

**RMRS Policy & Procedure Committee Concepts (DRAFT)**  
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- 1) Any unusual incident in the region should be considered intentional in nature until proven otherwise.
  - a. Define “unusual incident”.
  - b. Requires immediate notification of RMRS leadership.
    - i. RMRS leadership will await further details and proffer specific expertise or resources if requested.
    - ii. RMRS will institute its response plan if the situation warrants or
    - iii. RMRS will de-activate.
  
- 2) Of all the weapons in a terrorist’s arsenal, the use of biological agents would have the greatest and most far reaching impact on society.
  - a. Incubation period inhibits early detection.
  - b. Transmissibility potential facilitates exposure of disease to communities across a region, a state, a nation, & the world.
  
- 3) In most scenarios, an explosive, chemical, or radiological event will be a local one (i.e. a county) with well-defined exposed population, limited in time and geography.
  - a. The initial response is local supplemented by mutual aid and under the local Incident Command Structure.
  - b. It is likely that the local community or county can manage the entire event with its established resources.
  - c. RMRS should be notified of such a local event in order to
    - i. Alert entire region (adopt a defensive posture---consider elevating threat level status to orange or red)
      1. Improve the chance of apprehension of the perpetrators.
      2. Initiate other communities’ internal response plans.
    - ii. Marshal additional resources (vehicles, personnel, communications, etc.) should they be required.
  
- 4) Bioterrorism associated with transmissible agents should be the focus of education and planning since they have the potential of creating the greatest impact on a community in terms of spread, and nuances in management.
  - a. Increase recognition of and response strategies for Plague, Smallpox, & Viral Hemorrhagic Fevers.
    - i. Treatment & prophylaxis
  - b. Infection control practices
  - c. Education on isolation, quarantine, restricted movement.
  - d. Consider any unusual biological incident as a transmissible disease until proven otherwise.
    - i. Adequate PPE (e.g. N-95 respirators) should be the rule.

- 5) Some of the agents of bioterror are associated with significant morbidity and mortality. For example, smallpox carries with it a mortality rate of 30% and plague 90%. The previously reported mortality rate of inhalational anthrax of 90% was significantly less as a result of aggressive, intensive multi-specialty care. The amount of resources they required was immense. This can only be found in hospitals, not Alternative Care Sites (ACS). Based on historical precedent and the recent SARS epidemic, the designation of specific Infectious Disease Hospitals is a viable method of isolating an outbreak while, at the same time, concentrating the medical expertise to provide optimum care.
  - a. The concept of specific Infectious Disease Hospitals must be explored within the region.
  - b. It is possible that state or even Federal agencies will compel the region to develop 1 or more Infectious Disease Hospital. Identification of the most likely hospitals to assume that role and the logistics that would be required should be accomplished prior to an event.
  - c. An Infectious Disease Hospital should be situated at a location near other hospitals which would provide for the general care of the population.
  - d. At least two such hospitals should be identified within the region.
  - e. These hospitals should be able to handle all infectious patients of all ages.
  - f. The financial well-being of these hospitals should be guaranteed during the crisis.
  - g. Specific experts, consultants, and other necessary personnel should receive emergency credentialing in an expeditious manner.
  
- 6) It is possible that the first indication of an unusual biological incident will be recognized in one part of the region (i.e. county). There may be a desire to transfer this patient to a tertiary care center in another part of the region or state. This is usually accomplished between the “sending physician” and the “receiving physician.” The adherence to this routine policy runs the risk of spreading a serious infectious disease to virgin territories.
  - a. In the event an “unusual biological incident” is reported, no transfer may be accomplished without the consent of the responsible local public health commissioners.
  - b. A version of this policy was enacted during the SARS epidemic in Toronto.
  
- 7) Additional medical manpower is necessary to manage surge capacity and alternative care sites.
  - a. Quality as well as quantity of these volunteers should be non-competing equal goals.
    - i. Commo and logistics specialists should be recruited.
  - b. A database of each volunteer’s work experience, (skill set---both medical and non-medical), health limitations, contact numbers, etc. should be entered.
  - c. Workmen’s compensation and medical liability issues should be resolved.
  - d. Each volunteer should be responsible for developing a “Go-Pack”.

- i. Clothes (based on job requirements)
    - ii. Medications
    - iii. Food (e.g. ARC website)
    - iv. Water (ARC website)
    - v. Basic medical equipment
  - e. Two principal types of medical volunteers should be recognized.
    - i. The general health care worker with little or no experience in critical care, general medical procedures, or disaster management.
      - 1. Identified as the Medical Care Taskforce (MCT)
      - 2. May include medical/nursing students, allied health students, retirees, etc.
    - ii. The health care worker who has experience in critical care on a regular basis (e.g. EMT, paramedic, ICU nurses, trauma surgeons, emergency physicians, etc).
      - 1. Identified as the Critical Care Taskforce (CCT)
      - 2. Individually recruited to serve as volunteers.
    - iii. Since many of these volunteers work in occupations that have disaster response activities, a MOU should be developed between the RMRS and the parent organization that allows these volunteers to serve in RMRS activities.
      - 1. Maintains their income.
      - 2. No loss of job status.
  - f. These volunteers are possibly arriving from multiple organizations with little or no command and control hierarchy.
  - g. These volunteers should collectively be placed under the one umbrella subject to the existing Incident Command structure.
    - i. This is critical if they are principal players in an alternative care facility. And must develop an ICS within a specific locale.
  - h. Oversight of their education should be under RMRS.
  - i. Training should include an overview of terrorism in the context of an all-hazards response with specific training in areas where these volunteers may be most likely to assume duties.
    - i. It would be helpful to delineate potential tasks for each volunteer and provide specific education for those tasks.
- 8) In the event of an incident, there will be three general categories of patients seeking care.
- a. Victims of the incident.
  - b. Those who are asymptomatic, but potentially exposed (“worried well”).
  - c. The normal community baseline of patients who are not part of the incident, but who have the usual medical conditions that require care (e.g. strokes, MIs, MVAs, etc.).
- 9) Alternative care sites (ACS) must be developed to improve surge capacity for any event, but particularly a bioterrorist event.

- 10) The function of an alternative care site (ACS) must be well-defined.
  - a. Provision of prophylaxis/immunizations to the exposed population and/or
  - b. Quarantine of contacts and/or
  - c. Provision of medical care to patients/victims.
  
- 11) Unless the ACS is a previously-established hospital, it should not be used for the care of critically ill or injured patients.
  - a. These types of patients require immediate and intense management, critical care resources, and specialty and subspecialty consultations.
  - b. Many, if not most, physicians and other providers will not be comfortable caring for patients in unfamiliar surroundings, with inadequate resources, and with unknown ancillary staff.
  
- 12) The ACS would be a better place to manage the baseline medical care of a community (i.e. the typical Emergency Department patient).
  - a. It would require the services of a number of emergency physicians partnering with family practitioners and pediatricians and health extenders.
  - b. Any routine critical patient can be stabilized at the ACS and then transferred to the closest, most appropriate hospital.
  - c. Telemedicine links should be forged to connect primary care practitioners at the ACS with specialists and sub-specialists at tertiary care centers.
  
- 13) Alternative Care Sites (ACS) should be developed in well-known, easily-identifiable, accessible locations.
  - a. Identification of appropriate sites should begin now.
  - b. These locations should be publicized prior to an event.
  - c. The public should know prior to an event what the function of that site is.
  - d. Easy ingress/egress
  - e. Security
  - f. Should function under the ICS of the EOC.
  - g. EMS transportation between it and the closest hospital.
  - h. HIPAA and COBRA issues should be researched with regard to ACS.
  
- 14) Upon notification of an “unusual incident”, health care facilities should place their triage areas in a “forward” position.
  - a. Minimizes contamination of the health care facility.
    - i. Potentially contaminated victims can be identified and decontaminated outside of the hospital.
  - b. Allows an expeditious triage to alternative care sites of specific categories of patients.
    - i. Green and yellow patients may be sent to the closest ACS.
    - ii. Contacts may be sent to the closest ACS.
    - iii. The asymptomatic, but potentially exposed population may be sent to the closest ACS.

- 15) A review of the literature, especially with regards to the dosage and administration of antidotes (viz. amyl nitrite, sodium nitrite, sodium thiosulfate, atropine, & 2-PAMCl), reveals disparity. This is especially problematic in pediatric therapy and can cause confusion/errors whether the therapy is in the field or at the ACS/hospital. For example, some experts claim that the initial dosage of 2-PAMCl can be as low as 10mg/kg and others state it can be as high as 50mg/kg.
  - a. RMRS should acknowledge this problem.
    - i. This problem is more acute during a chemical incident where the immediate administration of antidotes can be life-saving.
  - b. Convene a panel of consultants to decide appropriate medications, indications, dosages, etc.
  - c. Make it standardized across the region as proposed “interim” guidelines.
  - d. Disseminate the final product as printed material to all pre-hospital and hospital providers which could be tacked onto a wall or a notebook for easy access.
    - i. It must always be kept in mind that there will be providers who will not have immediate access to physicians or consultants and must care for acute patients on their own for an extended period of time.
  
- 16) The potential of mass casualties and limited resources will require management decisions that could allocate those resources to segments of society that are more viable (pediatric vs. geriatric) or more critical (infrastructure personnel versus general public) to the survival of a community.
  - a. An ethicist should be added to future RMRS planning.
  - b. This would also enhance the credibility of RMRS in the eyes of the community.
  
- 17) The public, in general, in the face of a terrorist attack, will manifest specific fears, attitudes, and behavior that in many cases will not be compatible with current planning practices and may run counter to and impede governmental and non-governmental response activities. RMRS should
  - a. Review current literature on this topic.
  - b. Discuss planning activities with representatives of the general public in the region.
  - c. Incorporate the findings from the above endeavors to improve the regional response plan.
  
- 18) Certain segments of our society because of race, religion or other qualifiers have a distrust of government and fear discrimination in the face of a terrorist-induced Mass Casualty Incident. This is becoming increasingly clear in recent literature and is especially true with the younger age groups. This attitude may impede certain public health measures (e.g. quarantine) and require stricter enforcement practices (may be even more critical if law enforcement suffers personnel depletion).

- a. Identify particular ethnic, racial, and religious groups to whom this may apply.
  - b. Convene focus groups.
  - c. Identify key persons in these communities.
  - d. Obtain their feedback and their assistance.
  - e. Invite representatives to serve on committees to improve cultural/religious/ethnic imbalance.
- 19) The dissemination of critical information to the public before and during an incident is an essential component to ensure preparedness, cooperation, and trust on the part of the public.
- a. This must be addressed by RMRS now.
  - b. Consultation with media representatives with regard to
    - i. Public service announcements
    - ii. "Crawls"
    - iii. Information content: Incident, location, manifestations, contact information, therapy/prophylaxis (types & location), etc.
    - iv. Print dissemination to all reputable newspapers
    - v. Information in telephone books
    - vi. Multi-language
    - vii. One message throughout entire region to minimize confusion
  - c. Install a media representative on RMRS.
- 20) Coordination, cooperation, and communications between hospital and public health agencies are crucial to a successful response to a public health emergency. In many counties, because of the size of the county, prior history and number of hospitals, this symbiotic relationship is currently active at all levels. This spirit must be the norm throughout all the counties in the region.
- a. Since emergency departments will be key players in all kinds of preparedness and response activities, regular meetings between the Medical Directors/Nurse Directors of each ED and the Public Health Commissioner should either continue or be initiated.
- 21) The County Public Health Commissioner is the highest medical authority in his/her county. He/she have emergency powers that are not well-known to the general public and, even, to some health care providers. Some of these powers can be perceived as being violations of individual freedoms.
- a. Public Health Commissioners should increase their visibility in their communities.
  - b. Continue focusing educational efforts to their public by way of the media, town hall meetings, etc.
- 22) For most incidents, the major response will be limited to 1 county (e.g. chemical, explosives, etc.). Therefore, the lines of authority, including those of the Public Health Commissioner, are clear and well-defined. However, in the case of a natural or intentional dissemination of a transmissible biological agent, the

potential for an early dissemination to multiple counties would be significant. Public health activities must be coordinated among the counties so as not to disseminate contrary and conflicting information to the public and infrastructure personnel.

- a. This scenario, if not addressed already, should be addressed by a consortium of the Public Health Commissioners.
- b. Results from that consortium should be made available to RMRS.

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