MRC Volunteer Attends National Deployment Training—Harry Zerler

I was privileged to be selected to attend the Spring 2011 MRC National Deployment Training in Washington DC, conducted from March 28th to April 1st, where I joined two other NJ MRC volunteers, Chris Baggot of Oceanport, and Neil Begley of Freehold along with 26 other MRC volunteers from every part of the nation. The diversity of the training cadre was truly impressive and Cdr. Patrick Denis, Senior Program Officer with the US Public Health Service made it clear from the outset that civilian MRC volunteers are appreciated as a vital component of our country's emergency preparedness and response programs.

In Washington the cadre was schooled in the complex and impressive structure of partnerships among many public, private and military agencies that work together to meet the challenges of natural and man-made disasters. The group was granted security clearance to visit the Secretary's Operations Center (SOC) at HHS headquarters, where we observed first-hand the global monitoring and pin-point operational coordination capabilities that support preparation, deployment and demobilization of American disaster response teams at home or abroad. Our cadre was privileged to be briefed by senior military and civilian specialists, right up to Rear Admiral Boris Lushniak, Deputy Surgeon General of the United States.

Throughout the week we learned, talked, connected and practiced, blending the skills and strengths that culminated in a simulation exercise based on an aircraft disaster scenario. On our last day we shared congratulations and gave attention to next steps in building on the foundation training we had received. From this rich experience three lessons I took home are:

- our country truly depends on civilian MRC volunteers to support disaster response locally, nationally and globally;
- that training, preparation and practice with your team are essential to every deployment mission;
- and that each one of us can enhance our skills and extend our service through participation in the local and national programs of the Medical Reserve Corps.

If you want to learn more about national deployment and other programs you can be part of take some time to explore the MRC's national website: www.medicalreservecorps.gov

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Morris County Office of Health Management

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Medical Reserve Corps:
Northwest Regional Exercise

Letter From MCOHM Health Officer
Carlos Perez, Jr.

After numerous months of comprehensive planning, the Office of Health Management (OHM) along with Passaic, Sussex and Warren County Health Departments, conducted a full-scale regional public health emergency exercise on Saturday, May 14, 2011 at the Craigmeur Recreation Complex in Rockaway Township.

The exercise's principal aims were: (1) to test the ability of Morris County to call upon existing public health emergency mutual aid agreements with the three regional partners; (2) to test regional operational capabilities for the provision of mass vaccination and medication distribution clinics; and (3) to test the ability to establish a regional command for the coordination and management of resources.

Representatives from the NJ Department of Health & Senior Services along with Local Health Departments from the four participating counties were also in attendance. In addition, over 100 Medical Reserve Corps Volunteers from Morris, Passaic, Sussex, and Warren Counties performed pivotal activities during the exercise including filling in as actors, performing medical duties, and assisting with a variety of other ancillary functions.

The exercise permitted identification of numerous strengths along with specific areas requiring improvement. A formal After Action Report (AAR) along with a Corrective Action Plan for the exercise will be formulated over the summer months. Your input related to the exercise is very important to us. If you were unable to attend the MRC After Action Meeting held on July 14, 2011, please contact Cindie Bella to provide any comments.

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Why Anthrax?

The mass distribution portion of the Regional Exercise was a response to Anthrax. The CDC continues to identify anthrax as the most likely agent to be used in a biological attack. It only takes a small amount to infect a large number of people. It is inexpensively grown from just a few spores and can be engineered to be drug resistant, which means it will be more difficult to treat.

Anthrax is a naturally occurring bacteria in soil that can be transferred from infected animals to humans. By breathing in spores that have been engineered it can infect humans, as we saw in NJ in 2003 which involved letters with just one gram of powdered spores. 22 people were infected and five people died.

CDC working with state and local health departments manages a program called BioSense that detects potential bioterrorism releases, including anthrax.

Managing the Strategic National Stockpile to ensure medications can be quickly distributed when needed, is another way the CDC prepares. The third way to ensure preparedness is through exercises that help practice what to do in the event of an attack.

You can learn more about anthrax at: emergency.cdc.gov/agent/anthrax.

CORE Trainings

ICS 100/NIMS 700

MRC Orientation

Psychological First Aid

Family Disaster Preparedness

POD Management

FROM THE COORDINATOR–*Cindie Bella, R.N. B.S.N.*

On May 14th Morris County Office of Health Management (MCOHM) participated in our first Regional exercise with Warren, Sussex and Passaic Counties. The MRC and CERT volunteers came together to work at a Point of Distribution (POD) site with minimal support staff. Our exercise had two different scenarios, vaccination (influenza) in the morning which used three different types of syringes: traditional, Bio-Jector and Pharmajet. In the afternoon we tested pill distribution (Anthrax).

This all took place under a tent at Craigmeur Recreational Complex. I truly was impressed and proud of what a wonderful job everyone did. It was awesome how everyone came together as a team. You see this kind of camaraderie during real events but typically not during exercises. That just proves what a wonderful group of MRC and CERT volunteers we have.

There were members from the New Jersey Department of Health and Senior Services (NJDHSS) evaluating this exercise. Some were evaluating the flow of the exercise (how many people we processed per hour) and others were evaluating the MRC and how well they maintained the ICS command. We just had our After Action Report (AAR) meeting with the NJDHSS evaluators and the exercise planning team. NJDHSS stated that our exercise was one of the best that they had observed. They were impressed how well everyone worked together and maintained the ICS command structure.

This proves that all your time spent attending trainings has been time well spent. I would like to thank those of you who participated in this POD exercise, for making it a great success. I realize how valuable your free time is and to give a whole day of it so that we could accomplish our NJDHSS requirements and practice our skills shows how truly dedicated you all are.

Dr. Kikta's article on the Joplin tornado reminds us how quickly disaster can strike. The more practice we have through trainings and exercises, the more prepared we will be to respond as a team if the need arises.

FROM THE EPI—MEASLES

In 2011, outbreaks of measles (rubeola) have occurred in several states including Kansas, Minnesota, Utah, California, Rhode Island, Texas, Florida and Massachusetts. New Jersey has seen cases of measles as well.

The number of cases of measles in 2011 is on track to be the highest in a decade. The source of these outbreaks is importation from foreign travel, and some transmission has occurred to unvaccinated contacts. As of May 16, 2011, 33 European countries have reported more than 7,000 measles cases.

Prior to the development of measles vaccine in the 1960s and widespread immunization, virtually all children in the U.S. contracted measles. In the decade before the measles vaccination program began, an estimated 3—4 million people in the U.S. were infected each year, of whom 400—500 died, 48,000 were hospitalized, and another 1,000 developed chronic disability from measles encephalitis. Currently, endemic measles transmission has been eliminated from North and South America. All cases and outbreaks in the Americas originate in countries where measles is circulating.

Measles is highly contagious through respiratory droplets and smaller particles that can remain airborne up to 2 hours in closed settings. The infectious period starts during the measles prodrome (2 – 4 days prior to rash onset) and persists until 4 days after rash onset.

Healthcare providers should be alert to signs and symptoms of measles in persons with a history of recent travel outside the U.S. The incubation period is usually 7 to 18 days from exposure to onset of fever, and is usually about 14 days from exposure to onset of rash. Measles begins with a prodrome of fever, and the "3 Cs" - cough, coryza (symptoms of head cold) and conjunctivitis. After 2—4 days of prodrome, a rash begins at the hairline, then involves the face and neck and gradually proceeds downward, reaching the hands and feet.

About 30% of cases develop one or more complications, including pneumonia and ear infections. These complications are more common among children under 5 years of age and adults over 20 years of age.

Two doses of measles-containing vaccine, as combination MMR, separated by at least 28 days are recommended for all children starting at 12 months of age. More than 99% of persons vaccinated with 2 doses of MMR will develop immunity. Generally persons born before 1957 are considered immune.

We can not overemphasize the importance of immunization and prompt reporting to public health when measles is suspected.

AN ER PYSICIAN'S ACCOUNT OF THE JOPLIN TORNADO

My name is Dr. Kevin Kikta, and I was one of two emergency room doctors who were on duty at St. John's Regional Medical Center in Joplin, MO on Sunday, May 22, 2011.

You never know that it will be the most important day of your life until the day is over. The day started like any other day for me: waking up, eating, going to the gym, showering, and going to my 4:00 pm ER shift. As I drove to the hospital I mentally prepared for my shift as I always do, but nothing could ever have prepared me for what was going to happen on this shift. Things were normal for the first hour and half. At approximately 5:30 pm we received a warning that a tornado had been spotted. Although I work in Joplin and went to medical school in Oklahoma, I live in New Jersey, and I have never seen or been in a tornado. I learned that a "code gray" was being called. We were to start bringing patients to safer spots within the ED and hospital.

At 5:42 pm a security guard yelled to everyone, "Take cover! We are about to get hit by a tornado!" I ran with a pregnant RN, Shilo Cook, while others scattered to various places, to the only place that I was familiar with in the hospital without windows, a small doctor's office in the ED. Together, Shilo and I tremored and huddled under a desk. We heard a loud horrifying sound like a large locomotive ripping through the hospital. The whole hospital shook and vibrated as we heard glass shattering, light bulbs popping, walls collapsing, people screaming, the ceiling caving in above us, and water pipes breaking, showering water down on everything. We suffered this in complete darkness, unaware of anyone else's status, worried, scared. We could feel a tight pressure in our heads as the tornado annihilated the hospital and the surrounding area. The whole process took about 45 seconds, but seemed like eternity. The hospital had just taken a direct hit from a category EF5 tornado.

Then it was over. Just 45 seconds. 45 long seconds. We looked at each other, terrified, and thanked God that we were alive. We didn't know, but hoped that it was safe enough to go back out to the ED, find the rest of the staff and patients, and assess our losses.

"Like a bomb went off." That's the only way that I can describe what we saw next. Patients were coming into the ED in droves. It was absolute, utter chaos. They were limping, bleeding, crying, terrified, with debris and glass sticking out of them, just thankful to be alive. The floor was covered with about 3 inches of water, there was no power, not even backup generators, rendering it completely dark and eerie in the ED. The frightening aroma of methane gas leaking from the broken gas lines permeated the air; we knew, but did not dare mention aloud, what that meant. We had to use flashlights to direct ourselves to the crying and wounded. Where did all the flashlights come from? I'll never know, but immediately, and thankfully, my years of training in emergency procedures kicked in. There was no power, but our mental generators were up and running, and on high test adrenaline. We had no cell phone service in the first hour, so we were not even able to call for help and backup in the ED.

We worked as a team, determined to save lives. There were no specialists available -- my orthopedist was trapped in the OR. We were it, and we knew we had to get patients out of the hospital as quickly as possible. As we were shuffling them out, the fire department showed up and helped us to evacuate. Together we worked furiously, motivated by the knowledge and fear that the methane leaks could cause the hospital to blow up at any minute.

Things were no better outside of the ED. I saw a man crushed under a large SUV, still alive, begging for help; another one was dead, impaled by a street sign through his chest. Wounded people were walking, staggering, all over, dazed and shocked. All around us was chaos, reminding me of scenes in a war movie, or newsreels from bombings in Bagdad. Except this was right in front of me and it had happened in just 45 seconds.

Tragedy has a way of revealing human goodness. As I worked, surrounded by devastation and suffering, I realized I was not alone. The people of the community of Joplin were absolutely incredible. Within minutes of the horrific event, local residents showed up in pickups and sport utility vehicles, all offering to help transport the wounded to other facilities, including Freeman, the trauma center literally across the street. Ironically, it had sustained only minimal damage and was functioning (although I'm sure overwhelmed). I carried on, grateful for the help of the community.

Within hours I estimated that over 100 EMS units showed up from various towns, counties and four different states. Considering the circumstances, their response time was miraculous. Roads were blocked with downed utility lines, smashed up cars in piles, and they still made it through.

We continued to carry patients out of the hospital on anything that we could find: sheets, stretchers, broken doors, mattresses, wheelchairs—anything that could be used as a transport mechanism.

As I finished up what I could do at St John's, I walked with two RN's, Shilo Cook and Julie Vandorn, to a makeshift MASH center that was being set up miles away at Memorial Hall. It was also amazing to see how fast workers mobilized to set up this MASH unit under the circumstances. Supplies, food, drink, generators, exam tables, all were there—except pharmaceutical pain meds. I sutured multiple lacerations, and splinted many fractures, including some open with bone exposed, and then intubated another patient with severe COPD, slightly better controlled conditions this time, but still less than optimal.

But we really needed pain meds. I managed to go back to the St John's with another physician, pharmacist, and a sheriff's officer. Luckily, security let us in to a highly guarded pharmacy to bring back a garbage bucket sized supply of pain meds.

It time for me to go home. I was completely exhausted. I had seen enough of my first tornado.

How can one describe these indescribable scenes of destruction? The next day I saw news coverage of this horrible, deadly tornado. It was excellent coverage. The video will play forever in my mind.

Exerpts from
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