COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

To: Members of the State Board of Health

From: Juliann Bertone, Communications and Policy Analyst, Office of Emergency Preparedness and Response

Through: Dane Matthew, Director, Office of Emergency Preparedness and Response (DM)

Date: March 20, 2019

Subject: **Rulemaking Hearing**
Proposed Amendments to 6 CCR 1009-5, Regulation 4, Rules and Regulations Pertaining to Preparations for a Bioterrorist Event, Pandemic Influenza, or An Outbreak by A Novel and Highly Fatal Infectious Agent or Biological Toxin

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The department proposes the removal of Regulation 4, Preparations by Regional Emergency Medical and Trauma Services Advisory Councils (RETACs) for an Emergency Epidemic, within 6 CCR 1009-5. Regulation 4 was last updated in 2007; it was not included in the 2015 rewrite of this rule as the Office of Emergency Preparedness and Response wanted more time to study the role of RETACs in partnership with stakeholders. The Department and stakeholders agree that Regulation 4 imposes unnecessary and unenforceable requirements that do not improve the community's ability to respond to an emergency or duplicate other efforts.

No substantive edits occurred since the request for rulemaking and thus, members will find no additional yellow highlighting in the hearing document.

Thank you for your consideration.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1009-5, Regulation 4, Preparations For A Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin

Basis and Purpose.

Regulation 4, Preparations by Regional Emergency Medical and Trauma Services Advisory Councils (RETACs) for an Emergency Epidemic was written in 2007. Colorado has 11 RETACs which are authorized by statute to provide a coordinated approach to emergency medical and trauma care. Each council consists of five or more counties that participate through a local advisory council, responsible for creating a regional implementation plan for delivering emergency medical and trauma care. In addition to this required planning, RETACs have evolved into coordination, outreach and education roles. The advisory councils host trainings and speakers to their regions, and support community events around coordinated emergency medical care.

Regulation 4 imposes unnecessary and unenforceable requirements that do not improve the community's ability to respond to an emergency. The regulation requires RETACs to maintain up-to-date contact notification lists and conduct notification tests. RETACs, as entities, would not perform the notifications in the event of an emergency. As such is it is unnecessary and ineffective to impose this requirement. Community partners recognize the role of RETACs and have other means for engaging pre-hospital care organizations in the event of an emergency. Regulation 4 can be repealed without any impact on the other community partners identified in the rule. Further, the Department found that the structure established in the other sections of the rule is sufficient to meet the community's need and thus, it was unnecessary to substitute another local entity for the RETACs.

The regulation requires RETACs to advise plan development for all pre-hospital care organizations. It is not necessary to require RETACs perform this function as the Hospital Preparedness Program emphasizes Health Care Coalitions[1] and funding allocated through the program requires Colorado's 9 Health Care Coalitions to plan for emergencies with pre-hospital care organizations in their grant deliverables. This achieves the same outcome while providing local communities resources to engage in this work and integrate it into their daily operations. This in turn improves the Health Care Coalitions and pre-hospital care organizations ability to partner in responding to an emergency. This portion of Regulation 4 is also unnecessary and as written is not enforceable.

While Regulation 4 is being repealed, references to RETACs remain in the other sections of the rule as RETACs remain an emergency preparedness and response partner even if RETACs, as an entity, do not have a direct role in emergency response.

Specific Statutory Authority.
Statutes that require or authorize rulemaking: §24-33.5-703, §24-33.5-711.5, §25-1-502 and §25-1-108(c)(VI), C.R.S.

[1] Groups of local healthcare and responder organizations that collaborate to prepare for emergencies. More information can be found at https://www.colorado.gov/pacific/cdphe/health-care-coalitions.

Is this rulemaking due to a change in state statute?

_____ Yes, the bill number is _____. Rules are ___ authorized ___ required.

___X__ No

Does this rulemaking include proposed rule language that incorporate materials by reference?

_____ Yes ___ URL

__X___ No

Does this rulemaking include proposed rule language to create or modify fines or fees?

_____ Yes

__X___ No

Does the proposed rule language create (or increase) a state mandate on local government?

_X__ No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

REGULATORY ANALYSIS
for Amendments to
6 CCR 1009-5, Regulation 4, Preparations For A Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin

1. **A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.**

   A. Identify each group of individuals/entities that rely on the rule to maintain their own businesses, agencies or operation, and the size of the group:

      Colorado's 11 regional emergency medical and trauma services advisory councils will be affected by the proposed amendment.

   B. Identify each group of individuals/entities interested in the outcomes the rule and those identified in #1.A achieve, and if applicable, the size of the group:

      Pre-hospital care organizations, including but not limited to EMS service agencies and emergency medical responders.

   C. Identify each group of individuals/Entities that benefit from, may be harmed by or at-risk because of the rule, and if applicable, the size of the group:

      None.

2. **To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.**

   The proposed repeal eliminates language that does not align with current practice and thus, is confusing or not implementable by RETACs. The proposed repeal also eliminates duplication because coordination with pre-hospital care organizations can be accomplished through grant activities and current rule language rather than through RETACs and Regulation 4.

3. **The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.**

   None.

4. **A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.**

   Check mark all that apply:
   ___ Inaction is not an option because the statute requires rules be promulgated.
   ___ The proposed revisions are necessary to comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
   ___ The proposed revisions appropriately maintain alignment with other states or national standards.

_X_ The proposed revisions implement a Regulatory Efficiency Review (rule review) result, or improve public and environmental health practice.

_X_ The proposed revisions implement stakeholder feedback.

___ The proposed revisions advance the following CDPHE Strategic Plan priorities:

Goal 1, Implement public health and environmental priorities
Goal 2, Increase Efficiency, Effectiveness and Elegance
Goal 3, Improve Employee Engagement
Goal 4, Promote health equity and environmental justice
Goal 5, Prepare and respond to emerging issues, and
Comply with statutory mandates and funding obligations

Strategies to support these goals:
___ Substance Abuse (Goal 1)
___ Mental Health (Goal 1, 2, 3 and 4)
___ Obesity (Goal 1)
___ Immunization (Goal 1)
___ Air Quality (Goal 1)
___ Water Quality (Goal 1)
_X__ Data collection and dissemination (Goal 1, 2, 3, 4 and 5)
___ Implements quality improvement or a quality improvement project (Goal 1, 2, 3 and 5)
___ Employee Engagement (career growth, recognition, worksite wellness) (Goal 1, 2 and 3)
___ Incorporate health equity and environmental justice into decision-making (Goal 1, 3 and 4)
___ Establish infrastructure to detect, prepare and respond to emerging issues (Goal 1, 2, 3, 4, and 5)

___ Other favorable and unfavorable consequences of inaction: NA

5. **A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.**

Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. Repeal of the regulation cannot occur without rulemaking. Part of the repeal is based upon a non-regulatory pathway for accomplishing the work, i.e. the Hospital Preparedness Program grant activities.

6. **Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.**

See #5.

7. **To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.**

A study of RETACs, current Emergency Preparedness and Response grant activities, and pre-hospital care organizations partnerships informed this rulemaking proposal.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1009-5, Regulation 4, Preparations For A Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

Organization	**Representative Names**
Central Mountains RETAC	Anne Montera (Coordinator), Christ Montera, Josh Hadley, Jamie Woodworth (Chair), Richard Cornelius
Foothills RETAC	Linda Underbrink (Coordinator), Tom Candlin (Chair)
Mile-High RETAC	Shirley Terry (Coordinator)
Northeast Colorado RETAC	Jeff Schanhals (Coordinator), Dave Bressler (Chair)
Northwest RETAC	Addy Marantino (Coordinator), John Hall (Chair)
Plains to Peaks RETAC	Kim Schallenberger (Coordinator), Tim Dienst (Chair), Wendy Erickson
San Luis Valley RETAC	Jon Montano (Coordinator), Rodney King (With Conejos County Ambulance Services)
Southeastern Colorado RETAC	Josh Eveatt (Coordinator)
Southern RETAC	Brandon Chambers (Coordinator), Tom Anderson (Chair)
Southwest RETAC	Terry Foechterle (Coordinator)
Western RETAC	Danny Barela (Coordinator), Reg Vickers (Chair)
EMS for Children Colorado (EMSC)	Sean Caffrey
Colorado Resource for Emergency and Trauma Education (CREATE)	Ron Seedorf

The department has presented this information to Regional Emergency Medical and Trauma Advisory Councils (RETAC) at their statewide quarterly forums on March 7, 2018, December 5, 2018 and March 6, 2019. These quarterly meetings are a forum for Colorado's 11 Regional Emergency Medical and Trauma Advisory Councils to meet with CDPHE staff, trauma and EMS system stakeholders. RETAC forums serve an important informational and educational purpose in providing a venue to collectively plan and work on the development of Colorado's emergency medical and trauma systems. There have been no major factual or policy issues encountered through the stakeholder process. The amendment proposed has been supported by all stakeholders engaged.

The Office of Emergency Preparedness and Response sent the notification of the rulemaking to the stakeholders identified in the table above as well as CDPHE's Governor's Expert Emergency Epidemic Response Committee, local public health agencies, public health nurses, rural health clinics, hospitals, federally qualified health centers and via the office's monthly newsletter to partners ensuring all entities had the opportunity to provide feedback.

Stakeholder Group Notification

The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

____ Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

__x__ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

None.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking.

The proposed amendments do not have health equity or environmental justice impacts.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.		Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
X	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
X	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.	X	Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Office of Emergency Preparedness and Response

~~STATE BOARD OF HEALTH RULES AND REGULATIONS PERTAINING TO~~ PREPARATIONS FOR A BIOTERRORIST EVENT, PANDEMIC INFLUENZA, OR AN OUTBREAK BY A NOVEL AND HIGHLY FATAL INFECTIOUS AGENT OR BIOLOGICAL TOXIN

6 CCR 1009-5

_____

Adopted by the Board of Health on _____; effective _____.

In Section 24-33.5-703, C.R.S., emergency epidemic is defined as cases of an illness or condition, communicable or noncommunicable, caused by bioterrorism, pandemic influenza, or novel and highly fatal infectious agents or biological toxins.

Regulation 1. Preparations by Local Public Health Agencies for an Emergency Epidemic

1. Each local public health agency in this state subject to Section 25-1-501 et seq. and Section 25-1-108 et seq., C.R.S., is required to maintain an up-to-date notification list for an emergency epidemic. The list shall include at a minimum general or critical access hospitals, regional emergency medical and trauma advisory councils, rural health clinics or federally qualified health centers, and the local emergency management agencies within the jurisdiction of the local public health agency. Each local public health agency is required at least once per year: (A) to confirm the notification list is accurate and up to date, and (B) to conduct a notification test or real incident communications by a broadcast fax or another communications method for rapid notification.

2. Each local public health agency in this state subject to Section 25-1-501 et seq., C.R.S., is required to sign a uniform mutual aid agreement with all other local public health agencies subject to Section 25-1-501 et seq., C.R.S., that obligates the agency to render aid during an emergency epidemic unless the agency needs to withhold resources necessary to provide reasonable protection for its own jurisdiction. The agreement must be reviewed by the participating agencies at least every 5 years.

3. Each local public health agency subject to Section 25-1-501 et seq., C.R.S., shall maintain an agency response plan and associated Emergency Support Function #8 annex or the health and medical annex to the local emergency operations plan that mirrors the National Response Framework. The agency will implement the response plan and annex when the governor declares a disaster emergency that is the result of an occurrence or imminent threat of an emergency epidemic. The plan, and associated annex, shall be reviewed and updated as needed but at least every three years, and submitted at least every 3 years to the Colorado Department of Public Health and Environment (CDPHE), and local board of health. In addition, the local public health agency shall ensure that a copy of the plan(s) and associated annex are reviewed with and made available to its jurisdiction's local offices of emergency management, to all general or critical access hospitals, to rural health clinics or federally qualified health centers, and to all regional emergency medical and trauma services advisory councils (RETACs). The plan shall address the following areas:

   A) Organization and assignment of employees of the agency to work on controlling the emergency epidemic using the National Incident Management System;

   B) Having sufficient supplies, training for staff using personal protective equipment, and a process for the provision of personal protective equipment to employees who are

Commented [ND1]: Editorial comments below are information to assist those that are reviewing this rulemaking proposal. These comments will not be part of the adopted rule.

Commented [BJ2]: This requirement is not impacted by the removal of regulation 4. Local public health agencies will continue to work with RETACs when planning for a governor declared emergency.

assigned to work in areas where they may be exposed to ill and contagious persons or to infectious agents and waste. Personal protective equipment shall, at a minimum, be the equipment and supplies used to achieve standard precautions against bacterial and viral infections;

C) Procurement, storage and distribution of at least a three-day supply of an antibiotic as determined by CDPHE, that is effective against category A bacterial agents to be used as prophylaxis for all employees immediately responding. The plan shall include procurement of another antibiotic for a small number of employees who may be unable to take the antibiotic of first choice;

D) An emergency, after-hours call-down list of persons who may be needed to organize and respond to an emergency epidemic; such list shall include persons with experience and training in communicable disease epidemiology;

E) Creation of an operations center within the agency or participation in a local emergency operations center for the purpose of (i) centralizing telephone, radio, and other electronic communications; (ii) compiling surveillance data; (iii) maintaining a log of operations, decisions, resources, and orders necessary to control the epidemic; (iv) responding to executive orders of the governor regarding the emergency epidemic; (v) managing mass dispensing and vaccination activities;(vi) monitoring the situation, including infection control, in each general and critical access hospital within the agency's jurisdiction, doing this on-site as necessary and with assistance from CDPHE as appropriate; (vii) assessment and management of infection control in the community outside of the hospital; (viii) assessment and management, in coordination with general and critical access hospitals and the county coroner, of the disposal of human corpses in accordance with Emergency Support Function #8, and; (ix) management and dispensing of medical countermeasures to the public;

F) Organization, receipt, staffing, security, and logistics of the distribution and delivery of antibiotics, antiviral medications, vaccines, or other medical countermeasures delivered from the Strategic National Stockpile (SNS) needed in an emergency epidemic following the provisions of Emergency Support Function #8;

G) Identification of a public information officer who will assure sufficient coordination and personnel for multiple operational periods for providing information to the citizens of their jurisdiction about how to protect themselves, what actions are being taken to control the epidemic, and when the epidemic is over, and;

H) Implementation of a back-up communications system, such as 800 megahertz radios or amateur radio emergency services, that will be used for communication if and when telephone communications are disabled or not functioning.

4. Each local public health agency shall conduct at least one exercise of its plan every three years. If the agency activates its plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Each local public health agency shall complete an after-action report and improvement matrix within 60 days of exercise or real incident completion. The report and the improvement matrix will be submitted to CDPHE.

Regulation 2. Preparations by General or Critical Access Hospitals for an Emergency Epidemic

1. Each general or critical access hospital in this state is required to maintain an up-to-date notification list for an emergency epidemic. The list shall include any satellite clinics, acute care facilities, or trauma centers operated by the general or critical access hospital; offices of physicians and health care providers on the staff of the hospital, as available; and the local public health agency and local emergency management office serving the county in which the hospital is located. Each general or critical access hospital is required at least once per year: (A) to confirm

the notification list is accurate and up to date, and (B) to conduct a notification test or real incident communications by a broadcast fax or another communications method for rapid notification.

2. Each general or critical access hospital in this state shall maintain a plan that the general or critical access hospital will implement when the governor declares a disaster emergency that is the result of an occurrence or imminent threat of an emergency epidemic. The plan shall be reviewed and updated as needed but at least every 3 years, and submitted at least every 3 years to CDPHE. In addition, the general or critical access hospital shall review with and make available a copy of the plan(s) submitted pursuant to these regulations to its jurisdiction's local offices of emergency management, local public health or designated health and medical support lead agency, their regional emergency medical and trauma services advisory councils, and healthcare coalition. The plan shall address the following areas:

Commented [BJ3]: This requirement is not impacted by the removal of regulation 4. Hospitals will still be required to review with and make available their plans to RETACs.

A) Organization and assignment of employees and medical staff of the general or critical access hospital to work on controlling the emergency epidemic using the National Incident Management System;

B) Having sufficient supplies, training for staff using personal protective equipment, and a process for the provision of personal protective equipment to all staff and employees who are assigned to work in areas where they may be exposed to ill and contagious persons or to infectious agents and waste. Personal protective equipment shall, at a minimum, be the equipment and supplies used to achieve standard precautions against bacterial and viral infections;

C) Procurement, storage and distribution of at least a three-day supply of an antibiotic as determined by CDPHE, that is effective against category A bacterial agents to be used as prophylaxis for all employees and medical staff immediately responding. The plan shall include procurement of another antibiotic for a small number of employees who may be unable to take the antibiotic of first choice;

D) A process for recruiting and credentialing volunteers who may be asked to work or volunteer as needed to respond to an emergency epidemic;

E) Creation of an operations center within the general or critical access hospital for the purposes of: (i) centralizing telephone, radio, and other electronic communications; (ii) compiling morbidity and mortality data including the number of patients, number of available beds, and number of working staff and employees; (iii) receiving and responding to executive orders of the governor regarding the emergency epidemic; (iv) maintaining a log of operations, decisions, and resources necessary to maintain operations during the epidemic; (v) assessment and management of infection control within the general or critical access hospital, and; (vi) in coordination with local public health agencies and the county coroner, the disposal of human corpses;

F) Security of the facility and traffic management necessary to control unanticipated crowds or traffic;

G) Rapid transport of human diagnostic specimens to the state laboratory or as otherwise directed by CDPHE;

H) Implementation of infection control measures to prevent the spread of the disease to staff, employees, and other patients within the general or critical access hospital;

I) Coordination and communication with other general and critical access hospitals and pre-hospital care agencies to assure that patients with extreme, life-threatening, or emergency medical or traumatic conditions are not diverted from the general and critical access hospital;

J) Triaging all persons during an emergency epidemic in a manner that protects the facility, staff, and public, and routing these persons to the appropriate facility based on their medical status;

K) Organization, staffing, security, and logistics of the receipt, distribution and delivery of antibiotics, antiviral medications, vaccines, or other medical countermeasures delivered from the Strategic National Stockpile (SNS) needed in an emergency epidemic for employees and medical staff, and;

L) Implementation of a back-up communications system, such as 800 megahertz radios or amateur radio emergency services, that will be used for communication if and when telephone communications are disabled or not functioning.

3. Each general and critical access hospital shall conduct at least one exercise of its plan every three years. If the hospital activates its plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Each general and critical access hospital shall complete an after-action report and improvement matrix within 60 days of exercise or real incident completion. The report and the improvement matrix will be submitted to CDPHE.

Regulation 3. Preparations by Rural Health Clinics and Federally Qualified Health Centers for an Emergency Epidemic

1. Each rural health clinic licensed by CDPHE and certified by the Center for Medicaid and Medicare Services, and federally qualified health center that operates medical facilities or pharmacies is required to maintain an up-to-date notification list for an emergency epidemic. The list shall include any satellite clinics, acute care facilities, or trauma centers operated by the organization, as well as offices of physicians and health care providers working as full-time contractors or staff of the organization. Each rural health clinic and federally qualified health center is required at least once per year: (A) to confirm the notification list is accurate and up to date, and (B) to conduct a notification test or real incident communications by a broadcast fax or another communications method for rapid notification.

2. Each, rural health clinic and federally qualified health center providing acute care shall prepare a plan that the organization will implement when the governor declares a disaster emergency that is the result of an occurrence or imminent threat of an emergency epidemic. The plan shall be reviewed and updated as needed but at least every 3 years, and submitted at least every 3 years to CDPHE. In addition, each rural health clinic and federally qualified health center shall ensure that a copy of the plan(s) are reviewed with and made available to its appropriate community partners. The plan shall address the following areas:

A) Having sufficient supplies, training for staff using personal protective equipment and a process for the provision of personal protective equipment to employees who are assigned to work in areas where they may be exposed to ill and contagious persons or to infectious agents and waste. Personal protective equipment shall, at a minimum, be the equipment and supplies used to achieve standard precautions against bacterial and viral infections;

B) Rapid transport of human diagnostic specimens to the state laboratory or as otherwise directed by CDPHE, and;

C) Implementation of a back-up communications system, such as 800 megahertz radios or amateur radio emergency services, that will be used for communication if and when telephone communications are disabled or not functioning.

3. Each rural health clinic and federally qualified health center shall conduct at least one exercise of its plan every three years. If the rural health clinic or federally qualified health center activates its plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Each rural health clinic and federally qualified health center shall complete an after-action report and improvement matrix within 60 days of exercise or real incident completion. The report and the improvement matrix will be submitted to CDPHE.

~~**Regulation 4. Preparations by Regional Emergency Medical and Trauma Services Advisory Councils for an Emergency Epidemic**~~

~~1. Each regional emergency medical and trauma services advisory council in this state is required to maintain an up-to-date notification list of organizations for an emergency epidemic. The list shall include all pre-hospital care organizations within the jurisdiction of the regional emergency medical and trauma services advisory council. The council is required to conduct notification tests by a broadcast fax or by another communications method for rapid notification of these organizations at least twice per year.~~

~~2. Each regional emergency medical and trauma services advisory council shall advise the pre-hospital care organizations within its jurisdiction to develop a plan that the organization would implement when the governor declares a disaster emergency that is the result of an occurrence or imminent threat of an emergency epidemic. The organizations shall be advised that the plan should address the following areas:~~

~~A) Organization: using the National Incident Management System, assignment, reassignment, and alteration of normal work schedules of all staff and all employees of the organization who may be called on to work during an emergency epidemic;~~

~~B) Having sufficient supplies and a process for the provision of personal protective equipment against bacterial and viral infections to all staff and employees who are assigned to work in areas where they may be exposed to ill and contagious persons or to infectious agents and waste; personal protective equipment shall, at a minimum, be the equipment and supplies used to achieve standard precautions;~~

~~C) Procurement and storage of at least five days supply of doxycycline or other antibiotic, as determined by Colorado Department of Public Health and Environment to be used as prophylaxis for all employees. The plan should include procurement of another antibiotic for a small number of employees who may be unable to take doxycycline;~~

~~D) An emergency call-down list of off-duty or retired emergency medical service providers who may be asked to work or volunteer as needed to respond to an emergency epidemic.~~

Regulation ~~5~~ 4. Preparations by the Colorado Department of Public Health and Environment for an Emergency Epidemic

1. CDPHE is required to maintain an up-to-date notification list for an emergency epidemic. The list shall include the Governor's Office, members of the Governor's Expert Emergency Epidemic Response Committee, general or critical access hospitals, local public health agencies, regional emergency medical and trauma services advisory councils, and the state Department of Public Safety. CDPHE is required at least once per year: (A) to confirm the notification list is accurate and up to date, and (B) to conduct a notification test or real incident communications by a broadcast fax or another communications method for rapid notification.

2. CDPHE is required to sign a uniform mutual aid agreement with all other local public health agencies subject to Section 25-1-501 et seq., C.R.S., which obligates CDPHE to render aid during an emergency epidemic unless CDPHE needs to withhold resources necessary to provide

Commented [BJ4]: This requirement is not impacted by the removal of regulation 4. CDPHE will continue to maintain up-to-date notification lists and conduct notification tests that include RETACs.

reasonable protection statewide. The agreement must be reviewed by the participating agencies at least every 5 years.

3. CDPHE shall prepare an internal response plan and associated Emergency Support Function #8 to the state emergency operations plan that mirrors the National Response Framework, which CDPHE will implement when there is an occurrence or imminent threat of an emergency epidemic. The plan shall be reviewed and updated as needed but at least every 3 years and shall be submitted to the Colorado Board of Health every 3 years. The CDPHE Plan will be publicly available. The plan shall address the following areas:

A) Organization: using the National Incident Management System and assignment of potentially all employees of The Colorado Department of Public Health and Environment to work on controlling the emergency epidemic;

B) Having sufficient supplies, training for staff using personal protective equipment and a process for the provision of personal protective equipment to employees who are assigned to work in areas where they may be exposed to ill and contagious persons or to infectious agents and waste. Personal protective equipment shall, at a minimum, be the equipment and supplies used to achieve standard precautions against bacterial and viral infections;

C) Procurement, storage and distribution of at least a three-day supply of an antibiotic as determined by CDPHE, that is effective against category A bacterial agents to be used as prophylaxis for all employees immediately responding. The plan shall include procurement of another antibiotic for a small number of employees who may be unable to take the antibiotic of first choice;

D) An emergency, after-hours call-down list of persons who may be needed to organize and respond to an emergency epidemic; such list shall include persons with experience and training in communicable disease epidemiology;

E) Creation of an operations center within CDPHE for the purpose of (i) centralizing telephone, radio, and other electronic communications; (ii) compiling surveillance data; (iii) maintaining a log of operations, decisions, resources, and orders necessary to control the epidemic; (iv) apportionment of pharmaceuticals; (v) monitoring the situation statewide and especially where the emergency epidemic is occurring; (vi) assessment and management of infection control statewide, and; (vii) assessment and management, in coordination with general and critical access hospitals and the county coroner, of the disposal of human corpses in accordance with Emergency Support Function #8;

F) Distribution and delivery of antibiotics, antiviral medications, vaccines, or other medications delivered from the Strategic National Stockpile (SNS) needed in an emergency epidemic to locations determined by local public health agencies or local emergency management agencies;

G) Identification of a public information officer responsible for providing information to the citizens of the state about how to protect themselves, what actions are being taken to control the epidemic, and when the epidemic is over;

H) Maintenance of a rapid transport system for the delivery of human diagnostic specimens to the state laboratory, and;

I) Implementation of a back-up communications system, such as 800 megahertz radios or amateur radio emergency services, that will be used to communicate with the state office of emergency management and local public health agencies if and when telephone communications are disabled or not functioning; and maintenance of a rapid notification system.

4. CDPHE shall conduct at least one exercise of its plan every three years. If CDPHE activates its plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. CDPHE shall complete an after-action report and improvement matrix within 60 days of exercise or real incident completion.

Regulation 5 ~~6~~. Assessing Compliance with these Regulations

For the purposes of determining eligibility for the protections of Section 24-33.5-711.5, C.R.S., CDPHE shall review plans submitted pursuant to Regulations One through Three, may examine exercise evaluations, and may examine and inspect faxes transmitted or documentation of other communications methods used for rapid notification of contacts and agencies pursuant to Regulations One through Three.

Regulation 6 ~~7~~. Preparations by Public Health Nursing Services for an Emergency Epidemic

1. Each local health officer and county public health nursing service in this state subject to Section 25-1-601 *et seq.*, C.R.S., is required to maintain an up-to-date notification list for an emergency epidemic. The list shall include general or critical access hospitals and the local emergency management agencies within the jurisdiction of the local health officer and county public health nursing service. The local health officer and county public health nursing service is required to conduct notification tests by a broadcast fax or another communications method for rapid notification at least twice per year.

2. Each local health officer and county public health nursing service in this state subject to Section 25-1-601 *et seq.*, C.R.S., must sign a uniform mutual aid agreement with all other county and district public health departments and local health officers and county public health nursing services subject to Section 25-1-501 and 25-1-601 *et seq.*, C.R.S., that obligates the county or district public health department and local health officers and county public health nursing services to render aid during an emergency epidemic unless the county district public health department or local health officer and county public health nursing service needs to withhold resources necessary to provide reasonable protection for its own jurisdiction.

3. Each local health officer and county public health nursing service subject to Section 25-1-601 *et seq.*, C.R.S., shall prepare a plan that will be implemented when the governor declares a disaster emergency that is the result of an occurrence or imminent threat of an emergency epidemic. The plan must be able to be integrated with the Local Emergency Operations Plan(s) (LEOP) and the regional Public Health Preparedness and Response Plan. In addition, the local health officers and county public health nursing services shall provide a copy of the plan submitted pursuant to these regulations to the local offices of emergency management, to all general or critical access hospitals, and to all regional emergency medical and trauma services advisory councils within the jurisdiction of the public health nursing service.

Commented [BJ5]: This requirement is not impacted by the removal of regulation 4. Local health officers and county public health nursing services will still be required to make available their plans to RETACs.

The plan shall address the following areas:

A) Organization and assignment of potentially all employees of the public health nursing service under an approved incident management system to work on controlling the emergency epidemic;

B) Having sufficient supplies and a process for the provision of personal protective equipment against bacterial and viral infections to public health nursing services employees who are assigned to work in areas where they may be exposed to ill and contagious persons or to infectious agents and waste; personal protective equipment shall, at a minimum, be the equipment and supplies used to achieve standard precautions;

C) Procurement and storage of at least five days supply of doxycycline or other antibiotic, as determined by the state health department, to be used as chemoprophylaxis for all public health nursing services employees. The plan shall include procurement of another

antibiotic for a small number of public health nursing services employees who may be unable to take doxycycline;

D) An emergency, after-hours call-down list of persons who may be needed to organize and respond to an emergency epidemic; such list shall include persons with experience and training in communicable disease epidemiology;

E) Provide staffing to and participation in activities of the local emergency operations center (s) for the purpose of (i) centralizing telephone, radio, and other electronic communications; (ii) compiling surveillance data; and (iii) maintaining a log of operations, decisions, resources, and orders necessary to control the epidemic;

F) Creation of a system or participation in an organized system to: (i) monitor the situation, including infection control, in each hospital within the public health nursing service's jurisdiction, doing this on-site as necessary and with assistance from the state health department as appropriate; (ii) assess and manage infection control in the community outside of the hospital; and (iii) assess and manage, in coordination with hospitals and the county coroner, the disposal of human corpses;

G) The organization, staffing, security, and logistics of the distribution and delivery of antibiotics, antiviral medications, vaccines, or other medications needed in an emergency epidemic following the provisions of State Emergency Function #8, “Health, Medical and Mortuary”;

H) Identification of public spokespersons responsible for providing information to the citizens of their jurisdiction about how to protect themselves, what actions are being taken to control the epidemic, and when the epidemic is over; and

I) Implementation of a back-up communications system that will allow communication with the local emergency response structure if and when telephone communications are disabled or not functioning.