig, M.D., a board-certified emergency physician, is director of the Emergency Management Strategic Healthcare Group, where she serves as the principal advisor on emergency management and disaster

medicine to the Office of the Under Secretary for Health, Veterans Health Administration in the Department of Veterans Affairs. Dr. Koenig's previous professional experience includes serving as the director of prehospital and disaster medicine, Alameda County Medical Center, in Oakland, California, and associate professor on the emergency medicine faculty at the University of California-San Francisco. She spent time as a consultant in the Accident and Emergency Department at St. George's Hospital National Health Service Trust in London, England, where she held positions as co-director of the Emergency Department, director of undergraduate teaching, and honorary senior lecturer at the University of London. Dr. Koenig is an honors graduate in applied mathematics from the University of California-San Diego and received her medical degree from the Mount Sinai School of Medicine in New York.

Lt. Col. Erik A. Henchal, U.S. Army Medical Service Corps, is chief, Diagnostic Systems Division, USAMRIID. In addition, he is a research coordinator for Common Diagnostic Systems for the U.S. Army Medical Research and Materiel Command. Lt. Col. Henchal received his Ph.D. degree in microbiology from the Pennsylvania State University. He has served in positions of increasing responsibility in the U.S. Army, which included work in Africa, Thailand, and Germany. His research has focused on developing improved diagnostic assays and reagents for diseases of military importance. He is an author or co-author on more than 27 scientific papers.

Lt. Col. George W. Korch, Jr., is deputy commander of USAMRIID at Fort Detrick, Maryland. Prior to assuming that post, he served as chief of USAMRIID's Virology Division from 1996 to 1999. Earlier in his career, he held the positions of research entomologist and chief of the Rapid Diagnosis Department at the institute. Other assignments have included staff officer, Medical Biological Defense Research Program, U.S. Army Medical Research and Materiel Command; Lyme Disease program manager, U.S. Army Environmental Hygiene Agency; and commander, Fifth Medical Detachment, Seoul, Korea. Lt. Col. Korch holds a Ph.D. from the Johns Hopkins University School of Hygiene and Public Health. His scientific specialties include mammalogy and entomology; he has conducted research on hantaviruses and rickettsial diseases.

Irene Theresa Lumpkins has held the position of director, field health services/medical assistance transportation, Baltimore City Health Department, for seven years. She also serves as chairperson, Health and Safety Remediation Committee, Domestic Preparedness Program, and chairperson, Biological Metropolitan Medical Record Response System. Previous positions include 5 years as

licensing officer, Commercial Ambulance Services, and 12 years as director, Emergency Medical Services Team.

Frederick J. Manning, Ph.D., is a senior program officer in the Health Science Policy Program at the Institutes of Medicine (IOM). In six years at IOM, he has served as study director for projects addressing a variety of topics ranging from medical isotopes to potential hepatitis drugs, blood safety and availability, rheumatic disease, and resource sharing in biomedical research. Most recently, Dr. Manning served as study director for an IOM project that resulted in a report entitled “Chemical and Biological Terrorism: Research and Development to Improve Civilian Medical Response.” Prior to joining IOM, Dr. Manning spent 25 years in the U.S. Army Medical Research and Development Command, serving in positions that included director of neuropsychiatry at the Walter Reed Army Institute of Research and chief research psychologist for the Army Medical Department. Dr. Manning earned his Ph.D. degree in psychology from Harvard University.

Capt. William “Mike” Moultrie is a 27- year veteran of the Arlington County Fire Department. For the past seven years he has served as the deputy coordinator of emergency services. He is a certified emergency manager with the International Association of Emergency Managers in Falls Church, Virginia, and a Virginia state-certified hazardous materials technician. Captain Moultrie is the program manager for the Washington-area Metropolitan Medical Strike Team and currently serves as an assistant task force leader and lead instructor for the team, the first of its type in the nation. In addition, he is a senior instructor for the federal Domestic Preparedness Training Program, providing training to first responders across the nation. Captain Moultrie led the team that has developed an improved method of providing mass casualty decontamination for weapons of mass destruction incidents. This new method was first tried in “Exercise Cloudy Office” at the Pentagon in May 1998.

Col. Gerald W. Parker, D.V.M., is commander of USAMRIID at Fort Detrick, Maryland. Prior to assuming command of USAMRIID in March 1998, Colonel Parker served in a variety of assignments throughout his 20-year army career, including research area director for the Medical Chemical and Biological Defense Research Program at the U.S. Army Medical Research and Materiel Command. Colonel Parker’s military awards include the Meritorious Service Medal with three oak leaf clusters, the Army Commendation Medal with two oak leaf clusters, and the Overseas Ribbon. He is a recipient of the Surgeon General’s “A” Proficiency Designator in Physiology. Colonel Parker holds a D.V.M. degree from Texas A&M University and a Ph.D. in physiology from Baylor College of Medicine.

Trish Perl, M.D., M.Sc., is an assistant professor in the Division of Infectious Diseases and hospital epidemiologist at Johns Hopkins Hospital. Dr. Perl has devoted her career to tracking and preventing hospital-based and hospital-acquired infections. Her concern for the increasing problem of hospital-based outbreaks spurred her to help establish guidelines for preventing the spread of antibiotic-resistant organisms—the so-called “superbugs.” Dr. Perl is also an expert in general infectious disease treatment and tropical infectious diseases. She received her M.D. degree from the University of North Carolina and earned her M.Sc. from McGill University. Dr. Perl is also a member of the Johns Hopkins Center for Civilian Biodefense Studies.

Thomas M. Scalea, M.D., F.A.C.S., F.C.C.M., has been physician-in-chief at the R Adams Cowley Shock Trauma Center and chief of trauma and critical care since 1997. He also holds the following positions at the University of Maryland at Baltimore: professor of surgery; chief, Division of Trauma Surgery, Department of Surgery; and director, Program in Traumatology. He graduated from the Medical College of Virginia in 1978 and served his internship in medicine and surgery at St. Joseph’s Hospital in Syracuse, New York, and his residency and chief residency in surgery at Upstate Medical Center, Syracuse.

Gary M. Stephenson, M.S., is associate director for media relations at Johns Hopkins Hospital. Dealing with the media and getting accurate information to the public during a bioterrorism attack is the responsibility of hospital and government public relations officials. As an award-winning former medical and science journalist, Mr. Stephenson understands how reporters work and knows how to present critical information to the public. The work that he and others in similar positions do in conveying the concerns and cautions of hospital staff may make the difference between an isolated outbreak and widespread mayhem. Mr. Stephenson joined Hopkins in 1996 after serving in a similar position at the University of Maryland at College Park. His news beats at Hopkins include the business of medicine and the areas of re-engineering, outcomes research, clinical practice guidelines, and corporate communications. He also serves on the Hopkins Bioterrorism Response Task Force.



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