

*Editor's Introduction***KP Mid-Atlantic—Lessons Learned at Ground Zero of the Anthrax Crisis**

With the opening of a letter in the office of US Senator Tom Daschle on October 15, the stage was set for one of the most alarming and potentially dangerous public health crises in the nation's Capitol—a crisis that would force Kaiser Permanente's Mid-Atlantic States (KPMA) Region onto the medical forefront of a new era of bioterrorism.

Prior to October 2001, no case of inhalational anthrax had been seen in the United States in more than 25 years, and only 18 cases had been treated in the entire 20th century.³ So when the threat of mass bioterrorism became all too real in the aftermath of the events of September 11, infec-

tious disease clinicians all over the country scrambled to review what was known about a disease that virtually no one had seen.

Fortunately, the seven infectious disease physicians and the rest of the staff of the Permanente Medical Group of KP's Mid-Atlantic Region had a head start. The region already had a detailed Bioterrorism Readiness Plan in place, thanks to the painstaking preparations for the much-feared Y2K "bug" of 18 months earlier. They also had a Disaster Planning Task Force up and ready to lead and coordinate responses and had well-tested plans for an Emergency Operations Center (EOC), should the need arise. Immediately, they set about updating the

existing bioterrorism clinical practice guidelines and researching all potential infectious agents in addition to anthrax.

The need arose suddenly and dramatically on the weekend of October 20-21. The Washington area was already in a panic due to the confirmed release of anthrax spores from the Daschle letter, an event which precipitated the closing and testing of most Congressional offices and epidemiological screening of thousands of Capitol Hill staffers. But while scores of Capitol Hill people tested positive for exposure to anthrax and were put on antibiotics, until Sunday, October 21, no one in the Washington area had actually been confirmed by blood cultures to

have inhalational anthrax infection. Now, suddenly, three cases of inhalational anthrax infection, including one fatality, were confirmed by the Centers for Disease Control and Prevention (CDC)—all KP members. All three were also employees associated with the US Postal Service's big central processing and distribution facility on the District's Brentwood Road, NE. By Monday, a fourth Brentwood worker, not a KP member, also died of inhalational anthrax.

The next 10-12 days was an extraordinary time for the physicians and staff of KPMA. The crisis tested the region's clinical expertise, its ability to coordinate, integrate, distribute, and utilize

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By Lee Jacobs, MD, Associate Editor

*Commentary***"We're Proud of You, Mid-Atlantic KP!"**

As may be apparent from our past commentaries, those of us at *The Permanente Journal* are not bashful when it comes to acknowledging the cutting-edge work of Kaiser Permanente (KP) people across the country. The response of the KP Mid-Atlantic States (KPMA) Region to the recent anthrax bioterrorist attack is no exception. You need to hear their story and share the pride we all have in their work. Although some national news media did have very favorable remarks on the quality response of KP, there is much more to their journey, and so I want to tell you the rest of the story.

After witnessing firsthand the KPMA response to the anthrax-contaminated letters

while I was in the DC area, I can reassure our readers that, in the final analysis, the standard of care for response to such disasters was established by Kaiser Foundation Health Plan administrators and Permanente physicians and associate providers. I was reminded yet again that confronting major challenges does not create high-quality leadership rather it is during such situations that the quality of leadership is revealed. Such was the case recently in the Mid-Atlantic, where Kaiser Permanente's leadership was apparent to all observers.

In the early phase of the bioterrorism attack, the region leveraged national KP resources and convened a command center modeled after an earthquake center in the Northwest Region. This center focused on the need for timely and reliable information,

not always readily available in first-time disasters. The room was replete with several computer stations providing access to pertinent Web sites. This permitted clinical anthrax guidelines to be revised and distributed to frontline clinicians rapidly as new information was received. CNN was continuously projected on one wall as the major source of information as various health and criminal agencies scrambled to understand both the extent of the problem and their role in responding. Briefings took place at the large conference table in the middle of the command center as key people received and provided updates in person or through conference calls with leaders of all the peripheral medical facilities. I found it interesting

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massive amounts of constantly changing information, its capacity to respond to soaring demands for access and advice, and its ability to communicate and cooperate with a patchwork of community hospitals, other health care organizations, local and state public health authorities, public safety authorities, and the CDC. Recognizing that there were limits to what the region's own physicians could handle, Regional Medical Director Adrian Long, MD, put out a call for volunteer physicians from other KP Regions. The response was immediate: two Infectious Disease docs and 12 Internal Medicine docs were on site within days to help cover routine appointments, to provide support to advice

nurses and do telephone consults from the EOC.

By the time the immediate crisis abated in early November, a total of 40 members had been admitted to hospitals to rule out anthrax. Only three of those—the original three, including the member who died—were confirmed to have inhalational anthrax infections. But the actual level of anthrax-related patient activity may be better reflected by the nearly 1000 entries made in PACE (the region's electronic medical record) under the "HAZMAT" notation that was added a few days after the crisis broke.

KPMAS's extraordinary handling of the crisis has been widely reported, and applauded, in both

professional journals (including a JAMA article, dated November 28, 2001, mostly authored by MAPMG physicians) and the mass media, including NPR, all the major national dailies, and several TV news/talk shows.

The article on page 57 provides a close-up look at the crisis from the perspective of the infectious disease physician, Dr Susan Bersoff-Matcha, who treated the two surviving members. It is based on testimony she delivered to the House Committee on Veterans Affairs on November 14, 2001.

Complementing Dr Bersoff-Matcha's testimony, a brief companion article by Steven Black, MD, Co-Director of Kaiser Permanente's Vaccine Study Cen-

ter in Oakland, California, provides an expert point of view on the question of whether Americans should be mass-immunized for smallpox in anticipation of another bioterrorist crisis.

Dr Lee Jacobs, a *Permanente Journal* editor and infectious disease physician, who did volunteer service in the Mid-Atlantic Region during the crisis, gives an additional perspective on the KPMA response to this challenge and how KP was uniquely capable of meeting this challenge. ❖

^a "Doctors Defend Anthrax Diagnosis," ABCNews.com, November 21, 2001.

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how having to deal with so many unknowns in the disaster response necessitated collaboration among members of the team. Not just coordination or communication, but rather true collaboration—ie, you have some knowledge in this area, and I have some knowledge, and together, regardless of our disciplines or hierarchal job ranking, we are going to solve the problem. Dealing with the unknown—fertile ground for teamwork—is a Kaiser Permanente competency that was so well demonstrated in the anthrax attack.

Throughout the ordeal, all aspects of the care experience system in the KPMA were impacted with both the administrative and clinical people responding. While administrative people focused on the call center and appointment capacity to provide ac-

cess for worried members, the frontline clinicians appropriately adjusted their clinical approach to these patients. The infectious disease specialists dealt with the diagnostic and therapeutic aspects of this rare disease along with the stressful public relations interactions while at the same time doing their regular jobs. (Just further proof that infectious disease is the cornerstone of medicine!)

To supplement their staff during the high demand period, the MAPMG further leveraged the resources of the Permanente family and brought in several physicians from other Permanente Medical Groups. To be able to rapidly deploy these physicians out to the medical offices, they fast-tracked licensure, computer encounter training, and other necessary preparation so the physi-

cians could expeditiously be equipped to see patients. When the demands of the crisis subsided, the Medical Director, Dr Adrian Long sent personal letters of appreciation to those from other Permanente Groups who provided assistance, acknowledging in his comments that this level of support and caring is what makes a Permanente physician.

In summary, there is no doubt in my mind that, during this disaster, the members of KP could not have been in better hands. I do hope that health care organizations across the country will learn from the Mid-Atlantic's experience.

So, to the entire KP family in the Mid-Atlantic states ... from all of us across the program—Thank you! ❖