Bioterrorism Preparedness Coordination: An Ataxic Saga Continues

Bruce Clements, MPH[a]
R. Gregory Evans, PhD, MPH[a]

In spite of successes achieved in the war on terrorism and notwithstanding the tremendous investments recently made in our nation's security, an undercurrent of uneasiness still exists among those engaged in preparedness. As the 1990s drew to a close, recognition of the emerging threat of bioterrorism accelerated. The call went out heralding the need for closer collaboration among federal, state, and local agencies to combat this threat.[1,2] Academicians, advisory committees, and government auditors agreed that better coordination is needed at all levels of government.[3–5] In 2001, we observed our first bioterrorism fatalities and experienced an unprecedented spending campaign to prepare for future attacks. In spite of our best efforts, we in public health are still apprehensive. In spite of our progress toward better preparedness, we lack confidence in our efforts.

There is cause for this anxiety. The barriers to enhancing our collaborations are deeply ingrained in our federal spending processes. On January 31, 2002, the U.S. Department of Health and Human Services (DHHS) sent letters to state governors outlining how much money each state would receive from the $2.9 billion bioterrorism appropriations bill that President Bush had signed into law three weeks earlier. From receipt of that announcement, the states were given only six weeks to submit a detailed plan for responding to a bioterrorism attack or other public health emergency and strengthening core public health capacities related to preparedness.[6]

Although the sense of urgency is understandable given the events of 2001, this was not an effective approach for promoting the necessary collaboration among federal, state, and local governments. Furthermore, these funding infusions do not generate sustainable progress for public health preparedness. This funding approach only causes further division and duplication of efforts. The timeline for states to respond to DHHS was so severely compressed that there was little coordination between the states and those working on preparedness at the local level. Each state was required to conduct separate needs assessments for the preparedness training of their health care and public health workforce. Rather than mandating this assessment by each of the 50 states,

[a]Centers for the Study of Bioterrorism and Emerging Infections, School of Public Health, St. Louis University, St. Louis, MO

Address correspondence to: Bruce W. Clements, MPH, Associate Director, Centers for the Study of Bioterrorism and Emerging Infections, School of Public Health, St. Louis University, 3545 Lafayette Ave., Ste. 353, St. Louis, MO 63104; tel. 314-977-3221; fax 314-977-8150; e-mail <clements@slu.edu>.

© 2004 Association of Schools of Public Health

substantial resources would be saved by carefully examining assessments already completed and accomplishing a single national needs assessment to fill in the gaps. In response to findings derived from each assessment, many state health departments are embarking upon curriculum development for key clinical and non-clinical professionals in their state. Once again, development of this core curricular material by a single organization could achieve cost savings, standardization, and improved quality.

Detailed response plans addressing topics ranging from epidemiological surveillance to mass care and risk communication were required of each state. These plans were compiled and submitted to the Centers for Disease Control and Prevention (CDC) so quickly that they did not incorporate adequate input from the local level. Substantial efforts have been expended by major cities to develop regional plans addressing the same issues CDC required from the states. The funding of local public health preparedness has primarily been a function of the Metropolitan Medical Response System (MMRS) program of DHHS' Office of Emergency Preparedness (OEP). Until recently, the state public health planning coordination overseen by CDC and the local terrorism response planning overseen by OEP had both been accomplished under the larger umbrella of DHHS. With the establishment of the U.S. Department of Homeland Security, many DHHS preparedness functions are being transferred to the new department, including the OEP.[7] The consolidation of these functions may mark the beginning of a new era of planning coordination. However, the challenges of these sweeping changes include preservation of corporate memory, sustainment of priorities, and incorporation of bioterrorism preparedness planning into the intricate operations of our public health infrastructure. Concerns are rising that the incorporation of public health preparedness under the Department of Homeland Security may further disunite these activities from essential public health functions and undermine the integration of bioterrorism preparedness planning into our existing public health infrastructure.

In recent years, the MMRS program has been a hallmark of local preparedness planning. Underway since 1997, this initiative has provided planning support and guidance to more than 100 U.S. cities. MMRS has funded the preparedness efforts of 20 to 25 major U.S. cities each year for five of the past six years (1997, 1999–2002). Unlike typical grants or cooperative agreements used by the federal government to provide preparedness support for state and local activities, MMRS uses contracts that support development of products or "deliverables." These contracts require the submission of products that include detailed documentation of the planning and organization for a regional response to a terrorist attack. This contract approach builds in greater accountability since the funding is disbursed incrementally as each "deliverable" is submitted.

Perhaps the greatest flaw in this process, however, is the designation of one organization in a region as the lead agency and recipient of MMRS funds without mandates to include all significant response organizations in the defined region. Although the MMRS programs are intended to be regional in nature, much of the planning and preparedness accomplished through them stops at the political boundaries of the funded agencies. Even within the city or county in receipt of the funding, there is frequently inadequate participation from segments of the response community. MMRS contracts also circumvent state planning officials. As a result of this approach, many state planners have not integrated the existing MMRS-sponsored plans of their major cities into the state response plans. In spite of the MMRS program's limitations, it still stands out as one of the more successful investments made in our nation's preparedness.

Although a handful of sample plans from other cities are provided as guidance for newly funded MMRS cities, replication of other city response processes is discouraged. As a result, all of the nearly 100 plans submitted are unique. Although this presents an extraordinary opportunity to identify planning trends, critical gaps, and innovations, these plans have never been researched or summarized. A systematic review of submitted MMRS plans is needed. Taxonomies of these plans could provide important preparedness guidance to medium and smaller cities that may never qualify for funding through the MMRS program.

Effective public health emergency response planning continues to perplex even the best and brightest public health professionals. It is a complex challenge that is difficult to refine given the rarity of these events. Our best hope for effective planning assurance rests in the implementation of a coordinated exercise program. Realistic but manageable public health emergency scenarios should be developed and used to exercise regional plans. Exercises must include participation by multiple public and private organizations to test interagency communication and identify gaps in response. Although large-scale exercises like this have been conducted regularly for years by emergency management professionals, they often lack adequate public health input that is essential to testing all facets of preparedness. And public health professionals need

a greater understanding of the principles of emergency management. The converse is also true: Emergency managers need greater awareness of the principles of public health preparedness and the unique attributes involved in a bioterrorism response.

The weak point in our overall planning approach lies in coordination. Incongruous efforts by the federal, state, and local governments need more effective coordination. However, a single federal agency such as the Department of Homeland Security may force coordination of plans that are not well integrated into the processes and culture of public health organizations. If the resulting response infrastructure is developed as a separate island of resources and not part of what we do every day, it will not be successful or sustainable.

A closing thought for those striving on the front lines of public health preparedness: You have embarked upon a journey with no end. If your desire is to achieve complete preparedness in your community or state, you will never reach that goal. The dynamic nature of the threats, vulnerabilities, and response processes precludes any chance of absolute preparedness. If your hope is to continually strive and contribute toward better preparedness in spite of the processes and politics that may block your way or set you back, welcome to one of the most challenging and important tasks facing public health today.

REFERENCES

1. Shalala, DE. Bioterrorism: how prepared are we? Emerg Infect Dis 1999;5:492-3.
2. Hughes, JM. The emerging threat of bioterrorism. Emerg Infect Dis 1999;5:494-5.
3. Gilmore Commission (Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction). First Annual Report to the President and the Congress: assessing the threat. Washington: Gilmore Commission; 1999 Dec 15 [cited 2003 Apr 16]. Available from: URL: http://www.rand.org/organization/nsrd/terrpanel
4. Smithson A, Levy LA. Ataxia: the chemical and biological terrorism threat and the US response. Washington: Henry L. Stimson Center, Stimson Center Report No. 35; 2000 [cited 2003 Apr 16]. Available from: URL: http://www.stimson.org/cbw/pubs.cfm?id=12
5. General Accounting Office (US). Bioterrorism: coordination and preparation. Testimony of Janet Heinrich, Director, Health Care-Public Health Issues. GAO-02-129T (2001 Oct 5) [cited 2003 Apr 16]. Available from: URL: http://www.gao.gov/new.items/d02129t.pdf
6. Department of Health and Human Services (US). HHS announces $1.1 billion in funding to states for bioterrorism preparedness. HHS press release. 2002 Jan 31 [cited 2003 Apr 16]. Available from: URL: http://www.hhs.gov/news/press/2002pres/20020131b.html
7. General Accounting Office (US). Homeland Security: New department could improve coordination but transferring control of certain public health programs raises concerns. Testimony of Janet Heinrich, Director, Health Care-Public Health Issues. GAO-02-954T (2002 Jul 16) [cited 2003 Apr 18]. Available from: URL: http://www.gao.gov/new.items/d02954t.pdf