



DEPARTMENT OF THE ARMY  
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND  
2050 WORTH ROAD  
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO  
ATTENTION OF

MCPO-SA

30 MAR 2004

MEMORANDUM FOR COMMANDERS, MEDCOM REGIONAL MEDICAL  
COMMANDS

SUBJECT: Severe Acute Respiratory Syndrome (SARS) Planning Guidance and  
Tasking

1. References:

- a. Department of Defense Directive (DoDD) 6200.3, Emergency Health Powers on Military Installations, 12 May 2003.  
[http://services.tma.osd.mil/tricare\\_search/jsps2/webmain.jsp?NewQueryText=dodd&submit.x=6&submit.y=12](http://services.tma.osd.mil/tricare_search/jsps2/webmain.jsp?NewQueryText=dodd&submit.x=6&submit.y=12).
- b. MEDCOM Pamphlet 525-1, Medical Emergency Management Planning, 1 Oct 03.
- c. MEDCOM Regulation 525-4, U.S. Army Medical Command Emergency Management, 11 Dec 00.
- d. 2004 Hospital Accreditation Standards – Joint Commission on Accreditation of Healthcare Organizations.
- e. CDC Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), 8 January 2004: Supplements C and D. [www.cdc.gov/ncidod/sars/guidance](http://www.cdc.gov/ncidod/sars/guidance).
- f. Department of Defense (DoD) Smallpox Response Plan, 29 September 2002.  
<http://www.smallpox.army.mil/media/pdf/DODSpoxPlan.pdf>.

2. In accordance with references 1a-f above, this headquarters developed planning guidance for implementation of DoDD 6200.3 in relation to SARS. The tasking to the Regional Medical Command (RMC) and their Medical Treatment Facilities (MTFs) is to develop their individual plans to maintain operational effectiveness by minimizing disease and death due to SARS. The enclosed annexes/planning guidance provides an outline of the areas of considerations that should be used to prepare the individual RMC and MTF plans.

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3. This MEDCOM initiative is being coordinated with the Office of the Assistant Chief of Staff for Installation Management and their tasker to the Installation Management Agency for development of specific installation SARS plans. Please coordinate the SARS plan with the Garrison Commander.

4. Request the RMCs provide the following to this headquarters, ATTN: MCOP-P (Mr. Grunwald), NLT 30 days from the signature of this memo.

a. The RMC plan and each of your MTF plans.

b. Recommend a Public Health Emergency Officer (PHEO) for the RMC and each MTF in accordance with reference 1a above. Provide a list of the RMC and MTF PHEOs to MEDCOM Health Care Operations (Plans).

5. MEDCOM Health Care Operations (Plans) will review each RMC and MTF plan and provide feedback to the RMCs. The evaluation process will be ongoing and will involve the MEDCOM Inspector General Organizational Inspection Program.

6. Our points of contact for this action are LTC Angela Ross, Proponency Office for Preventive Medicine-San Antonio, Commercial (210) 221-7998 or DSN 471-7998, e-mail: Angela.Ross@amedd.army.mil; and Mr. Michael Grunwald, MEDCOM Health Care Operations(Plans), Commercial (210) 221-6425 or DSN 471-6425, e-mail: Michael.Grunwald@amedd.army.mil.

FOR THE COMMANDER:



KENNETH L. FARMER, JR.  
Major General  
Chief of Staff

Encl  
as

CF (w/encl):

Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs),  
111 Army Pentagon, Washington, DC 20310-0111

## Severe Acute Respiratory Syndrome (SARS) Planning Guidance

POC	Annex/Title
<p><u>Infectious Disease Consultant</u> COL David Dooley Comm (210) 916-5554 DSN 421-5554</p> <p><u>Infection Control Nursing Consultant</u> Ms. Jane Pool Comm (703) 805-0044 DSN 655-0044</p>	Annex A – Isolation and Infection Control Guidelines
<p><u>MEDCOM PAO</u> Mr. Jaime Cavazos Comm (210) 221-7105 DSN 471-7105</p>	Annex B – Public Affairs
<p><u>MEDCOM ACSIE&amp;FM</u> COL Carmen Rinehart Comm (210) 221-8077 DSN 471-8077</p>	Annex C – Medical Treatment Facility's Building System-Related Considerations
<p><u>Clinical Laboratory Science Consultant</u> COL Noel R. Webster (210) 221-6344 DSN 471-6344</p> <p><u>Director Microbiology DPALS (BAMC)</u> LTC William Nauscheutz Comm (210) 916-0329 DSN 421- 0329</p>	Annex D – Specimen Collection, Transport Guidelines, and Testing
<p><u>MEDCOM SJA</u> Mr. Charles Orck Comm 210-221-8400 DSN 471-8400</p>	Annex E – Index of Legal References

<p><u>Pharmacy Consultant</u> COL Mike Heath Comm (703) 681-5959 DSN 761-5959</p> <p><u>Deputy Army Pharmacy Program Mgr, HP&amp;S, OTSG</u> LTC Jasper Watkins III Comm (703) 681-2996 DSN 761-2996</p>	<p>Annex F – Pharmacy Support Guidelines</p>
<p><u>MEDCOM Logistics</u> LTC Earl Smith II Comm (210) 221-8527 DSN 471-8526</p>	<p>Annex G – Logistical Support Guidelines</p>
<p><u>VETCOM</u> LTC Margaret N. Carter Comm (210) 221-6694 DSN 471-6694</p>	<p>Annex H – Veterinary Services Planning Guidelines</p>
<p><u>MEDCOM IG</u> LTC(P) Tempsie Jones Comm (210) 221-6017 DSN 471-6017</p>	<p>Annex I – Inspector General Role</p>

# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

## ANNEX A TO SARS PLANNING GUIDANCE ISOLATION AND INFECTION CONTROL GUIDELINES

### 1. References.

a. CDC Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), 8 January 2004; Supplement C.  
[www.cdc.gov/ncidod/sars/guidance](http://www.cdc.gov/ncidod/sars/guidance).

b. Association for Professionals in Infection Control and Epidemiology (APIC). APIC Text of Infection Control and Epidemiology. Washington, DC: June 2002.

c. Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Practices Advisory Committee (HICPAC). Recommendations for isolation precautions in hospitals. *Am J Infect Control* 1996; 24:24-52. [www.cdc.gov/ncidod/hip/isolat/isolat.htm](http://www.cdc.gov/ncidod/hip/isolat/isolat.htm).

d. Centers for Disease Control and Prevention. Guideline for Infection Control in Health Care Personnel, 1998. *Am J Infect Control* 1998; 26:289-354. *Infect Control Hosp Epidemiol* 1998; 19:407-63. [www.cdc.gov/ncidod/hip/guide/infectcontrol98.pdf](http://www.cdc.gov/ncidod/hip/guide/infectcontrol98.pdf).

e. CDC Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), 8 January 2004; Supplement D.  
[www.cdc.gov/ncidod/sars/guidance](http://www.cdc.gov/ncidod/sars/guidance).

f. CDC Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), 8 January 2004; Supplement B.  
[www.cdc.gov/ncidod/sars/guidance](http://www.cdc.gov/ncidod/sars/guidance).

g. CDC. Guidelines for laundry in healthcare facilities. February 5, 2002.  
[www.cdc.gov/od/ohs/biosfty/laundry.htm](http://www.cdc.gov/od/ohs/biosfty/laundry.htm).

h. CDC. Sterilization and disinfection. <http://www.cdc.gov/ncidod/hip/sterile/sterile.htm>.

i. Annex E – Index of Legal References, SARS Response Plan.

2. General. DA will augment CDC Guidance for Preparedness and Response to Severe Acute Respiratory Syndrome (SARS) (Reference 1a.) in anticipation of or responding to an outbreak of SARS. This document summarizes the guidance in the CDC recommendations and serves as a guideline for medical treatment facilities (MTFs) for preparation before, and response during, an outbreak.

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3. Mission. MTFs will develop plans in preparation for the appearance of SARS in the world and the local communities. Goals include the rapid identification and isolation of all potential SARS patients, and the appropriate implementation of infection control practices to prevent transmission. Infection-control officers in each MTF will provide subject-matter expertise on specific procedures. Preventive medicine and public health personnel, and infectious-disease physicians, will provide additional support and guidance as indicated.

### 4. Plan.

#### a. Definitions.

(1) Isolation. The separation of a person or group of persons from other people to prevent the spread of infection.

(2) Quarantine. The restriction of activities or limitation of freedom of movement of those presumed exposed to a communicable disease, to prevent contact with people not exposed. Although quarantine measures may be instituted and enforced for either individuals or populations, the term is used more frequently to discuss measures taken at a population level.

(3) Triage. The evaluation of the level and character of illness in presenting patients, with pre-planned levels of care assigned. Triage allows for the provision of appropriate, rapid care as needed, while maintaining protection from communicable illnesses for the public as well as health care workers.

#### b. Assumptions.

(1) Most exposures to SARS occur in hospitals or other healthcare settings from SARS coronavirus (CoV) infected patients.

(2) SARS-CoV-infected healthcare workers, patients, and visitors can propagate and disseminate infection within and outside healthcare facilities.

(3) SARS-CoV transmission risks are primarily from unprotected exposures to unrecognized cases in both inpatient and outpatient settings.

(4) SARS-CoV transmission occurs primarily through large respiratory droplets and close contact with infected patients.

(5) Exposure during aerosol-generating procedures may increase transmission risks.

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(6) Strict adherence to appropriate infection control practices, including use of personal protective equipment, helps prevent transmission.

### c. Planning Factors.

(1) Education and training in anticipation of the first SARS case presenting to an MTF must take place before any outbreak occurs. The MTF should organize a planning committee to develop an institutional preparedness and response plan.

(2) A strategy for surveillance, screening, and evaluation for SARS, at various levels of SARS prevalence in the world and the community, should be developed.

(3) Effective response includes appropriate transmission-based isolation measures. Plans should be developed to permit all applicable measures as directed by infection control practitioners, and by references 1a.- d.

(4) The current availability of infrastructure and resources to care for SARS patients and strategies for meeting increasing (surge) demands should be determined and developed. Surge demands from multiple spheres (shortages of staff, personal protective equipment, ventilators, housekeepers, etc.) should be expected and planning should be performed.

(5) Strategies should be developed to communicate with and educate staff and patients.

(6) Communication with the local and regional health departments should be established and plans formulated before the appearance of SARS.

### d. Providing Care.

(1) Several state and federal laws and healthcare certification standards address issues of access to emergency care services. Although these laws and standards are not necessarily applicable to MTFs, they represent important policy objectives for the healthcare system and public health community.

(2) Therefore, consistent with mission requirements and other applicable rules and procedures, MTF planning will be based on a premise of providing care to patients with infectious diseases such as SARS.

(3) Once the MTF admits a patient with SARS, the MTF is obligated to provide appropriate care or risk potential liability for abandonment. If an MTF staff member refuses to care for a patient with a contagious disease, the MTF has a responsibility to see that care is rendered, even if this means transferring the patient to another facility where appropriate care will be provided.

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(4) Healthcare personnel will not be excused from providing care to patients with infectious diseases. MTF personnel policies should specifically address employee insubordination or unreasonable refusals to treat patients.

(a) MTFs will provide their staff specific information to assuage fears of occupational exposure to infectious agents such as the SARS-CoV. Content will include appropriate personal protective equipment (PPE, e.g., gowns, gloves, respirators, goggles) to protect against the transmission of infectious diseases.

(b) If an employee, after individual education and counseling, refuses to perform his or her duties in caring for infected patients, the MTF may either attempt to accommodate the employee by job reassignment or institute disciplinary action. In doing this, the hospital will have to act within any relevant limitations imposed by the National Labor Relations Act or collective bargaining agreement.

e. Quarantine. References 1e. and 1i. discuss various laws, regulations, and factors affecting quarantine, to include the basis for the assumption of emergency powers on military installations in the event of a public health emergency. Use only after obtaining legal counsel. If you restrict movement, you may be responsible for sustaining those restricted.

### 5. Execution.

#### a. Concept of Operations.

(1) A planning and decision-making structure that ensures the capacity of the MTF to detect and respond appropriately will be established. This structure should consist of an internal, multidisciplinary committee with responsibility and authority for SARS preparedness and response. Suggested members are delineated in reference 1a. In addition, a local or state health department staff member should be identified who will serve as the liaison for SARS preparedness and response.

(2) A written SARS preparedness and response plan should be developed. This plan will incorporate the topics addressed in this document. Patient triage, isolation, logistics, and staffing should be discussed in advance of a SARS outbreak in order to manage cases appropriately while minimizing the risk of transmission to other patients, personnel, and visitors.

b. General Tasks and Responsibilities. These general tasks/issues will need to be coordinated:

(1) Respiratory Protection Program. Each MTF will develop or enhance a Respiratory Protection Program that includes medical clearance of personnel likely to be called on to wear a

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NIOSH-approved N95 particulate respirator, fit testing of that respirator, and appropriate occupational record-keeping. These programs will comply with Occupational Safety & Health Administration standard 1910.134.

(2) Personal Protective Equipment (PPE). MTFs will develop plans for providing PPE to their staff, in various sizes and adequate numbers, and at no cost to the workers.

(3) Safety and Security. MTFs will coordinate with installation provost marshals or other military police units for the physical security of MTF property and personnel. This will include the control of access to the MTF if command decisions are made to limit the admissions or transfers of patients, or to limit visitors (reference 1a.).

c. Specific Tasks and Responsibilities. Specific components of the SARS response plan that will need to be individually developed will include (reference 1a.):

(1) Surveillance and Triage.

(a) In the *absence* of known SARS activity worldwide, establish surveillance aimed at early detection of cases and clusters of respiratory infections that might signal the re-emergence of SARS.

- Participate in surveillance activities to detect new SARS cases, in accordance with public health guidelines (reference 1g.).

- Screen all patients hospitalized with pneumonia for the three following characteristics that might indicate a higher index of suspicion for SARS-CoV infection:

- In the 10 days before illness onset, travel to or close contact with other ill persons who recently traveled to a previously affected SARS area, or

- Employment as a healthcare worker, or

- Close contact with person(s) recently found to have radiographic evidence of pneumonia without an alternative diagnosis

- Post visual alerts (in appropriate languages) at the entrances to all outpatient facilities (emergency departments, physicians' offices, outpatient clinics) requesting that patients inform healthcare personnel of respiratory symptoms when they register for care and describing recommended "respiratory etiquette" precautions (detailed below).

(b) In the *presence* of global SARS activity, establish surveillance to promptly identify and report all new SARS cases that present for evaluation at the MTF.

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- Continue to implement case detection and reporting efforts as detailed above and in reference g.
- Develop a strategy and assign responsibility for regularly updating clinicians and intake and triage staff on the status of SARS locally, nationally, and internationally.
- Train intake and triage staff on how to assess risks for SARS and use any applicable tools to screen patients.
- Educate clinical healthcare providers about the signs and symptoms of and current risk factors for SARS.
- Institute a strategy to monitor the health of staff and patients who are potentially exposed to SARS.

--Determine the threshold at which screening of persons entering the facility will be initiated and at what point screening will escalate from passive (e.g., signs at the entrance) to active (e.g., direct questioning). Screening will likely need to be coordinated with access controls (see below). In addition to visual alerts, other potential screening measures include:

--Priority triage of persons with respiratory symptoms

--Triage stations outside the facility to screen patients before they enter

--Telephone screening of patients with appointments

- Screen all patients presenting to emergency rooms or hospital clinics with a fever or symptoms of lower respiratory infection for SARS risk factors. Report any potential SARS cases or clusters of febrile respiratory illness among healthcare workers according to the guidance in reference 1g.

- Other, enhanced activities may be considered (reference 1a.).

(2) Clinical evaluation of patients. To date, no specific clinical or laboratory findings can distinguish SARS from other respiratory illnesses reliably and rapidly enough to inform management decisions that must be made soon after a patient presents to the healthcare system. Therefore, early clinical recognition of SARS still relies on a combination of clinical and epidemiologic features. Although exposure history is a main factor in the diagnosis, many SARS patients do share some suggestive clinical characteristics. These include: presence of fever and other systemic symptoms 2 to 7 days before onset of a dry cough and dyspnea, presence of

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radiographic evidence of pneumonia in most patients by day 7 to 10 of illness, infrequent presence of upper respiratory tract symptoms, and lymphopenia. The clinical set point for considering SARS will vary by likelihood and level of risk of exposure. Potential sources of exposure will vary by the status of SARS locally, nationally, and globally. Potential SARS patients need to be evaluated and managed in a way that protects healthcare workers, other patients, and visitors. All potential SARS patients must be evaluated using safe work practices:

- Assign only trained and fit-tested emergency staff to evaluate possible SARS patients.
- Instruct staff to wear appropriate PPE (judged by level of patient risk and epidemiology).
- Use droplet precautions when caring for any patient with both fever and respiratory symptoms.

(a) In the *absence* of known SARS activity worldwide, a routine evaluation of respiratory illnesses should be performed and a low index of suspicion for SARS maintained. The overall likelihood that a given patient with fever or respiratory illness has SARS will be exceedingly low unless there are both typical clinical findings and some accompanying epidemiologic evidence that raises the suspicion of exposure to SARS-CoV. An approach for evaluating patients with pneumonia in the absence of SARS worldwide is more completely described in reference 1a., Appendix C1.

- For all patients with febrile and/or respiratory illnesses, a routine diagnostic and therapeutic workup should be performed.
- For patients with radiographically confirmed pneumonia that is severe enough to require hospitalization, isolation, and infection control procedures as described in references 1a., 1c., and 1d. should be performed.
- In the setting of no transmission in the world, evaluation and management for possible SARS should be considered only for adults, unless there are special circumstances that make the clinician and health department consider a child to be of potentially higher risk.

(b) In the *presence* of SARS activity worldwide, the index of suspicion for SARS should be increased as appropriate based on the patient's symptoms and epidemiologic risk factors. The positive predictive value of even early clinical symptoms in this situation (e.g., fever or respiratory symptoms in the absence of pneumonia), while still low, may be higher if used in combination with an epidemiologic link to a setting in which SARS has been documented.

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- Consider initiating “a universal respiratory etiquette strategy” for the MTF. Provide surgical masks or tissues to all patients presenting with respiratory symptoms, place patients with respiratory symptoms in a private room or cubicle as soon as possible, and implement use of surgical masks by healthcare personnel during evaluation of patients with respiratory symptoms. For patients who cannot wear a surgical mask, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them, and the importance of hand hygiene after handling this material. Provide hand hygiene materials in waiting room areas, and encourage patients with respiratory symptoms to perform hand hygiene. Designate an area in waiting rooms where patients with respiratory symptoms can be segregated (ideally by at least 3 feet) from other patients who do not have respiratory symptoms. Additional components of a universal respiratory etiquette strategy are delineated in reference 1a.

(4) Patient Placement, Isolation, and Cohorting. Appropriate patient placement is a significant component of effective SARS control. Each healthcare facility should develop a strategy and procedures to: (1) quickly separate potential SARS patients from other patients, and (2) implement appropriate isolation precautions. Further recommendations to minimize the risk of transmission to staff, patients, and visitors can be found in reference 1a.

(5) Other integral components for a Preparedness and Response Plan for MTFs include:

(a) Engineering and environmental controls (reference 1a.).

--The appropriate numbers of functioning negative airflow rooms for hospitalizing patients with SARS should be planned for, both for incidental numbers but also surge capacity. If such rooms are not available, planning for how non-negative airflow rooms could be modified if needed to achieve appropriate airflow direction and/or air exchanges should be performed.

--Planning for a location in the hospital for a “SARS unit” where patients and the staff caring for them can be cohorted should be done.

--A plan should be considered for the creation of a SARS evaluation center, where patients (especially when SARS is known to be in the community) with compatible symptoms could be separated from the general presenting population, for separate evaluation.

(b) Exposure reporting and evaluation.

--The rapid reporting and evaluation of persons exposed to SARS will be an important measure in early identification and isolation.

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- All patients with fever or respiratory symptoms should be questioned about recent close contact with persons suspected to have SARS and about exposure to locations in which recent SARS-CoV transmission is documented or suspected to have occurred. Persons with such an exposure history should be evaluated for SARS-CoV infection as described in reference 1a., Appendix C3.

(3) Infection Control and Respiratory Etiquette. Basic infection control practices in the healthcare facility must be reinforced. SARS provides a reminder of the risks of nosocomial transmission of respiratory pathogens and an opportunity to improve overall infection control in MTFs. During the 2003 epidemic, public health authorities quickly recognized the importance of infection control as the primary means for containing SARS. All MTFs need to reemphasize the importance of basic infection control measures for the control of SARS.

- Educate staff about the importance of strict adherence to and proper use of standard infection control measures, especially hand hygiene and isolation (see references 1a., 1c., and 1d.).

- Reinforce education on the recommended procedures for standard, contact, and airborne precautions (<http://www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm>).

- Ensure that personnel have access to fit-testing and instructions on respirator use.

- Determine how infection control training and education will be provided for all hospital personnel and visitors who may be affected by SARS.

- Develop posters and instructional materials designed to: (1) teach appropriate hand hygiene and standard precautions, (2) teach the correct sequence and methods for donning and removing personal protective equipment, (3) instruct on actions to take after an exposure, and (4) instruct visitors and patients with symptoms and SARS risk factors to report to a specified screening and evaluation site.

The importance of respiratory etiquette to help decrease transmission of SARS-CoV and other respiratory pathogens must be emphasized. Many viral and some bacterial respiratory pathogens (e.g., influenza, adenovirus, respiratory syncytial virus, *Mycoplasma pneumoniae*) share transmission characteristics with SARS-CoV and are also frequently transmitted in healthcare settings. Implementation of “respiratory etiquette” practices can decrease the risk of transmission from unrecognized SARS patients and also control the spread of other, more common, respiratory pathogens.

- Patients should be educated about the importance of respiratory etiquette practices for preventing the spread of respiratory illnesses.

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--Educate the staff on risks and protection from exposure to SARS. If not already established, an exposure reporting process, for both high-risk and not high risk procedures, should be in place. Procedures should be established for managing symptomatic healthcare workers who have cared for or been exposed to a SARS patient (reference 1a.).

### (c) Staffing needs and personnel policies (reference 1a.).

--The appearance of SARS in an MTF will challenge that facility's ability to meet staffing, organizational, and resource needs.

--Strategies will need to be developed to meet the range of staffing needs that might be required to manage a SARS outbreak, to include possibly the pre-assignment of staff who are trained and prepared for the necessary procedural care of SARS patients, with appropriate infection control.

### (d) Supplies and equipment (reference 1a.).

--Both consumable (e.g., PPE, hand hygiene supplies) and durable (e.g., ventilators) will be needed to care for SARS patients. It can be anticipated that the ability to order replacement supplies will be strained by the presence of a community SARS outbreak. Planning should occur in anticipation of these events, and a back-up plan created in the case of limited supplies.

### (e) Communication and reporting (reference 1a.).

--Adequate communication with local health departments must be maintained, and a mechanism established to perform this.

--Plans to communicate with other MTFs, local healthcare facilities, and the public must be made.

## 6. Operational Constraints.

### a. Training and Education.

(1) MTFs will know how to readily access educational materials (e.g., CDC and DoD websites), including fact sheets specific for healthcare workers (HCW), ancillary staff, families, worried well, and patients. Have paper or CD-ROM versions of fact sheets available, in case access to the Internet is lost.

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(2) MTFs will provide education for people with special needs (e.g., those with low English literacy), using culturally appropriate and culturally competent providers.

(3) MTF policies and procedures will be readily available to staff using appropriate technology (e.g., Intranet, CD-ROM, paper).

b. **Signage.** MTFs will prepare a supply of standard precaution and transmission-based precaution instructional signs (e.g., airborne-isolation signs, contact-isolation signs).

c. **Staff Safety.** MTFs are responsible for education on personal protective measures by all staff members with possible patient contact, including hand hygiene and personal protective equipment. The MTF is responsible for fit-testing of NIOSH-approved, at a minimum, the N-95 particulate respirators.

### 7. Administration and Logistics.

#### a. Supplies and Equipment.

(1) **Linen.** MTFs will develop plans for handling linens in a SARS outbreak. Linen will be handled with care to avoid contamination of the environment. MTFs will provide laundry workers with appropriate PPE, including a fit-tested NIOSH-approved N95 particulate respirator, gown, and disposable gloves. Workers will wear PPE appropriately when in contact with soiled linen. Linen will be sanitized using appropriate hot wash temperatures, detergent according to manufacturers' recommendations, and adequate amounts of bleach (reference 1h).

(2) **Regulated Medical Waste (RMW).** MTFs will develop plans for handling RMW in a SARS outbreak. Abide by whichever regulations are most stringent in your area: federal, state, or local. All bodily fluids are safely disposed of via the sanitary sewer. All waste generated by SARS cases will be treated as RMW.

(3) **Cleaning, Disinfection, and Sterilization of Equipment and Environment.** A component of contact precautions is careful management of potentially contaminated equipment and environmental surfaces.

(a) When possible, noncritical patient-care equipment should be dedicated to a single patient (or cohort of patients with the same illness).

(b) If use of common items is unavoidable, do not use potentially contaminated, reusable equipment for the care of another patient until it has been appropriately cleaned and reprocessed. MTFs will establish policies and monitor for compliance.

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(c) EPA-approved hospital-grade germicides (“hospital-approved disinfectants,” HAD) will kill the SARS-CoV. Decontamination of equipment should occur in accordance with current CDC recommendations, manufacturer’s instructions, and facility procedures (reference 1h.).

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## ANNEX B TO SARS PLANNING GUIDANCE PUBLIC AFFAIRS

### 1. References.

- a. DoD Directive 6200.3, Emergency Health Powers on Military Installations, 12 May 2003.
- b. MEDCOM Pamphlet 525-1, Public Affairs Annex T (Medical Emergency Management Planning), 1 October 2003.
- c. United States Army. Army Crisis Communications Preparation Guide. Washington, DC: January 1999. <http://www.dtic.mil/armylink/apac/Documents/crisiscommguide.pdf>.

2. General. DoD Directive 6200.3 provides policy for the protection of military installations, facilities, and personnel in the event of public health emergency due to biological warfare, terrorism, or communicable disease outbreaks. The directive empowers commanders to declare public health emergencies and invoke quarantines on installations under their command. U.S. Army Medical Command Public Affairs Offices will, within established quarantine constraints, coordinate with their respective installation PAO to help facilitate media coverage of the Army's medical support of the Federal Response Plan (FRP).

a. Mission. The MEDCOM/RMC/MTF Public Affairs Officers (PAOs) will inform and educate relevant audiences regarding the various public health threats, their symptoms, and preventive measures. These audiences should also be advised regarding the potential need for a quarantine of installations to help isolate and control the spread of the health threat. Further, PAOs will support and augment the government lead agency in helping to respond to media queries related to the health threat(s), quarantine, and any military support to civilian agencies/authorities.

b. Assumption. The first suspected or confirmed case of a serious health hazard within the installation will generate intensive local, regional, state, national, and international media interest. Dealing with a potential outbreak will require extensive communications activities among numerous government agencies.

c. Background. Reference 1a outlines DoD's plans and activities addressing emergency health powers on military installations. Reference 1b details MEDCOM public affairs planning in support of medical emergency management planning before and after a health hazard outbreak. This plan reflects the government goal of synchronizing messages from government lead agency ("speaking with one voice"). Reference 1c provides suggestions for developing installation communications plans for dealing with emergency situations.

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### 3. Communications Objectives.

a. To help instill and maintain public confidence in the installation commander's leadership, credibility, the installation's healthcare system, and its ability to work in coordination with civilian authorities to respond to, and manage a health hazard outbreak. Public messages will be coordinated and will provide accurate, rapid, and complete information to educate, calm fears, and maintain public order.

b. To minimize, as much as possible, public panic and fear related to the outbreak and the installation's quarantine.

c. To rapidly provide the public, healthcare providers, policymakers, and the media access to accurate, consistent, and comprehensive information about the particular health hazard, its treatment, and the management of the situation.

d. To address and correct, as quickly as possible, rumors, inaccuracies, and misperceptions.

e. To provide accurate, consistent, and highly accessible information and materials through the coordination of communication efforts with installation PAOs and other Federal, State, and local partners.

### 4. Strategies.

a. Support timely and aggressive education of service members, DoD civilians, contract employees and retirees, and their families about the health hazard outbreak and quarantine.

b. Ensure the public and media perceive that the military and public health systems are prepared for such contingencies and are working to treat those affected and to contain the health hazard.

c. Ensure all supporting medical activities have credible and trained spokespersons to answer media, Congressional, and public queries related to the military's support of the government lead agency efforts.

d. Encourage media and other interested parties with questions to use installation, DoD and government websites (e.g., [www.cdc.org](http://www.cdc.org); [www.fema.org](http://www.fema.org)) for additional information.

e. Leverage all DoD communications tools and products to support the government lead agency efforts and to educate the various publics.

## **Severe Acute Respiratory Syndrome (SARS) Planning Guidance**

f. Decentralize information to the lowest level, empowering local commands to provide answers to media and other public inquiries about the military's support of lead agency efforts as well as the military's handling of any cases that occur on military installations.

5. **Communication Challenges and Threats.** To address these challenges, specific message maps, and communication tools will be developed identifying:

- a. The source of health hazard or outbreak.
- b. The subtle differences between quarantine, isolation, and restriction of movement.
- c. The purpose of contact tracing and surveillance.
- d. Prioritization for immunization.
- e. Means of counteracting misinformation, controlling rumors, and minimizing alarm.

6. **Primary Audiences and Stakeholders.**

a. U.S. military personnel, including Active Component, Reserve Components, and DoD civilians.

- b. Family members and other healthcare beneficiaries.
- c. DoD leadership.
- d. Congress and the Executive Branch.
- e. Government civilian agencies that respond to terrorist events.
- f. American public via public media.
- g. Government contract personnel.

7. **Responsibilities.**

a. U.S. Army Medical Command Public Affairs Office.

(1) Creates and maintains an on-going crisis communications plan.

(2) Creates and distributes PAO and other informational products as needed to subordinate units.

## **Severe Acute Respiratory Syndrome (SARS) Planning Guidance**

(3) Conducts media training for senior leadership.

(4) Posts appropriate messages/articles about the health hazards and outbreak on the MEDCOM websites.

(5) Supports outbreak education efforts in MEDCOM command information products and ensures all products include the CDC and FEMA websites: [www.cdc.org](http://www.cdc.org); [www.fema.org](http://www.fema.org).

### **b. Army Medical Center/Hospital/Military Treatment Facility Public Affairs Offices.**

(1) Prepare and distribute press releases, in coordination with installation PAOs and DoD, if an outbreak develops and as it progresses. Additional involvement is needed for outbreaks directly affecting military installations.

(2) Use DoD PAO and all other products in responding to media queries.

(3) Encourage each MTF commander to act as a spokesperson and/or identify subject matter experts to respond to media queries.

(4) Coordinate with installation PAO and DoD agencies and government lead agency subject matter experts to respond to requests for interviews.

(5) In coordination with installation PAOs, prepare advisories and responses to media queries on medical aspects of the emergency.

(6) Design or modify websites with plague information, updates, fact sheets, frequently asked questions and answers, and healthcare provider resources, including patient and public education materials.

(7) Monitor public media for articles and inform leadership of stories that have high impact on the medical department.

(8) Provide public-affairs advice to all agencies that request assistance.

(9) Identify PAO representatives to augment the government's lead agency.

(10) Respond quickly and accurately to requests for information about the military's support of CDC.

## **Severe Acute Respiratory Syndrome (SARS) Planning Guidance**

c. Healthcare providers. Augment their own knowledge of the particular health hazard or outbreak and its treatment to ensure their ability to answer Soldier and media questions and help relieve anxiety.

# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

## ANNEX C TO SARS PLANNING GUIDANCE

### MEDICAL TREATMENT FACILITY BUILDING SYSTEM-RELATED CONSIDERATIONS

1. Infectious disease healthcare is provided from the waiting room or triage area through isolation for diagnosis and treatment. Isolation is the critical infectious disease control response to be supported by building systems. The building systems-related considerations for these medical function areas are dependent upon the MTF type –(inpatient or outpatient), the level of infectious disease activity, and the transmission risk associated with a given infectious disease. For example, if no infectious disease cases have been reported anywhere, there may be no need to consider imposing a building system requirement. Operational protocol such as dividing the waiting area so that patients with respiratory symptoms do not sit near others is a practical consideration.

2. As the potential or risk of infectious disease cases increases or cases are confirmed, e.g., a public health emergency, more extensive responses are considered. The more extensive responses include building system considerations. The following building system considerations are feasible for our MTFs. They are well aligned with the Severe Acute Respiratory Syndrome Plan dated 25 November 2003 as stated in the DoD Smallpox Response Plan, Annex C. These considerations are intended to supplement CDC guidance and be part of our Infectious Disease Response Plan. The considerations are grouped into three categories – Low-Cost/No-Cost, Immediate, and Long Term:

a. Low-Cost/No-Cost considerations focus on using existing building systems most effectively to minimize nosocomial infections.

b. Immediate considerations primarily include those that can be classified as adjustments to existing building systems.

c. Long-Term considerations involve building system alteration that will require construction time and may require design time.

### 3. Low-Cost/No-Cost Considerations

a. If a patient is suspected of having an infectious disease, it is advisable to move the patient to an airborne infectious isolation room (AIIR). If the facility has an AIIR, check that valid certification exists and will be updated at least annually. The required room conditions are 78 F/68 F summer/winter room temperature, minimum 6 total supply air changes - at least 2 of which shall be outside air, 10% negative room pressurization, and air exhausted from the room to outside the MTF. Typically the exhausted air does not require filtration if its discharge point

## Severe Acute Respiratory Syndrome (SARS) Planning Guidance

from the MTF is located at least 30 feet from windows, doors, and walkways. Reference: MIL-HDBK-1191, Chapter 8 and Appendix A.

b. If there is no existing AIIR and one is deemed necessary for a given MTF, select an appropriate room to be retrofitted to provide the required conditions listed above. If no AIIR exists and there is an immediate need, have an appropriate room identified from those exhausted, preferably with a negative pressurization, e.g. a decontamination room, soiled linen or utility rooms, certain physical therapy rooms, or bathrooms. The controls for the exhaust fans serving rooms that are converted to AIIR's on an emergency basis shall be adjusted to ensure continuous operation while the room is occupied by a suspected or confirmed infectious-diseased patient. If the existing rooms of this type are not appropriate, identify a neutral pressurized room that can be isolated. The neutral room shall be located where (1) occupant activity is minimal and (2) adjoining rooms can be vacated, if necessary. The "isolated" neutral room may be considered if the number of suspected or confirmed patients exceeds the number of AIIRs.

c. When the number of patients greatly exceeds the number of existing AIIRs, consider employing the established practice of cohorting. Identify in advance an appropriate group of rooms, or area, that is preferably exhausted and under negative pressure. Options include exam rooms, a large physical therapy area, patient bedrooms, or an ambulance garage. For larger patient numbers consider a zone such as one served by a given air handling unit, i.e., an HVAC zone. This minimizes the risk of transmitting airborne contaminants to areas adjoining the cohorted zone. For even larger patient numbers consider a building wing such as in a patient bedroom tower, a clinic area, or a dedicated detached MTF. Once again, HVAC zoning shall be considered when identifying larger patient number areas within an existing facility for cohorting.

### 4. Immediate Considerations

a. In a period of increased infectious disease risk or confirmed cases, more protective measures are considered. A first line of defense is to increase the AIIR inventory. The building system considerations for satisfying the immediate need for this protective measures are most feasibly provided by system adjustments. Immediate adjustments are focused on room air changes and pressurization.

b. A given room's supply diffuser control damper adjustment may establish negative room pressurization and increase air changes where necessary to convert the existing room to an AIIR. Supply and return air balancing damper adjustment may also accomplish this. If the room has a dedicated terminal unit, it may be adjusted to assist in establishing negative pressurization and increase total air changes if necessary.

c. As the number of existing rooms served by a given air handling unit, i.e. rooms within a given HVAC zone, increases, additional adjustments shall be considered. Supply air fan, return air fan and exhaust fan may be adjusted to assist in establishing the required room conditions.

## Severe Acute Respiratory Syndrome (SARS) Planning Guidance

### 5. Long-Term Considerations

a. Proactive building system considerations for an infectious disease response plan can focus on being prepared to provide isolated healthcare to a large number of high-risk or confirmed cases. Considerations can include isolating a group of rooms, a larger number of rooms constituting a dedicated area within an existing MTF, a detached existing MTF, or constructing a dedicated MTF.

b. When considering a group of rooms for cohorting patients, attempt to identify rooms served by a common terminal unit. This provides a better opportunity to establish required room conditions by adjustment only. Otherwise, redesign and construction will be required.

c. For larger numbers of rooms, attempt to identify rooms on both sides of a given corridor. If supply air to the corridor can be increased to create positive pressurization, then neutral cohorting rooms will be relatively negative to the corridor. This lowers the transmission risk if patient rooms cannot be adjusted to negative pressurization and may provide an acceptable level of isolation. For assured isolation in accordance with required room conditions, redesign and construction will be required. The redesign and construction may be accomplished in-house depending upon the given MTF staffing.

d. When identifying a group of rooms to be used for isolating patients, it is advisable to select a group served by the same air handling unit, i.e., within a given HVAC zone. This also provides a better opportunity to establish room conditions with minimum redesign and construction effort. If the number of isolation rooms deemed necessary is large enough to require more than one HVAC zone, consider identifying an area that is conducive to isolating protocol such as a wing – e.g., a patient bed tower, a dedicated area – e.g., outpatient clinics within a MEDCEN, or a dedicated detached MTF – e.g., a clinic. These larger areas provide the opportunity to establish the required room conditions by adjusting existing building systems. If adjustment is not feasible, constructing the rooms in one area will minimize the redesign and construction effort.

e. Where redesign and alteration of an existing MTF is not feasible or justified, a dedicated isolation center addition or detached MTF can be custom designed as required.

# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

## ANNEX D TO SARS PLANNING GUIDANCE

### SPECIMEN COLLECTION, TRANSPORT GUIDELINES, AND TESTING

#### 1. Reference.

Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), 8 January 2004, Centers for Disease Control and Prevention. <http://www.cdc.gov/ncidod/sars/guidance>

#### 2. General. This DoD Laboratory Annex augments the DoD SARS Plan.

a. Mission. Military medical treatment facility (MTF) clinical laboratories participate in the Laboratory Response Network (LRN), a collaborative effort of the Centers for Disease Control & Prevention (CDC) and the Association of Public Health Laboratories ([www.bt.cdc.gov/LabIssues/index.asp](http://www.bt.cdc.gov/LabIssues/index.asp)). These laboratories maintain personnel trained to process clinical microbiology specimens and detect suspicious microbes that might indicate use of bioterrorism agents. Accordingly, they will follow CDC guidance for collecting and processing specimens. MTFs will be prepared to assist in the collection and shipment of clinical specimens from potential SARS patients.

b. Assumptions. Not applicable.

c. Planning Factors.

(1) MTF clinical laboratories are designated as Sentinel (formerly Level A) and Reference (formerly Levels B and C) laboratories within the LRN.

(2) Six Regional Medical Centers offer the CDC polymerase chain reaction (PCR) test for detection of SARS RNA in clinical specimens. These laboratories can support testing of potential SARS patients seen at their respective facilities. Other AMEDD MTF should have SARS testing done at their State Public Health laboratory.

d. Coordinating Instructions.

(1) If there are no known SARS cases worldwide, then a healthcare provider admitting a patient with radiographic evidence of pneumonia should determine if the patient had been in a previously SARS-infected region within the past 10 days; if the patient is a healthcare worker with direct patient contact; and if the patient had any close contacts with radiographic proven pneumonia with no definitive diagnosis. If the patient replies to the affirmative for any of the three questions, the healthcare provider should notify the local health department, and rule out sepsis,

## Severe Acute Respiratory Syndrome (SARS) Planning Guidance

bacterial pneumonia, influenza and RSV. If testing for alternative infections is positive, treat the patient as indicated. If all lab testing is negative, consult with the local Health Department to look for evidence of clusters of pneumonias. If clusters of pneumonia are evident, consider SARS testing in consultation with the health department or MEDCEN with SARS testing capability.

(2) If there is currently SARS activity anywhere in the world, then a patient admitted for fever or respiratory illness having been in a SARS location, or exposure to persons suspected of having SARS, should be placed under SARS isolation precautions. The local Health Department should be notified. The patient should be tested for influenza, RSV, bacterial sepsis, and bacterial pneumonia. If the patient has radiographic evidence of pulmonary infiltrates, consult with the local Health Department to test the patient for SARS. If the patient has no radiographic evidence of pulmonary infiltrates, consider SARS testing only if no alternative diagnosis is determined, and if the fever or respiratory symptoms persist.

### 3. Execution.

a. Concept of Operations. Training providers in recognition of patients with symptoms of SARS illness is key to determining the need for SARS testing, as well as testing to determine alternative diagnoses. Since many microbes can cause symptoms similar to SARS disease, healthcare providers should collect specimens to determine alternative presence of causative pathogens. The healthcare provider should collect blood cultures to determine if the patient has a bloodstream infection. Sputum for culture and Gram stain can help detect bacterial pneumonia. The patient can also be tested for influenza and RSV, both with direct antigens and viral cultures. Rapid antigens can also be used to detect urinary *Legionella* antigen. In the absence of alternative diagnoses, and when the patient has at least one risk factor for SARS exposure, healthcare providers should consult with the local Health Department for SARS testing. All SARS testing is experimental, and patients should sign a consent form for SARS testing. Health Departments may perform PCR for SARS RNA, and/or perform serology tests to detect antibody to the SARS-CoV. Specimen collection guidelines are defined in Appendix 1. Biosafety guidelines for the safe collection and handling of these clinical specimens are found in Appendix 2. Test results should be discussed and interpreted with Health Department officials. All positive SARS PCR tests will be confirmed at the CDC. Regional Medical Centers also offer SARS testing for patients within their MTFs. MEDCEN SARS testing is limited to the Lab Response Network PCR test for SARS-CoV RNA. These tests are experimental, so the patient should sign a consent form for SARS testing. Any positive SARS PCR test results will be confirmed at the CDC.

#### b. Tasks and Responsibilities.

(1) The MTF Commander is responsible for:

(a) Training healthcare providers to recognize the symptoms of SARS, and to be able to determine if the patient has any risk factors that might indicate the need for SARS testing.

## Severe Acute Respiratory Syndrome (SARS) Planning Guidance

(b) Ensuring that the clinical laboratory staff is trained and qualified to provide proper shipping of clinical specimens to the local Health Department for SARS testing. Additionally, pathologists and appropriate staff will be provided training for the safe processing, storage, and specimen collection from the bodies of patients who may have succumbed to SARS.

(2) The initial health-care provider who suspects a patient is high risk for SARS will notify the MTF commander immediately. The MTF will implement SARS infection control measures.

(3) The Laboratory Medical Director, Department of Pathology, will ensure that laboratory personnel responsible for shipping specimens are trained on shipping procedures and maintain inventories of proper shipping supplies (Appendix D-1, Appendix D-2). The laboratory must have a person trained and certified in shipment of hazardous substances including infectious agents. This person must be recertified every 2 years. The US Army Center for Health Promotion and Preventive Medicine (USACHPPM) provides such training ("Transport of Biomedical Materials"), as may other Services or Agencies. Information on this training is provided on the CHPPM web page at <http://chppm-www.apgea.army.mil/TrainCon/datePage.aspx>.

c. Report results through the Chain of Command. If PCR is done in-house, report all results to the local Health Department.

### 4. Administration and Logistics.

a. Equipment. The MTF will provide fit-tested NIOSH-approved N-95 masks or higher or HEPA-filtered respirators to personnel designated as part of the smallpox specimen collection teams.

b. Air Transportation. MTFs will support transportation of smallpox specimens (biological agents), coordinated with the FBI, State Public Health Lab officials, or the CDC according to International Air Transport Association (IATA) guidelines. A copy of the Dangerous Goods Regulations (DGR) can be obtained by calling 1-800-716-6326 or through the Internet at [www.iata.org](http://www.iata.org) or [www.who.int](http://www.who.int). Biological agents are considered hazardous materials and their transportation is subject to regulatory control. Appendix D-6 directs the detailed procedures for packaging possible smallpox samples. A designated person in the MTF laboratory must be certified in infectious disease shipping. Prior coordination is required with personnel at the local Transportation Office or the Air Transportation Operations Center (ATOC) to ensure shipping requirements are followed for movement by military air or ground transportation.

c. Maritime Transportation. Maritime shipping of hazardous agents is covered by the International Maritime Dangerous Goods Code (incorporating Amendment 30-00). This document is published by the International Maritime Organization ([www.imo.org/home.asp](http://www.imo.org/home.asp)).

## **Severe Acute Respiratory Syndrome (SARS) Planning Guidance**

5. Command, Control, and Communications. Communication about a suspected SARS case cannot be delayed. Notification of higher headquarters is required. Consultation with the State Public Health Department is required when patients are deemed to be high-risk for SARS.

6. Special Situations.

a. SARS Testing in U.S. European Command (EUCOM). Landstuhl Regional Medical Center (LRMC) is a Lab Response Network Reference Lab, and has SARS PCR testing capability. Specimens that are positive for SARS RNA by PCR must be confirmed at the CDC. Landstuhl RMC Preventive Medicine personnel should notify the Host Nation public health system through established chains of communication. Additionally the Technical Escort Unit (TEU) may be available for sample transport. Coordination with the TEU flows from the MTF commander to the Unified Command Surgeon's Office.

b. SARS Testing in U.S. Pacific Command (PACOM). Tripler Army Medical Center is a Lab Response Network Reference Lab, and has SARS PCR testing capability. Specimens that are positive for SARS RNA by PCR must be confirmed at the CDC.

# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

## APPENDIX D-1

### SPECIMEN SHIPPING.

#### 1. Guidelines for Packaging and Transporting Biological Agents.

a. Biological agents include infectious agents of humans, plants, and animals, as well as the toxins that may be produced by microbes and by genetic material potentially hazardous by itself or when introduced into a suitable vector. Etiologic agents and infectious substances are closely related terms that are found in the transfer and transportation regulations. Biological agents may exist as purified and concentrated cultures, but may also be present in a variety of materials such as body fluids, tissues, and soil samples. Biological agents and the materials known or suspected to contain them are recognized by federal and state governments as hazardous materials and their transportation and transfer is subject to regulatory control.

b. Transportation refers to the packaging and shipping of these materials by air, land, or sea, generally by a commercial conveyance. Transfer refers to the process of exchanging these materials between facilities.

2. Transportation. Regulations on the transportation of biological agents are aimed at ensuring that the public and the workers in the transportation chain are protected from exposure to any agent that might be in the package. Protection is achieved through:

a. The requirements for rigorous packaging that will withstand rough handling and contain all liquid material within the package without leakage to the outside.

b. Appropriate labeling of the package with the biohazard symbol and other labels to alert the workers in the transportation chain to the hazardous contents of the package.

c. Documentation of the hazardous contents of the package should such information be necessary in an emergency situation.

d. Training of workers in the transportation chain to familiarize them with the hazardous contents so as to be able to respond to emergency situations.

#### 3. Regulations.

a. U.S. Public Health Service. 42 CFR Part 72. Interstate Transportation of Etiologic Agents. This regulation is in revision to harmonize it with the other U.S. and international regulations. <http://www.cdc.gov/od/ohs/biosfty/shipregs.htm>.

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b. U.S. Department of Transportation (DOT). 49 CFR Parts 171-178, Hazardous Materials Regulations. Applies to the shipment of both biological agents and clinical specimens. <http://hazmat.dot.gov/rules.htm>.

c. U.S. Postal Service (USPS). 39 CFR Part 111, Mailability of Etiologic Agents, codified in the Domestic Mail Manual 124.38: Etiologic Agent Preparations, <http://www.access.gpo.gov> or [www.usps.gov](http://www.usps.gov).

d. Occupational Health and Safety Administration (OSHA), 29 CFR Part 1910.1030, Occupational Exposure to Bloodborne Pathogens. Provides minimal packaging and labeling requirements for transport of blood and body fluids within the laboratory and outside of it, <http://www.osha.gov/comp-links.html>.

e. Dangerous Goods Regulations (DGR), International Air Transport Association (IATA). These regulations provide packaging and labeling requirements for infectious substances and materials, as well as clinical specimens that have a low probability of containing an infectious substance. These are the regulations followed by the airlines. These regulations are derived from the Committee of Experts on the Transport of Dangerous Goods, United Nations Secretariat, and the Technical Instructions for the Transport of Dangerous Goods by air that is provided by the International Civil Aviation Organization (ICAO). <http://www1.iata.org/NR/ContentConnector/CS2000/SiteInterface/pdf/cargo/dg/43rev8April22.pdf>.

f. Importation of Etiologic Agents of Human Disease, 42 CFR Part 71 Foreign Quarantine, Part 71.54 Etiologic Agents, Hosts and Vectors. This regulation requires an import permit from the Centers for Disease Control and Prevention for importing etiologic agents of human disease and any materials, including live animals or insects, that may contain them. An application and information on importation permits may be obtained by calling 1-888-CDC-FAXX and enter document number 101000 or via <http://www.cdc.gov/od/ohs/biosfty/impptper.html>. See also [http://www.unm.edu/~sheaweb/sheamannual/biosfty/biosaf\\_i.htm](http://www.unm.edu/~sheaweb/sheamannual/biosfty/biosaf_i.htm).

g. Importation of Etiologic Agents of Livestock, Poultry and Other Animal Diseases, 9 CFR Parts 92, 94, 95, 96, 122, and 130. These regulations require an import permit from the United States Department of Agriculture (USDA), Animal and Plant Health Inspection Service (APHIS), Veterinary Services to import or domestically transfer etiologic agents of livestock, poultry, other animals, and any materials that might contain these etiologic agents. Information may be obtained at (301) 734-3277, or from the Internet at: <http://aphisweb.aphis.usda.gov/ncie>.

h. Transfer of Select Biological Agents of Human Disease. Regulations on the transfer of biological agents are aimed at ensuring that the change in possession of biological materials is within the best interests of the public and the nation. These regulations require documentation of the personnel, facilities, and justification of need for the biological agent in the transfer process and subsequent approval of the transfer process by a federal authority. The following regulations fit in

## **Severe Acute Respiratory Syndrome (SARS) Planning Guidance**

this category: 42 CFR Part 72.6, Additional Requirements for Facilities Transferring or Receiving Select Agents. Facilities transferring or receiving select agents must be registered with the CDC and each transfer of a select agent must be documented. Information may be obtained on the Internet at: <http://www.cdc.gov/od/ohs/lrsat>.

i. Export of Etiologic Agents of Humans, Animals, Plants and Related Materials, Department of Commerce (DOC), 15 CFR Parts 730 to 799. This regulation requires that exporters of a wide variety of etiologic agents of human, plant and animal diseases, including genetic material, and products which might be used for culture of large amounts of agents, will require an export license. Information may be obtained by calling the DOC Bureau of Export Administration at 202-482-4811 or through the Internet at: <http://bxa.fedworld.gov>, or <http://www.bxa.doc.gov>.

# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

## APPENDIX D-2

### SPECIMEN PACKAGING.

1. General Packaging Requirements for Transport of Biological Agents and Clinical Specimens. Figures 1 and 2 illustrate the packaging and labeling of infectious substances and clinical specimens in volumes of less than 50 ml, in accordance with the provisions of subparagraph 72.3(a) of the regulation on Interstate Shipment of Etiologic Agents (42 CFR, Part 72). A revision is pending that may result in additional package labeling requirements, but this has not been issued in final form as of the publication of this fourth edition of *Biosafety in Microbiological and Biomedical Laboratories* (BMBL).

a. Figure 1 below shows the generalized "triple" packaging (i.e., primary receptacle, water tight secondary packaging, durable outer packaging) required for a biological agent of human disease or materials known or suspected of containing them. This packaging requires the "Infectious Substance" label shown in Figure 2 on the outside of the package. This packaging must be certified to meet rigorous performance tests as outlined in the DOT, USPS, Public Health Service (PHS), and IATA regulations.

b. Clinical specimens with a low probability of containing an infectious agent are also required to be "triple" packaged, but performance tests require only that the package shall not leak after a 4-foot drop test. DOT, PHS, and IATA require a "clinical specimen" label on the outside of the package.

c. The shipper's name, address, and telephone number must be on the outer and inner containers.

d. For additional information about proper use of dry ice, see 49 CFR, parts 100-185, and the IATA Dangerous Goods Regulations.

e. For additional information about shipping paper requirements, see 49 CFR 172.200 and in Section 8 of the IATA Dangerous Goods Regulations.

2. Shipping suspected biological threat agents to the CDC.

a. Use the following address: Centers for Disease Control and Prevention, 1600 Clifton Road NE, ATTN: DASH (forward to RRAT Lab), Atlanta, GA 30333.

b. For shipping questions relating to sending specimens to the CDC, call (404) 639-3235.

# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

Figure 1. Packing and Labeling of Infectious Substances

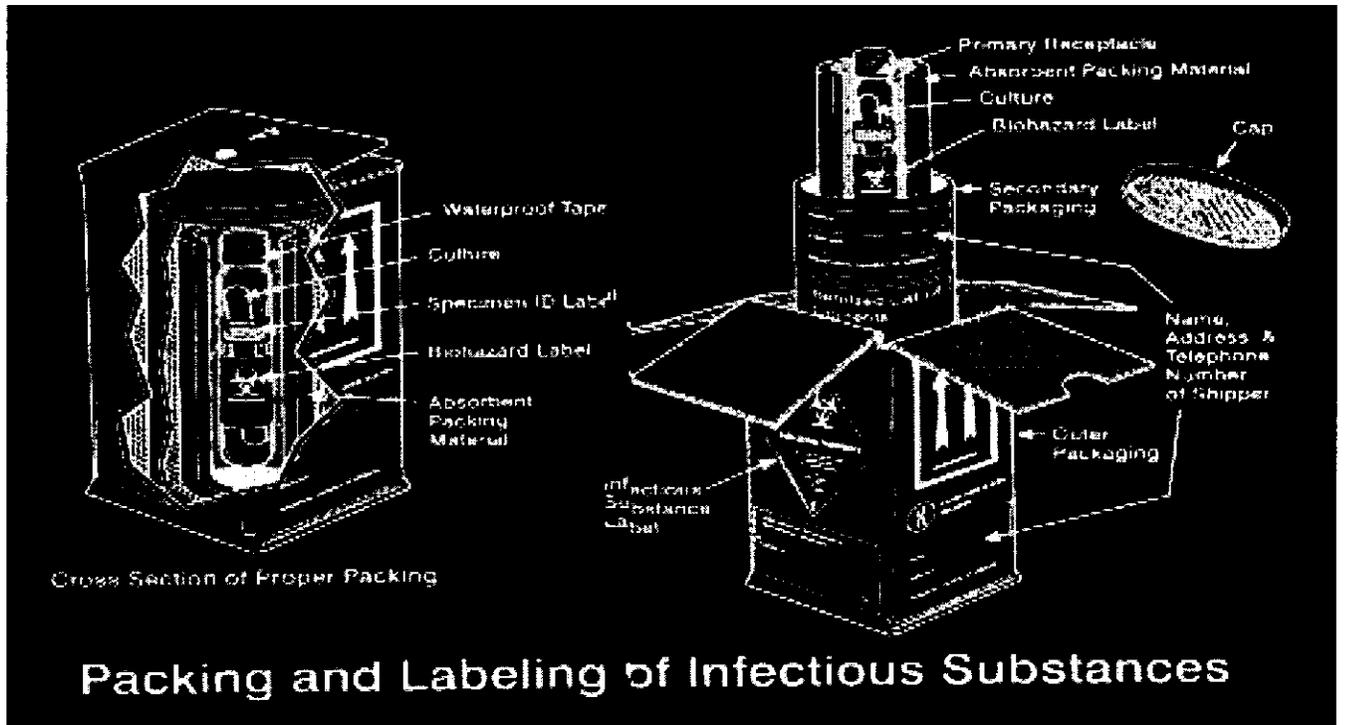
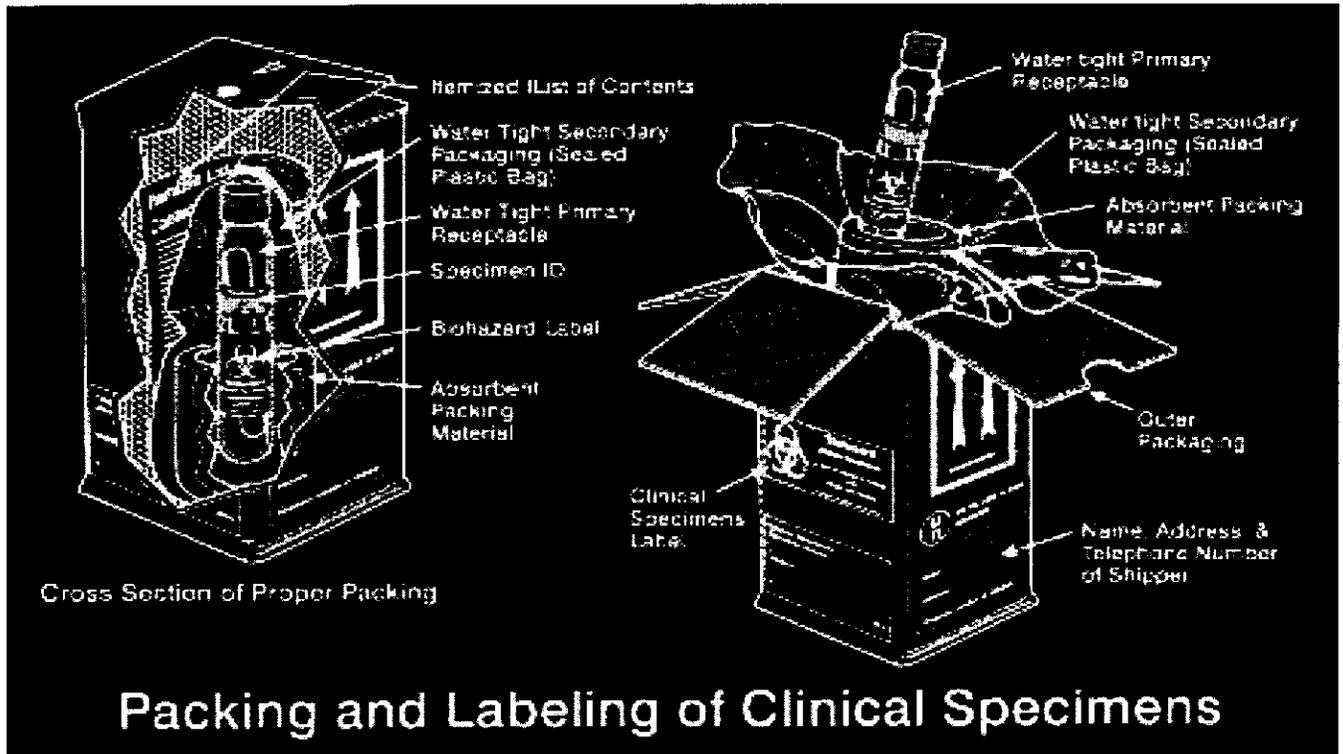


Figure 2. Packing and Labeling of Clinical Specimens

## Severe Acute Respiratory Syndrome (SARS) Planning Guidance



# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

## ANNEX E TO SARS PLANNING GUIDANCE INDEX OF LEGAL REFERENCES

1. Emergency Powers authorized under DoD Directive 6200.3, paragraphs 4.6 and 4.7, [http://services.tma.osd.mil/tricare\\_search/jsps2/webmain.jsp?NewQueryText=dodd&submit.x=6&submit.y=12](http://services.tma.osd.mil/tricare_search/jsps2/webmain.jsp?NewQueryText=dodd&submit.x=6&submit.y=12).

4.6. During a declared public health emergency, a commander, in consultation with the Public Health Emergency Officer (PHEO), may exercise special powers relating to military property on the affected military installation. To the extent necessary for protecting or securing military property or places, associated military personnel, or the installation mission, such special powers may also apply to property not owned by the Department of Defense, but present on a DoD installation or other area under DoD control. Such special powers are the following:

4.6.1. Collecting specimens and performing tests on any property or on any animal, living or deceased, as reasonable and necessary for emergency response.

4.6.2. Closing, directing the evacuation of, or decontaminating any facility, decontaminating or destroying any material, or asserting control over any animal that endangers the public health.

4.6.3. Using facilities, materials, and services for purposes of communications, transportation, occupancy, fuel, food, clothing, healthcare, and other purposes and controlling or restricting the distribution of commodities as reasonable and necessary for emergency response.

4.6.4. Controlling evacuation routes on, and ingress and egress to and from, the affected military installation.

4.6.5. Taking measures to safely dispose of infectious waste as may be reasonable and necessary for emergency response.

4.6.6. Taking measures reasonable and necessary, in accordance with applicable law, to obtain needed healthcare supplies, and controlling use and distribution of such supplies to achieve the greatest public health benefit.

4.7. During a declared public health emergency, a commander, in consultation with the PHEO, may exercise special powers relating to persons necessary to prevent the spread of communicable diseases. To the extent necessary for protecting or securing military property

## **Severe Acute Respiratory Syndrome (SARS) Planning Guidance**

or places and associated military personnel, such special powers may also include persons other than military personnel who are present on a DoD installation or other area under DoD control. Such special powers are the following:

4.7.1. Military personnel may be ordered to submit to a physical examination and/or testing as necessary to diagnose or treat. Persons other than military personnel may be required as a condition of exemption or release from restrictions of movement to submit to a physical examination and/or testing as necessary to diagnose the person and prevent the transmission of a communicable disease. Qualified personnel shall perform examinations and testing, which shall not be likely to result in serious harm to the individual.

4.7.2. Restrictions of movement may be implemented to prevent the spread of communicable diseases. In the case of military personnel, restrictions of movement, including isolation or quarantine, or any other measure necessary to prevent or limit transmitting a communicable disease may be implemented. In the case of persons other than military personnel, restrictions of movement may include limiting ingress and egress to, from, or on a military installation, isolation under subparagraph 4.7.3., or quarantine under subparagraph 4.7.4.

4.7.3. Individuals may be isolated to prevent the spread of a communicable disease. Isolation measures may be implemented in healthcare facilities, living quarters, or other buildings on a military installation. Isolation measures do not lessen the responsibilities of the Military Health System to provide the best medical care feasible to infected persons.

4.7.4. Individuals may be placed in quarantine to prevent the spread of a quarantinable communicable disease. In the case of a quarantine of individuals other than military personnel, the following requirements apply:

4.7.4.1. In the United States, the PHEO shall coordinate with the Centers for Disease Control and Prevention (CDC) in relation to CDC actions under the quarantine authorities provided in references (e), (f), and (g). Overseas, coordination shall be with appropriate host-nation public health officials.

4.7.4.2. The needs of persons quarantined shall be addressed in a systematic and competent fashion. Places of quarantine shall be maintained in a safe and hygienic manner, designed to minimize transmission of infection or other harm to persons subject to quarantine. Adequate food, clothing, medical care, and other necessities shall be provided.

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4.7.4.3. A person subject to quarantine shall obey the rules and orders established by the PHEO, shall not go beyond the quarantine premises, and shall not put himself or herself in contact with any person not subject to quarantine, except as the PHEO authorizes.

4.7.4.4. No person may, without authorization, enter a quarantine premises. A person who by reason of unauthorized entry poses a danger to public health becomes subject to quarantine.

4.7.4.5. Quarantine shall be accomplished through the least restrictive means available, consistent with protection of public health. Quarantine of any person shall be terminated when no longer necessary to protect the public health.

4.7.4.6. The PHEO shall, as soon as practicable, provide to every individual subject to quarantine written notice of the reason for the quarantine and plan of examination, testing, and/or treatment designed to resolve the reason for the quarantine. The PHEO shall provide to any person subject to quarantine who contests the reason for quarantine an opportunity to present information supporting an exemption or release from quarantine. Such information shall be reviewed by the commander or a senior officer or employee of the command designated by the commander and not previously involved in any factual determination concerning the person. The reviewing official shall exercise independent judgment and promptly render a written decision on the need for quarantine for the person.

4.7.5. Military personnel may be ordered to submit to vaccination or treatment, subject to special rules applicable to use of investigational new drugs under DoD Directive 6200.2 (reference (k)). Persons other than military personnel may be required as a condition of exemption or release from restriction of movement to submit to vaccination or treatment as necessary to prevent transmitting a communicable disease. Qualified personnel shall perform vaccination and treatment, consistent with appropriate medical standards, including appropriate medical exemption criteria, which shall not be likely to result in serious harm to the individual. DoD Instruction 6205.4 (reference (l)) does not apply to vaccinations under this paragraph.

4.7.6. The PHEO may take measures reasonable and necessary for testing and safely disposing of corpses in order to prevent the spread of disease, ensuring proper labeling, identification, and records regarding circumstances of death and disposal.

4.7.7. Protected health information shall be used and disclosed as necessary to ensure proper treatment of individuals and prevent the spread of communicable diseases.

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2. It is DoD policy that military installations, property, personnel, and other individuals working, residing, or visiting military installations shall be protected under applicable legal authorities against communicable diseases associated with biological warfare or terrorism or other public health emergency. Military commanders' actions regarding isolation or quarantine on a military installation of infected or possibly infected DoD and non-DoD personnel will be determined by the nature of the outbreak and the laws, regulations, and policies concerning those specific types of situations, especially regarding people other than military personnel. Commanders must obtain legal and medical advice on individual situations from their legal and medical staffs. Local legal advice will reflect state law and coordination with civilian authorities.

3. Applicable legal authorities include:

a. Sections 113, 3013, 5013, and 8013 of Title 10, United States Code. Generally provides authority to conduct the affairs of the Department of Defense authorized by the Constitution and laws of the United States.

b. Section 797 of Title 50, United States Code, (Internal Security Control of Subversive Activities, Security regulations and orders; penalty for violation). Authorizes any lawful regulation or order for protecting or securing any property or places subject to the jurisdiction, administration, or in the custody of the Department of Defense relating to ingress or egress or otherwise providing for safeguarding the same against destruction, loss, or injury by accident or by enemy or other subversive actions.

c. Section 1382 of Title 18, United States Code (Crimes, Entering military, naval, or Coast Guard property). Authorizes the regulation of entry onto military installations.

d. Section 301 of Title 5, United States Code. Authorizes regulations for the custody, use, and preservation of Government property.

e. Sections 243, 264, 266 of Title 42, United States Code.

f. Executive Order 12452, "Revised List of Quarantinable Communicable Diseases," 1983.

g. Title 42, Code of Federal Regulations, Part 70, "Interstate Quarantine".

References 3e through 3g authorize the Director of the Centers for Disease Control and Prevention (CDC) to establish a quarantine to prevent the spread of communicable diseases into the United States, from State to State, or, in time of war, affecting military and other national defense personnel, and to support State quarantines.

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h. Title 42, United States Code, section 97 (42 USC 97; Appendix A-5). Authorizes military officers commanding any fort or station upon the seacoast to enforce quarantines or other restraints established by the health laws of any State respecting vessels and ports, and "all such officers of the United States shall faithfully aid in the execution of such quarantines and health laws, according to their respective powers and within their respective precincts, and as they shall be directed, from time to time, by the Secretary of Health and Human Services."

i. DoD Directive 5200.8, "Security of DoD Installations and Resources," April 25, 1991. Every military commander required by DoD Directive 5200.8 (reference (h)) to issue regulations for protecting and securing property or places under his or her command shall designate a Public Health Emergency Officer (PHEO), who shall be a senior health professions military officer or DoD civilian employee affiliated with the command of the commander or of a higher level or associated command. Authorities and responsibilities of the PHEO under this Directive are subject to the direction and authority of the commander making the designation. The PHEO should be the Command Surgeon, local equivalent, hospital commander, or other senior leader with experience and training in functions essential to effective public health emergency management.

j. DoD 5200.8-R, "Physical Security Program," May 13, 1991.

k. DoD Instruction 2000.18, "Department of Defense Installation Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive Emergency Response Guidelines," December 4, 2002.

l. DoD Directive 6200.2, "Use of Investigational New Drugs for Force Health Protection," August 1, 2000. Military personnel may be ordered to submit to vaccination or treatment, subject to special rules applicable to use of investigational new drugs under DoD Directive 6200.2. Persons other than military personnel may be required as a condition of exemption or release from restriction of movement to submit to vaccination or treatment as necessary to prevent transmitting a communicable disease. Qualified personnel shall perform vaccination and treatment, consistent with appropriate medical standards, including appropriate medical exemption criteria, which shall not be likely to result in serious harm to the individual. DoD Instruction 6205.4 does not apply to these vaccinations.

m. DoD Instruction 6205.4, "Immunization of Other Than U.S. Forces (OTUSF) for Biological Warfare Defense," April 14, 2000.

n. DoD Directive 6200.3, Emergency Health Powers on Military Installations, May 12, 2003 (Certified Current as of November 24, 2003). Note: Please review paragraph 4 in its entirety.

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o. The Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, 42 USC 5121. Under the Stafford Act, a Governor may request that the President declare a major disaster or emergency if an event is beyond the combined response capabilities of the affected state, territorial, and local governments. Based on the severity and magnitude of the situation, the President may issue a major disaster or emergency declaration. Following a declaration, the President may direct any federal agency to use its authorities and resources in support of state and local assistance efforts. If an emergency involves an area or facility for which the federal government exercises exclusive or primary responsibility and authority, the President may unilaterally direct the provision of emergency assistance. The Governor of the affected State will be consulted if possible. Under the Stafford Act and DoD Directive 3025.1, commanders retain their “immediate response” authority.

p. DoD Directive 3025.15, Military Assistance to Civil Authorities, dated 18 February 1997. Governs military assistance during times of civil emergency. The “Department of Defense shall cooperate with and provide military assistance to civil authorities as directed by and consistent with applicable law, Presidential Directives, Executive Orders, and this Directive.”

q. Army Regulation 40-12, SECNAVINST 6210.2A, Air Force Joint Instruction 48-104. Quarantine Regulations of the Armed Forces, 24 January 1992.

r. Army Regulation 525-13, Antiterrorism, 4 January 2002.

s. Centers for Disease Control & Prevention (CDC), Smallpox Response Plan & Guidelines, 23 September 2002, <http://www.bt.cdc.gov/DocumentsApp/Smallpox/RPG/>.

t. Executive Order 13295: Revised List Of Quarantinable Communicable Diseases, dated 4 April 2003, <http://www.cdc.gov/ncidod/sars/executiveorder040403.htm>.

u. CDC, Fact Sheet on Legal Authorities for Isolation/Quarantine, dated 23 April 2003, <http://www.cdc.gov/ncidod/sars/factsheetlegal.htm>.

v. DoD Smallpox Response Plan, 29 Sep 2003, Annex C, Appendix C-9, Appendix C-11, and Appendix C-12; <http://www.smallpox.army.mil/media/pdf/DODSpoxPlan.pdf>.

4. Penalties (see DoD Directive 6200.3, paragraph 4.8).

4.8. Individuals subject to any emergency health powers under paragraphs 4.6. or 4.7. shall be advised that violators of orders under this Directive may be charged with a crime under 50 U.S.C. 797 (reference (b)) and subject to punishment of a fine up to \$100,000, or imprisonment for not more than 1 year, or both.

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4.8.1. In the case of military personnel, these potential sanctions are in addition to applicable military law authorities, to the extent allowed by law.

4.8.2. In the case of any person who refuses to obey or otherwise violates an order under this Directive, the commander of a DoD installation may detain those not subject to military law until civil authorities can respond. The commander shall coordinate with civil authorities to ensure the response is appropriate for the public health emergency.

Note: Under the Posse Comitatus Act (18 USC 1385 and other federal law, e.g., 10 USC, chapter 18), and under DoD policy, military personnel in a Title 10 duty status (as distinguished from Title 32 National Guard duty status) generally may not participate in law-enforcement activities within the United States, except as otherwise authorized by statute or the Constitution. Consequently, military personnel acting under Title 10 shall not collect evidence; interrogate witnesses or suspects; engage in searches for or seizure of evidence; seize, arrest, or apprehend civilians; or otherwise operate as law-enforcement officers, unless specifically authorized by law. Law-enforcement assistance is not ordinarily part of consequence-management operations. The National Guard, when performing state active duty under Title 32, is not bound by the prescriptions of the Posse Comitatus Act.

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## ANNEX F TO SARS PLANNING GUIDANCE PHARMACY SUPPORT GUIDELINES

### 1. References.

a. DoD Directive 6200.3, Emergency Health Powers on Military Installations, 12 May 2003.

b. CDC Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), 8 January 2004; Supplement D: Community Containment Measures, Including Non-Hospital Isolation and Quarantine, Appendix D3.

c. AR 40-3, Medical, Dental, and Veterinary Care, 12 November 2002.

d. MEDCOM Pam 525-1, Medical Emergency Management Planning, 1 October 2003.

2. Purpose. DoD Directives 6200.3 provides policy for the protection of military installations, facilities, and personnel in the event of public health emergencies due to biological warfare, terrorism or communicable disease outbreaks. The directive empowers commanders to declare public health emergencies and invoke quarantines on installations under their command. This annex provides a support template for the Medical Treatment Facility's Department of Pharmacy to execute in response to a Severe Acute Respiratory Syndrome (SARS) outbreak.

3. Concept. It is the intent of a Medical Treatment Facility (MTF) Department of Pharmacy to support a SARS outbreak either external or internal to the facility. Because of potential exposure and quarantine time, it is important the pharmacy environment is conducive to meeting the needs of the staff. It is recommended that the Department of Pharmacy establish a Pharmacy Operations Center (RXC). All requests and questions concerning pharmacy support should be directed to the RXC prior to submitting inpatient prescriptions, medication supply request, bulk drug orders, and ambulatory prescription writing.

### 4. Responsibilities. MTF Pharmacy Division:

a. Prepare to execute the MTF Emergency Management Plans (EMP).

b. Pharmacists in collaboration with other healthcare providers must develop treatment guidelines to recommend drug dosing, monitoring, and adjunct therapy.

c. Ensure that an adequate supply of pharmacy providers are trained in surveillance and monitoring.

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d. Amend local policy to allow pharmacist to dispense medication in isolated areas of the MTF and perform triage with patients who were concerned they were displaying SARS symptoms in non-isolated areas IAW local policy.

e. Coordinate with the Logistics Operations Center in the distribution of emergency pharmaceuticals and vaccines.

f. Coordinate actions with state boards of pharmacy and other regulatory agencies.

### 5. Procedures.

a. Pharmacists must be fully integrated into the EMP and be used as sentinels and message bearers.

b. Provide pharmacy support at the MTFs/RMCs to the SARS isolation wards, to the quarantine population in building(s) outside the MTF, and to the non-SARS hospital patients.

c. Identification of increased resources to address above.

d. Ensures pharmacy and/or medication dispensing staging area supporting the clinic administering vaccines/medication is in compliance with the existing State and/or Federal Laws; assisting and advising healthcare providers on matters involving the use of vaccines/medication; operating pharmacy sterile preparation areas, the point of use drug distribution system, and ambulatory services IAW AR 40-3; maintains control substance accountability IAW AR 40-3 (Appendix B, Inventory, Control, and Accountability of Controlled Substances), and IND drugs accountability IAW AR 40-7.

e. Upon notification that a SARS outbreak has occurred, the MTF pharmacies will sequester any stock of Ribavirin and Interferon on hand and begin controlling the Ribavirin and Interferon as if it were a Schedule II narcotic IAW AR 40-3, Appendix B (Inventory, Control, and Accountability of Controlled Substance).

f. The RXC will activate Pharmacy contamination control procedures to contain the spread of SARS virus within the area of pharmacy operations.

g. RXC will ensure PPE issues for pharmacy staff are clarified.

h. Prepare to receive, store, and issue pharmaceuticals in support of the SARS outbreak and contact and coordinate with nursing and laboratory services to provide inpatient support.

i. RXC will activate the emergency communication strategy and coordinate with IMO to connect pharmacies to real-time, online communications systems.

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j. Coordination with healthcare providers and medical logistics for the increase requirements for supplies/equipment to treat SARS patients and staff.

k. Chief of Pharmacy will delegate the following to RXC team members.

(1) Medical maintenance procedures for SARS operations to include PBO authority.

(2) Environmental Services for both SARS and Non-SARS areas of operation.

(3) Transportation management procedures for the delivery of medication to the SARS isolation wards, the quarantine population in building(s) outside the MTF, and to the non-SARS hospital patients, and to ongoing ambulatory pharmacy operations.

l. Chief, Department of Pharmacy, will operate the pharmacy with respect to departmental security and access, inpatient services, ambulatory services, sterile products, adverse drug reaction/medication error documentation, new drug request, personnel, IAW AR 40-3.

# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

## ANNEX G TO SARS PLANNING GUIDANCE LOGISTICAL SUPPORT GUIDELINES

### 1. References.

a. DoD Directive 6200.3 (Emergency Health Powers on Military Installations).

b. CDC Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), 8 January 2004: Supplement D: Community Containment Measures, Including Non-Hospital Isolation and Quarantine, Appendix D3.

c. AR 40-61, Medical Logistics Procedures and Policies, 25 January 1995.

d. MEDCOM Pam 525-1, Military Operations, Medical Emergency Management Planning, 1 October 2003.

2. Purpose. DoD Directive 6200.3 provides policy for the protection of military installations, facilities, and personnel in the event of public health emergencies due to biological warfare, terrorism or communicable disease outbreaks. The directive empowers commanders to declare public health emergencies and invoke quarantines on installations under their command. This annex provides a support template for a Medical Treatment Facility Logistics Division/ Directors of Logistics to execute in response to a Severe Acute Respiratory Syndrome (SARS) outbreak.

3. Concept. It is the intent of a Medical Treatment Facility Logistics Division to logistically support a SARS outbreak either internal to the facility or to its parent installation. Because persons who have been exposed to SARS may require quarantine for as long as 10 days, it is important to ensure that the environment is conducive to meeting the ongoing physical, mental, and medical needs of the individual. In support of this mission it is highly recommended that the Logistics Division, establish a Logistics Operations Center (LOC) or internal operating cell to centralize all logistical requirements and direct logistical operations. All requests and questions concerning logistical support should be directed to the LOC prior to submitting supply requisitions, medical equipment relocations, supply and services contracting support commitment or obligations, and any other logistical requirement.

### 4. Responsibilities. MTF Logistics Division

a. Prepare to execute internal and installation Emergency Management Plans.

b. Prepare to provide medical logistics support to assigned installation or surrounding areas.

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- c. Prepare to receive, store, and issue Class VIII in support of the SARS outbreak.
- d. Contact and coordinate medical logistical support with local and State planning authorities, as required.
- e. Ensure higher headquarters (Regional Medical Command) is informed of the situation and any additional logistical requirements.
- f. Educate staff about the importance of strict adherence to and proper use of standard infection control measures, especially hand hygiene and isolation.

### **5. Procedures.**

- a. The existing logistics system will be used to the maximum extent possible in concert with current MTF and Installation Emergency Preparedness Plans.
- b. The Chief, Logistics Division, will develop a support plan with the appropriate clinical staff to determine critical medical supply lists with the priority of issue and support for example, the Intensive Care Unit, followed by the Immediate Care Area, and the Minimal Care Area.
- c. All personnel will be readily available within the Logistics Division. Requests for support should be routed through the LOC or the EOC. Additionally, the Logistics Division will coordinate with the Infection-control officers or subject-matter expertise on specific personnel protection procedures
- d. Supply and Distribution Procedures for emergency operations:
  - (1) The Logistics Division should determine where critical supply packages could be stored. This includes specifics such as: Drugs maintained in the Pharmacy, supplies for each of the patient care areas, and medical supplies for external customers.
  - (2) All materiel and services ordered in support of the SARS outbreak will be processed through established logistics automated information systems (DMLSS or TAMMIS), to include all government credit card transactions. The mandatory source for medical materiel is Defense Supply Center Philadelphia (DSCP). However, established DoD Regional Prime Vendor Distributors will be utilized to the greatest extent possible. Medical materiel not available through the DoD Regional Prime Vendor Distributors may be locally procured.
  - (3) Coordinate with the Pharmacy for the increase requirement for supplies/equipment to treat SARS patients.

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### **e. Medical Maintenance Procedures for emergency operations:**

(1) Functions will cease during the SARS epidemic. During this situation Logistics Support Teams (at the discretion of the Maintenance Chief and with concurrence of the Logistics Division Chief) may be pre-positioned in critical areas such as Radiology, Pathology laboratories, the emergency room, and other critical care locations to provide immediate assistance.

(2) Only under the most extreme circumstances will Logistical Support Team personnel join the general labor pools, act as litter bearers, etc.

### **f. Environmental Service Procedures:**

(1) Environmental and Housekeeping services are performed under the existing contractor or in-house government employees.

(2) Emergency response by the contractor or government employees may be required (over and above routinely scheduled work) to provide for patient and staff welfare. The hospital must be maintained in a hygienically clean condition during the SARS epidemic and re-sanitized after the epidemic.

(3) The contractor shall be familiar with the MTF Emergency Management Plan and shall participate in exercises.

(4) The contractor shall establish an emergency recall system for contractor employees who may be required to work in the event of a SARS outbreak or contingency operation. The Contractor's emergency recall system shall require that the Government notify only the Contractor's Representative of an emergency situation to initiate the Contractor's recall system.

(5) Coordinate with the Environmental Service Officer and the Safety Manager for the management, handling, and disposal of regular and hazardous waste. Additionally, the MTF will provide the staff specific information to assuage fears of occupational exposure to SARS. Content will include appropriate personal protective equipment (PPE, e.g., gowns, gloves, respirators, goggles) to protect against the transmission of infectious diseases.

(6) Linen will be handled with care to avoid contamination of the environment. Laundry workers will be provided appropriate PPE. Workers will wear PPE appropriately when in contact with soiled linen. Linen will be sanitized IAW appropriate standards/guidelines.

### **g. Equipment and Property Management Procedures:**

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(1) The Property Book Officer (PBO) will follow current prescribed regulatory policies and guidelines for procurement, accounting, and management of equipment. In the event of a SARS occurrence, Medical and non-medical equipment should be identified and pre-positioned in designated locations for immediate delivery when required.

(2) Local and Regional SOP's will be used for accountability policy and procedures. Property used and identified in support of patient evacuation will be accounted for using the procedures outline in AR 40-61. These procedures will specify "user friendly methods" for temporary hand receipt and lateral transfers of equipment to support current operations.

### **h. Transportation Management Procedures:**

(1) Any section needing additional vehicle support will initiate a vehicle requests through the EOC to the Transportation Coordinator, who will then coordinate with TMP for additional vehicles.

(2) Transportation priorities will be determined at the EOC.

(3) The Transportation Coordinator should develop a matrix of existing/current transportation resources and requirements.

# Severe Acute Respiratory Syndrome (SARS) Planning Guidance

## ANNEX H TO SARS PLANNING GUIDANCE VETERINARY SERVICES PLANNING GUIDELINES

1. Situations requiring veterinary services notification by MTF operations:
  - a. Patients with food or water borne illness caused by a terrorist act or from food or water obtained from military sources, particularly if other locations may be involved.
  - b. Identification of an epidemic or reportable case of a human pathogen also infecting or contaminating animals (examples are SARS, some strains of influenza, West Nile Virus, monkey pox, tularemia, New-variant Creutzfeldt-Jakob disease).
  - c. Any type of quarantine.
  - d. Situations that cause disruption to installation living conditions that may require evacuation or rescue of pets or animals located on the installation.
2. Situations requiring MTF operations notification by veterinary services:
  - a. Epidemic or reportable case of animal pathogen also infecting or contaminating humans.
  - b. Significant contaminate in military food supply chain.
  - c. Human disease identified outside of the MTF in the course of food inspection duties.
3. Veterinary services capabilities:
  - a. Risk management assessment/communication: Veterinarians with board specialty certification and/or master degrees in preventive medicine available and able to communicate with clinicians, PAO or to the press regarding diseases, or situations affecting animals and people (list specific resources).
  - b. Risk assessment of installation/specific facility for food security/food safety.
  - c. Assessment of food sources implicated in human disease, laboratory food analysis for confirmation, and legal evidence requirements (list time factors for shipping samples).
  - d. Identification of potential additional targets for food used as a weapon.
  - e. Experience with the practical aspects of quarantine management.

## **Severe Acute Respiratory Syndrome (SARS) Planning Guidance**

- f. Active veterinary clinics with radiology/anesthesia/medical/surgical/diagnostic equipment, drug and sanitation equipment supplies for potential use for humans (list specific resources).
  - g. Trained veterinary clinicians for use as triage officers or other contingency.
  - h. Animal technicians for laboratory/phlebotomy and other general medical use.
  - i. Deployable SMART-veterinary team for all of above, equipped with PAPR and other personnel safety devices.
  - j. Animal rescue, husbandry, control, euthanasia, and disposal.
  - k. Others as applicable.
4. Recall/Points of contact:
- a. On-call veterinary officer.
  - b. Command and Control.
  - c. Alternate.
  - d. SMART-V activation.
5. It is essential to include veterinary personnel in training exercises to allow proper planning and coordination, as well as create a reasonable expectation of capabilities. Communication and early incorporation of veterinary assets into the assessment phase of the exercise should be given highest priority.
6. Many medical contingencies have accompanying veterinary public health issues that occur outside the walls of the MTF. The veterinary annex should be examined and completed for each medical contingency plan to serve as the basis for identification, communication and coordination of public health issues that are the joint responsibility of the RVC and RMC commanders.

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## ANNEX I TO SARS PLANNING GUIDANCE INSPECTOR GENERAL ROLE

1. Reference AR 20-1, Inspector General Activities and Procedures, 29 March 2002.
2. The RMC Inspector General (IG) will assess the overall compliance with the MTF SARS plan through the Organizational Assessment Program (OA)/Organizational Inspection Program (OIP).
3. The RMC IG will ensure that, at every level:
  - a. The MTF SARS plan is reviewed annually by the appropriate proponent.
  - b. The proponent uses the MTF SARS checklist of critical tasks and any systematic issues are reported to the IG.
4. The IG will advise the commander of the effectiveness of the MTF SARS program as a part of the OAP/OIP and in accordance with reference above.