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With COVID mission over,

Pentagon plans for next pandemic

ABC News

7-9 minutes

U.S. military medical teams deployed during the coronavirus

pandemic brought back lessons as the Defense Department looks to see

what worked and what didn't

WASHINGTON -- A COVID-19 patient was in respiratory

distress. The Army nurse knew she had to act quickly. It was the peak of this year's

omicron surge and an Army medical team was helping in a Michigan hospital.

Regular patient beds were full. So was the intensive care. But the nurse heard of an

open spot in an overflow treatment area, so she and another team member raced

the gurney across the hospital to claim the space first, denting a wall

in their rush.

When she saw the dent, Lt. Col. Suzanne Cobleigh, the leader of the

Army team, knew the nurse had done her job. “She’s going to damage the

wall on the way there because he’s going to get that bed," Cobleigh said. "He's going to

get the treatment he needs. That was the mission.”

That nurse's

mission was to get urgent care for her patient. Now, the U.S. military mission is to use the

experiences of Cobleigh's team and other units pressed into service against the

coronavirus pandemic to prepare for the next crisis threatening a large

population, whatever its nature. Their experiences, said Gen. Glen

VanHerck, will help shape the size and staffing of the military's medical

response so the Pentagon can provide the right types and numbers of forces needed

for another pandemic, global crisis or conflict.

One of the key lessons

learned was the value of small military teams over mass movements of

personnel and facilities in a crisis like the one wrought by COVID-19.

In the early

days of the pandemic, the Pentagon steamed hospital ships to New York

City and Los Angeles, and set up massive hospital facilities in convention

centers and parking lots, in response to pleas from state government

leaders. The idea was to use them to treat non-COVID-19 patients,

allowing hospitals to focus on the more acute pandemic cases. But

while images of the military ships were powerful, too often many beds went

unused. Fewer patients needed non-coronavirus care than expected, and

hospitals were still overwhelmed by the pandemic.

A more agile

approach emerged: having military medical personnel step in for

exhausted hospital staff members or work alongside them or in additional

treatment areas in unused spaces. “It morphed over time,”

VanHerck, who heads U.S. Northern Command and is responsible for homeland

defense, said of the response. Overall, about 24,000 U.S. troops were

deployed for the pandemic, including nearly 6,000 medical personnel to

hospitals and 5,000 to help administer vaccines. Many did multiple tours.

That mission is over, at least for now. Cobleigh and her team members were

deployed to two hospitals in Grand Rapids from December to February, as

part of the U.S. military's effort to relieve civilian medical workers. And just last week

the last military medical team that had been deployed for the pandemic finished its stint

at the University of Utah Hospital and headed home.

VanHerck told

The Associated Press his command is rewriting pandemic and

infectious disease plans, and planning wargames and other exercises to determine if

the U.S. has the right balance of military medical staff in the active duty

and reserves.

During the pandemic, he said, the teams' make-up and

equipment needs evolved. Now, he's put about 10 teams of physicians,

nurses and other staff — or about 200 troops — on prepare-to-deploy orders

through the end of May in case infections shoot up again. The size of the teams ranges

from small to medium.

Dr. Kencee Graves, inpatient chief medical officer

at the University of Utah Hospital, said the facility finally decided to seek help

this year because it was postponing surgeries to care for all the COVID-19

patients and closing off beds because of staff shortages. Some patients

had surgery postponed more than once, Graves said, because of critically ill

patients or critical needs by others. “So before the military came, we were

looking at a surgical backlog of hundreds of cases and we were low on

staff. We had fatigued staff." Her mantra became, "All I can do is show up and hope

it’s helpful."

She added,

"And I just did that day after day after day for two years.”

Then in came a 25-member Navy medical team.

“A number of staff were

overwhelmed," said Cdr. Arriel Atienza, chief medical officer for the Navy team. "They

were burnt out. They couldn't call in sick. We're able to fill some gaps and needed

shifts that would otherwise have remained unmanned, and the patient

load would have been very demanding for the existing staff to match." Atienza, a

family physician who's been in the military for 21 years, spent the Christmas

holiday deployed to a hospital in New Mexico, then went to Salt Lake City in

March. Over time, he said, the military “has evolved from things like pop-up

hospitals" and now knows how to integrate seamlessly into local health

facilities in just a couple days. That integration helped the hospital staff

recover and catch up.

“We have gotten through about a quarter of our surgical

backlog,”
Graves said.
”We did not
call a backup
physician this
month for the

hospital team … that's the first time that's happened in several months. And

then we haven't called a patient and asked them to reschedule their surgery

for the majority of the last few weeks."

VanHerck said the pandemic also

underscored the need to review the nation's supply chain to ensure that the right

equipment and medications were being stockpiled, or to see if they were coming

from foreign distributors.

“If we’re relying on getting those from a foreign

manufacturer and supplier, then that may be something that is a national

security vulnerability that we have to address," he said.

VanHerck said

the U.S. is also working to better analyze trends in order to predict the needs for

personnel, equipment and protective gear. Military and other government

experts watched the progress of COVID-19 infections moving across

the country
and used that
data to predict
where the next
outbreak might
be so that staff

could be prepared to go there.

The need for mental health care for the

military personnel also became apparent. Team members

coming off difficult shifts often needed someone to talk to. Cobleigh said

military medical personnel were not accustomed to caring for so

many people with multiple health problems, as are more apt to be found in a

civilian population than in military ranks. "The level of sickness and

death in the civilian sector was scores more than what anyone had

experienced back in the Army," said Cobleigh, who is stationed now at Fort

Riley, Kansas, but will soon move to Aberdeen Proving Ground in

Maryland.

She said she found that her staff needed her and wanted to “talk

through their stresses and strains before they'd go back on shift."

For the civilian

hospitals, the lesson was knowing when to call for help.

“It was the bridge to help

us get out of omicron and in a position where we can take good care of our

patients," Graves said. “I am not sure how we would have done that without them.”