



## National Pharmaceutical Stockpile Support Annex

### Regional Coordinating Organizations

Metropolitan Washington Council of Governments  
National Capital Region National Pharmaceutical Stockpile Task Force

### Local Coordinating Jurisdictions

Alexandria  
Arlington County  
Bowie  
College Park  
District of Columbia  
Fairfax  
Fairfax County  
Falls Church  
Frederick County  
Gaithersburg  
Greenbelt  
Loudoun County  
Rockville  
Montgomery County  
Prince George's County  
Prince William County  
Takoma Park

### District of Columbia Health Organizations

District of Columbia (DC) Department of Health  
DC Office of the Chief Medical Examiner  
DC Department of Health and Human Services  
DC Public Schools  
DC Employee Health Services  
DC Fire & Emergency Medical Services  
DC Department of Mental Health  
DC Emergency Management Agency  
Metropolitan Police Department

### Maryland State and Local Health Organizations

Maryland Department of Health and Mental Hygiene  
Maryland Institute of Emergency Medical Services Systems  
Maryland Office of the Chief Medical Examiner  
Maryland Emergency Management Agency  
Maryland State Police

Montgomery County Hospital Groups  
Prince George's County Hospital Groups  
Montgomery County Department of Health and Human Services  
Prince George's County Health Department  
Frederick County Health Department  
County Public Schools

**Virginia State and Local Health Organizations**

Virginia Department of Emergency Management  
Local Emergency Management Agencies  
Virginia Department of Health  
Virginia Office of the Chief Medical Examiner  
Arlington County Health Department  
City of Alexandria Health Department  
Fairfax County Health Department  
Loudoun County Health Department  
Prince William County Health District  
County Public Schools  
County and State Employee Health Services  
County Emergency Medical Services  
Northern Virginia Emergency Medical Services Council

**Federal Government Organizations**

U.S. Department of Health and Human Services  
Office of Public Health Emergency Preparedness  
Office of Emergency Preparedness  
Centers for Disease Control and Prevention (CDC)  
Food and Drug Administration  
National Institutes of Health  
Department of Defense  
Veterans Health Administration  
Federal Emergency Management Agency  
U.S. Capitol, Office of the Attending Physician  
Federal Police Forces

**Private-sector Health Organizations**

DC Hospitals (including military hospitals)  
National Capital Region—Emergency Response (NCR-ER)  
Maryland Hospitals (including military hospitals)  
Virginia Hospitals (including military hospitals)  
Northern Virginia Emergency Response Coalition  
American Red Cross (National Capital Chapter)  
Clinical Pastoral Resources  
Mental Health Crisis Network (Metro Chapter NASW)  
State Pharmaceutical Associations  
Free-standing Emergency Clinics

## I. Introduction

### A. Purpose

The National Pharmaceutical Stockpile (NPS) Annex facilitates the ability of each jurisdiction to communicate and coordinate with the other jurisdictions across state lines during a regional health emergency that necessitates a request for the NPS to the Centers for Disease Control and Prevention (CDC).

### B. Scope

1. The NPS Annex focuses on the need for requesting, distributing and dispensing the NPS in response to a large, unusual disease outbreak or other public health emergency with local, state and federal impact and requiring inter-jurisdictional coordination across the region.
2. If a terrorist attacks using a weapon of mass destruction (biological, chemical, explosive, nuclear, or radioactive) or a major natural disaster or technological accident occurs, state and local jurisdictions will probably deplete their supplies of pharmaceuticals and other medical items quickly. Congress, anticipating this situation, established the NPS Program and assigned it the mission of providing large quantities of essential medical items to states and communities during an emergency.
3. Managed by the CDC, the NPS Program has built its response on the assumption that state or local authorities would know they had a problem in the early hours of an emergency due to increases in patient volumes, but would not necessarily be able to immediately identify the specific problem.
4. The first shipment (known as a 12-hour Push Package) would arrive in 12 hours or less of the federal decision to deploy and would contain a broad range of materiel that authorities could use to protect and treat several hundred thousand people for an ill-defined threat.
5. Movement of the NPS throughout the region will use the best available route and mode of transportation available. If the roads or bridges are congested this may include Metro, Amtrak, CSX, VRE and MARC trains.
6. Security for the storage and transportation of the NPS will be a cooperative effort between local, state and federal agencies.
7. Following the identification of the specific threat, subsequent shipments from vendors (known as vendor-managed inventory) would contain quantities of specific drugs to combat that threat.

## II. Policies

- A. The NPS Annex will not override the authority, policies or inter-jurisdictional agreements of any federal agency, state government, or local government or jurisdiction.
- B. The Metropolitan Washington Council of Governments (COG) will facilitate coordination between member organizations to ensure the NPS Annex procedures are maintained and in concert with the stated missions and objectives of the Regional Emergency Coordination Plan (RECP).
- C. Essential Elements of Information (EIs) will be shared through the Regional Incident Communication and Coordination System (RICCS) as required by the incident.

## III. Situation

### A. Regional Emergency Condition

- 1. Recognition of the presence of an emerging disease outbreak by the jurisdictions through their bio-surveillance systems or the announcement of the intentional or accidental release of a biological agent will alert the region to a possible public health emergency.
- 2. Terrorists' use of a weapon of mass destruction that results in large numbers of casualties exceeding the resources currently available in the region and creating an area-wide shortfall will prompt the use of the procedures contained in the NPS Annex to bring more supplies to the national capital area.

### B. Planning Assumptions

- 1. The NPS Annex will specifically address the actions of the jurisdictions in the National Capital Region. The District of Columbia, Maryland and Virginia comprise the three primary jurisdictions in the NCR. The local jurisdictions within the NCR include the Maryland counties (and incorporated areas) of Montgomery, Prince George's and Frederick; the Virginia counties (and incorporated areas) of Arlington, Fairfax, Prince William, and Loudoun; and the City of Alexandria. In addition to these jurisdictions, several components of the federal government may be involved.
- 2. Although the NCR plan for the distribution of the stockpile does not currently include Frederick County, COG will include the county in its coordination efforts in the National Capital Area.

3. Knowledge of a terrorism-related event in one jurisdiction will spread quickly to other jurisdictions.
4. The worst-case scenario that must be accommodated will be the release of a communicable agent such as plague or smallpox that affects all jurisdictions and produces the need to provide preventive therapy and treatment to a large number of citizens, while attempting to control the spread of disease by human contact.
5. The Mayor of DC or the Governor of MD or VA, or their designee(s), can request the NPS based on a problem in their respective jurisdiction(s). Coordination of that request with the other primary NCR jurisdictions will be effected through the individual emergency operation centers/emergency communications centers and the RICCS.
6. All NCR jurisdictions will have to work together to share the NPS. CDC will likely not have enough materiel or personnel to support each jurisdiction individually.
7. The NPS that arrives for the NCR will not have to support simultaneous events in other parts of Maryland or Virginia that are outside the NCR (e.g., Annapolis, Baltimore, Richmond, or Norfolk). CDC will separately support such events.
8. Governments and treatment facilities (e.g., hospitals) in all jurisdictions will be responsible for using existing drug and other medical supplies to protect those who will initially respond to an event (e.g. EMS, fire, police, medical, government) for approximately 24 to 36 hours and to treat initial victims until delivery of NPS supplies to dispensing, treatment, and other delivery sites begins.
9. NPS authorities at CDC will coordinate the time and location of the delivery of the NPS with representatives of the primary NCR jurisdictions who will jointly decide where to centrally receive, stage, and distribute the NPS. If the Federal Response Plan is activated, NPS arrival will be coordinated with Federal Emergency Management Agency (FEMA) officials.
10. The decision where to locate central receiving will depend on an assessment of the jurisdictions that will need NPS materiel as well as the suitability, readiness, and proximity of available sites in the NCR.

11. The contents and quantities of the NPS shipments that arrive will depend on the nature and scale of the problem. However, the initial shipment will include two high-capacity drug-repackaging machines that CDC personnel will operate and eight electronic machines for pill counting that CDC personnel will help NCR personnel use.
12. The requirement for CDC to operate or assist in the operation of electronic pill counting and automated drug repackaging equipment, the relatively small number of machines in the NPS, and the limited number of CDC personnel accompanying the NPS require placement of all equipment at one centralized repackaging site.
13. It is intended that requests from each jurisdiction for NPS materiel will be coordinated through the RICCS.
14. The distribution of all NPS materiel will occur based on the best available epidemiological and surveillance data in the NCR that is communicated through the RICCS in coordination with the Disease Surveillance Annex and R-ESF #8.

## **IV. Concept of Coordination**

### **A. General**

1. The NPS function will establish a capability to collect, analyze, synthesize, and disseminate information pertinent to the deployment of the NPS in conjunction with R-ESF #5 and the RICCS.
2. An event requiring the request and distribution of the NPS will necessitate timely and critical coordination between local, state and federal governments.
3. Local jurisdictions that participate in the NPS request and distribution will coordinate and execute their respective authorities and program responsibilities during the regional emergency.
4. Requests for information through RICCS regarding emergency regional materiel requirements will be referred to the NPS Task Force, which is the liaison to RICCS for the coordination of matters related to NPS request and distribution throughout the region.

## **B. Organization**

Request, receipt and distribution of the NPS in the NCR will be coordinated under the auspices of the NCR NPS Task Force with support from the COG Health Officials Committee and the U.S. Department of Health and Human Services' Office of Emergency Preparedness. The task force, which comprises representation from primary and local jurisdictions, has developed the *National Capital Region Plan for Receiving and Distributing the National Pharmaceutical Stockpile* and continues to work on the design of an effective command structure, which is necessary for coordinating this effort regionally.

## **C. Notification**

Upon notification by any jurisdiction of a potential or actual regional emergency, RICCS will provide a communication platform to support the coordinated response of the participating agencies. RICCS provides for the multi-directional flow of communications. Communications will be made in cooperation with R-ESF #2—Communications Infrastructure.

1. RICCS notification is for informational purposes only. RICCS is designed to facilitate the ability of all pieces of the medical community to communicate with one another and with the public in an emergent situation.
2. RICCS is not intended to usurp regular channels of communication but rather to facilitate the coordination of communication when the system must be expanded to deal with an unusual situation.
3. RICCS can provide the mechanism for coordinating an effective response across agencies and local and primary jurisdictions and provide critical information to the public on dispensing of medications and to healthcare providers on clinical protocols.

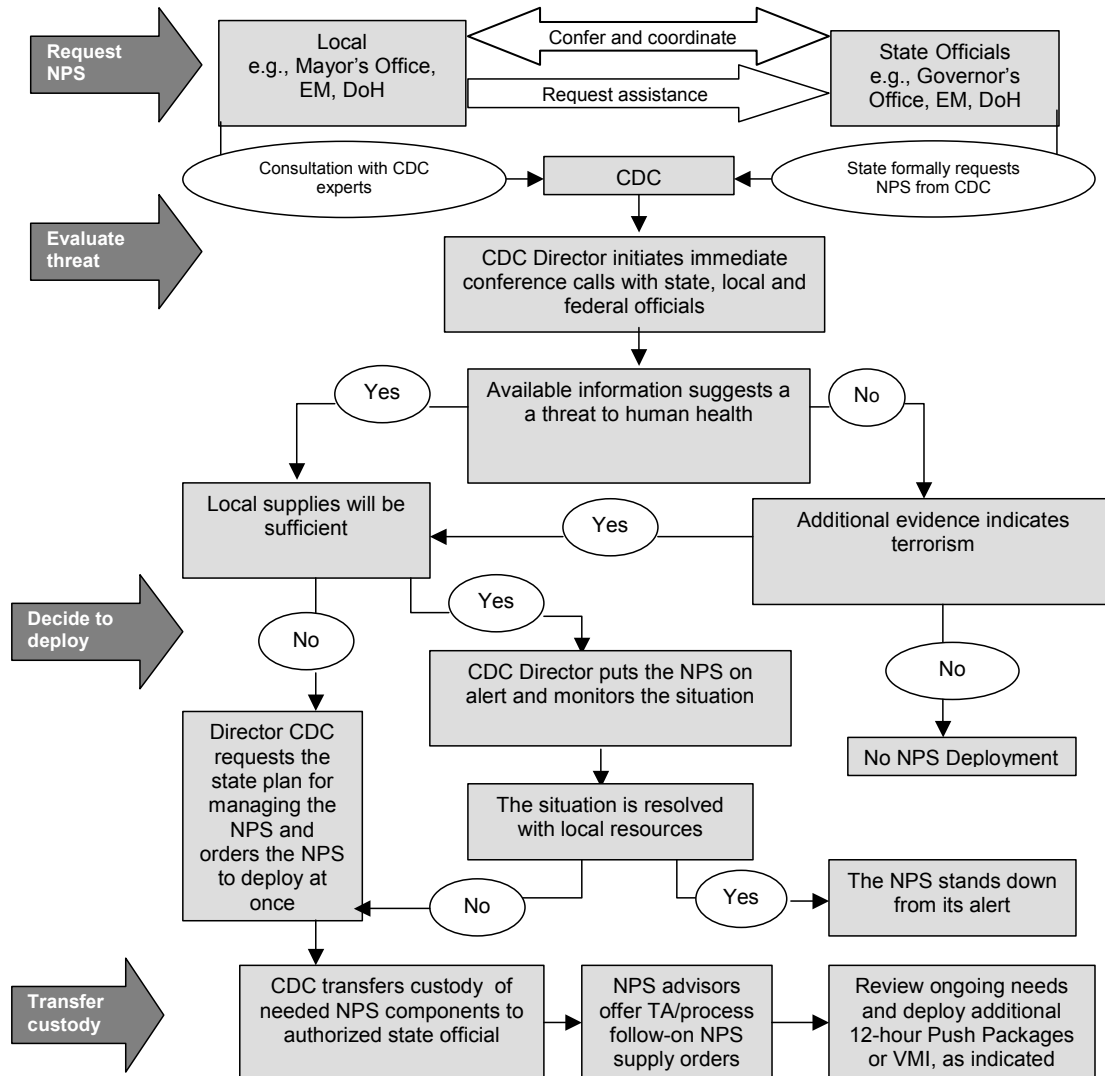
## **D. Coordination**

### **1. Initial Actions**

The first local or primary jurisdiction that identifies a potential problem related to the release of a weapon of mass destruction will inform other NCR jurisdictions through normal channels of communication and, if it believes it necessary, initiate a request for the NPS through the primary jurisdiction.

If request of the NPS is deemed necessary, communication among the affected areas will be coordinated and information shared through RICCS.

The primary jurisdictions will decide where to centrally receive, stage, and repackage the NPS for the NCR. This will require a 10,000- to 15,000-square-foot location that is within 25 miles of the Capital, provides controlled room temperatures, and has convenient access to highways and other forms of transportation.



**Fig 1. Requesting the National Pharmaceutical Stockpile**  
 Courtesy CDC: "Receiving, Distributing, and Dispensing the National Pharmaceutical Stockpile"  
 Version 9, April 2002.

## 2. Continuing Actions

Pill counting equipment will be located in one central repackaging location but will be supplemented with manual repackaging by volunteers from each of the primary jurisdictions at the central repackaging site.

Material will be delivered from the central repackaging site to primary jurisdictions for distribution to local jurisdictions.

Local jurisdictions will also provide manual repackaging using bulk antibiotics in the NPS that will be delivered from the centralized receiving and staging facility.

- The location, number, and operation of dispensing and treatment sites will be a local jurisdiction responsibility. Local health departments will be responsible for dispensing medications and/or administering vaccines.

## 3. Stand Down

At the point where the regional emergency is no longer affecting more than one jurisdiction, nor requires inter-jurisdictional communication and coordination, a notification will be made through RICCS and a stand-down debriefing conference call will take place.

As there may be many long-term secondary effects that require regional attention (large numbers of ventilator-dependent patients, or individuals requiring long-term antibiotic support), there may need to be regional communication on an ongoing basis for some incidents.

## 4. After-action Critique

Within four weeks of stand-down of the regional health emergency, information for an after-action critique will be gathered by the participating organizations, and the NPS Task Force (in conjunction with the Health Officials' Committee) will convene a meeting of interested persons to share lessons learned.

## V. Responsibilities

### A. Participating and Supporting Agencies

All healthcare entities in the region (both public and private), emergency management agencies and other participating organizations will, to the best of their ability, contribute information to RICCS as required by the incident and RECP policy.

### B. Essential Elements of Information

1. One of the primary purposes of the RECP is to facilitate the exchange of information among the signatory agencies during emergency situations. R-ESF #5—Information and Planning is responsible for the exchange, analysis, reporting and dissemination of regional information. R-ESF #5 contains detailed information about the process of information exchange and describes regional EEs, which have been determined as the minimum essential information categories to satisfy coordination needs among the R-ESFs and with RICCS.

2. In addition to regional EEs covered in R-ESF #5, other EEs to be exchanged may include, but not be limited to:

- Availability of necessary drugs and pharmaceutical supplies;
- Status of transportation systems;
- Status of storage location of stockpiles;
- Status of security of stockpile locations;
- Number of current casualties;
- Projected needs considering demographics;
- Communicable versus non-communicable disease;
- Hospital capacities to include number of intensive care beds and ventilators;
- State resources—pharmacy distribution, oxygen availability and transport capacity;
- The number of locations that central receiving/staging will need to supply;
- The materiel requirements for each site;
- Security requirements for facilitating movement of vehicles to transport the NPS, controlling crowds and protecting personnel, equipment and materiel; and
- Overall resource shortfalls, response needs and priorities.

## VI. Preparedness Cycle

### A. Planning

1. Planning includes a comprehensive review of existing capabilities and an analysis of strengths and gaps.
2. Roles and responsibilities during an incident are defined and communications interfaces developed so that all sectors of the healthcare and emergency management community can exchange information concerning the need for, and subsequent receipt and distribution of, the NPS. This enables effective decision-making and communication thereof to all necessary parties and identifies the processes needed to respond quickly.
3. The NCR NPS Task Force, Health Officials Committee and COG are responsible for maintaining the NPS preparedness cycle.

### B. Training

1. Train all parties to understand and use their jurisdictions' correct channels of communication when requesting the NPS;
2. Use the NPS video to train members to understand the NPS contents and methods of operation;
3. Use of the CDC's Training, Education, and Demonstration (TED) package is highly recommended and will provide an opportunity for jurisdictions to train together in deployment of the NPS. It includes Logistics, Repackaging, Distribution and Dispensing;
4. Cross-train personnel to work in different functional areas;
5. Provide orientation (basic understanding) and individual training (staff roles and responsibilities); and
6. Ensure training is ongoing.

**C. Exercises**

1. Exercises, both local and regional, are conducted on a regular basis and the participation of COG and the different local and primary jurisdictions is solicited to create a coordinated regional response structure;
2. Exercises will be tabletop, functional, and/or field exercises that will cover all elements of the healthcare community in conjunction with their counterparts in other emergency response in requesting, receiving and distributing the NPS; and
3. Ensuring multi-disciplinary, multi-agency participation as cooperation is a key component of an effective response mechanism.

**D. Evaluation**

After-action reports (AARs) will be developed for both real and notional events.

**E. Corrective Action**

Lessons learned from exercises and real world experiences will be captured and entered into a database where they are available on request by the member jurisdictions.