Richard Serino
Chief of Department, Boston EMS
Senate Subcommittee on Bioterrorism and Public Health Preparedness
***Local Planning and Coordination for Medical Preparedness* – Written Responses**
April 5th, 2006

1) Effective medical response to a national catastrophe requires a sufficient number of medical personnel. Establishing alternative care sites will only be effective if they are staffed with trained health care providers. Currently, the federal government possesses several mechanisms to support this activity - NDMS, ESAR-VHP, Medical Response Corps, and the Commissioned Corps. How should the recruiting, credentialing, training, and managing of permanent and temporary federal health care providers best be accomplished? How can the federal government best organize and deploy health care providers to assist in the response to a national emergency?

The staffing issues that will arise during a medical crisis are some of the most challenging surge planning issues that local, state and federal officials face. The programs in place to address these challenges represent a good start in the effort to provide adequate trained staff, however these programs must be expanded and coordinated. Specifically, the National Disaster Medical System must be expanded and better supplied; he Emergency System for Advanced Registration of Volunteer Health Professionals must be fully implemented and expanded; and the Medical Reserve Corps must be fully funded and supported. Additionally, it is essential to promote and assist local efforts to address surge capacity needs.

The National Disaster Medical System must be expanded and adequately supported. The Disaster Medical Assistance Teams (DMAT) are primarily local and regional organizations that can be federalized during a crisis. For the most part, the DMATs are managed in states that face a regular need for medical surge capacity. While this often means that the teams are very well trained, it also means that during the time of a crisis teams are being pulled from locations where the personnel are still needed. For example, many of the Florida teams that responded to the Gulf Coast had just recently been involved in hurricane response in their own jurisdictions. Furthermore, the current structure of the DMATs, mandating a “three-deep” format, still does not provide adequate depth to insure full mobilization. The depth is not uniform across all specializations and thus leads to teams with significant gaps. The DMAT teams need to be expanded in numbers and in distribution. Through funding and other incentives, all states should be encouraged to help establish teams, and those teams should have sufficient depth to field well rounded medical organizations during a crisis.

While federalized assets such as the DMATs provide one critical surge resource, volunteers will provide the bulk of any medical response during a sustained crisis. The credentialing and organization of these volunteers provides an ongoing and unique challenge. While programs such as the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) are steps in the right direction, they have yet to make a significant impact on the local level. The program is only in its very initial

stages of rollout and it does not address many of the broader credentialing issues likely to come up during a crisis. ESAR-VHP must be fully implemented and expanded in conjunction with the Medical Reserve Corps, but it must also be supplemented with a broader national initiative. The federal government must push for a way to achieve universal credentialing for medical professionals involved in disaster response. If there is even the slightest chance of responding to a crisis, the individual must have pre-existing credentials and these must be recognizable across local and state boundaries. A credentialing program could include a universal symbol added to a driver's license or an additional national card issued during the time of initial credentialing.

Additionally, volunteer organization remains a distinct challenge. The Medical Reserve Corps must be completely funded. While surge capacity is a universally recognized issue, the funding for the Medical Reserve Corps is constantly threatened. The program must be expanded through more effective recruitment, advertising, and improved training. The program should also be organized in conjunction with further efforts.

Finally, In Boston, one of our great successes has been the Metropolitan Medical Response System staff sharing agreement. The MMRS agreement applies to staff and equipment and establishes that participating institutions cover liability and compensation for their staff, whether it is to help the city or another health care facility. Furthermore, the sending institution guarantees the staffs' credentials. The agreement has been implemented three times, twice for immunization clinics for Hepatitis A outbreaks and once during Hurricane Katrina. Efforts like the MMRS agreement provide the basis for expanded surge capacity and can serve as a model for state and federal efforts.

Once our volunteer programs are guaranteed long-term support, they need to be integrated into a comprehensive response plan. Those with experience, specifically the DMATs and the military will always best perform local response at the site of a disaster. Shelters and overflow hospitals are perfect places to Incorporate ESAR-VHP and medical reserve corps volunteers. If leadership and organization can be incorporated from the various hospitals, as our MMRS staff sharing agreement has done in Boston, these groups will be up and running faster. Additionally, if we are to guarantee these volunteers will show and be able to perform to their maximum capacity then we must guarantee that their workers compensation and liability protection is covered. Finally, these groups can provide added service at vaccination clinics and during the reception of displaced persons.

2) The medical preparation for, and response to disasters requires significant logistical support - medical supplies, pharmaceuticals, transportation, medical evacuation, etc. What is the most effective way to optimally support a federal medical response? Which federal agency should take the lead?

During a large-scale medical response to a crisis, the primary logistical challenge is not the initial one, but the immediate follow-on response. Specifically, in addressing the needs of the National Disaster Medical System and the Disaster Medical Assistance Teams, the medium term logistical support requirements must be re-examined.

DMATs are specifically designed to deploy with a 72hr supply of materials. One of the great successes of the DMATs was the initiative to provide all teams with dedicated trailers for pre-packaged deployment. This, however, has not solved the issue of supply, both in terms of immediate needs and longer-term requirements. Many DMATs are unable to sustain sufficient supplies for many types of deployments. In particular, there remain outstanding equipment requirements that must be addressed. While these needs are specific to each team, for example some Massachusetts teams lack environmental control units for their medical tents, it creates a larger problem during a deployment, critical time is spent trying to acquire or borrow needed equipment. Furthermore, while the teams do deploy with a 72-hour supply, the follow-on for this supply is inadequate. One suggestion is to develop additional DMAT caches such that a replacement 72-hour cache is immediately deployed behind a DMAT team. This way, as a team runs out of supplies, they need not spend critical time tracking down specific items, but will always have a complete additional stock of supplies waiting to fill in needs.

Since the DMATs were incorporated into FEMA, logistics have improved: they now have emergency pharmaceutical caches, trucks, warehouse space, and a radio cache ready for deployment. However, there is still much to be done. For example, in the Katrina response, providers found that only certain antibiotics could be used for soft tissue wounds because of regional variation in the bacteria. FEMA logistics was unable to process this change from the usual antibiotic cache even after several weeks. Clearly, we need strong logistics, with a medical background.

Logistical needs are not confined to the DMATs. The federal government must find a way to better address equipment needs during a surge incident. The National Pharmaceutical Stockpile and the Strategic National Stockpile are critical assets, however, they are not well integrated into local response capabilities. While the need for confidentiality and security in these caches is understandable, they are only useful if the people who use the equipment know what they will find and are familiar with its use. Federal and local agencies must find a way to coordinate the security needs of these stockpiles with the practical needs of efficient deployment.

3) National medical preparation and response to mass casualties is dependent upon integrating multiple components, including a largely private health care delivery system. What steps must be taken to foster a more coordinated response that includes a strong public-private partnership?

Federal, state, and local governments must pursue every opportunity to incorporate the medical community into planning and training. The worst possible outcome is for people to be exchanging business cards on the day of a crisis. It is only

through ongoing coordination, exercises, and trainings that full integration is maintained. In Boston, we have had real success by insuring the medical community has a seat in homeland security planning and discussions, by including the medical community in regular exercises and drills, and by providing effective training that spans disciplines.

Locally, we have learned the value of existing relationships. Our successes in medical planning come from bridging the gap between a well-integrated medical community and the public safety and federal agencies that play central roles in homeland security and emergency preparedness. As the result of extensive experience working with the Conference of Boston Teaching Hospitals to manage disaster planning in the city as well as more mundane day-to-day emergency planning, there is an existing group of local officials and private organizations that have worked hand in hand for years. By establishing and carrying forward committees and organizations that address planning and response issues, the people who will have to work together in a disaster already know each other. Furthermore, by including the medical community in the planning process, many people have learned how important such planning is. There is now a seat for the medical community on the U.S. Attorney's Joint Terrorism Task Force and the Anti-Terrorism Advisory Council. The medical community is an integral part of Boston's Homeland Security planning, and while some formal structures are still missing, they now have a seat at the table.

One of our lessons learned is that the medical community needs to be considered part of the critical infrastructure. Communications, infrastructure protection, and integration into existing emergency management structures are all tasks that flow from this acceptance of the private medical infrastructure into the public response community.