

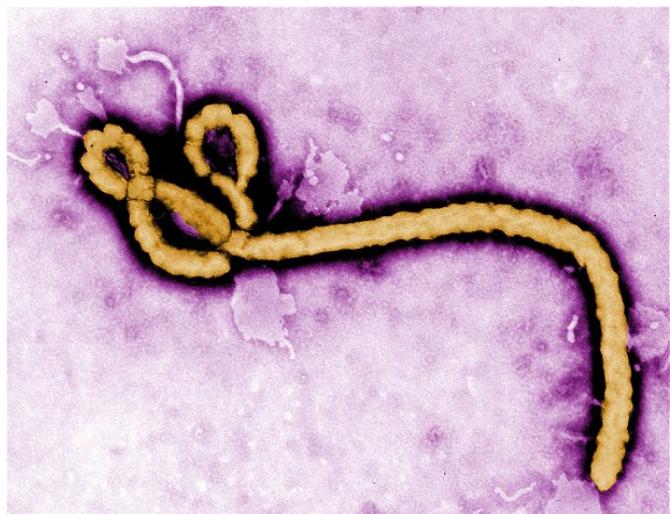
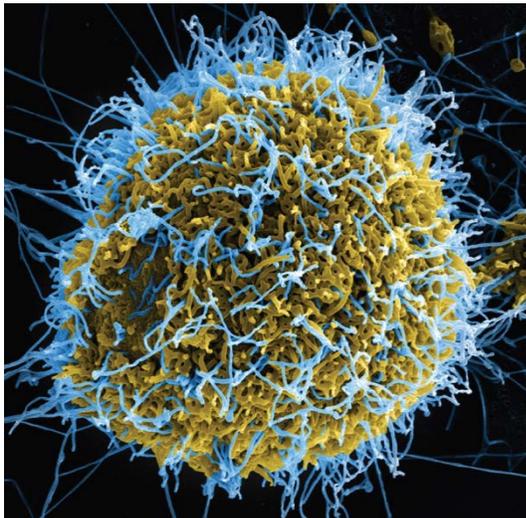


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Maine Ebola Response Plan

January 7, 2016



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Preface

The Maine Ebola Response Plan (ERP) was developed in response to a global outbreak of Ebola Virus Disease in 2014.

The development of the State of Maine Ebola Response Plan was facilitated by the Maine CDC's public health emergency preparedness staff in a collaborative and cooperative effort that was inclusive of Maine CDC Subject Matter Experts (SMEs) as well as external SME response partners. As a result of this intense, comprehensive, collaborative planning initiative, the Maine CDC developed and implemented systems and processes that will enable public health, healthcare and other emergency responders with the capability to detect and respond efficiently, effectively and seamlessly should a case of Ebola occur in Maine.

It is important to note that the systems and processes that were developed for this ERP are directly transferable to any Viral Hemorrhagic Fever (VHF) disease with direct contact transmission that may emerge and threaten the health of the people of Maine. If other VHF diseases emerge as a public health threat, a disease specific Annex will be added to this ERP using the Investigation Protocol template provided by Infectious Disease Epidemiology. (See **Appendix M**)

Acknowledgements

The Maine CDC would like to acknowledge the many internal and external stakeholders who contributed to the development and implementation of the State of Maine Ebola Response Plan. The stakeholders include:

DHHS:

Commissioner's Office

Maine CDC staff, including:

- Public Health Emergency Preparedness
- Infectious Disease Epidemiology; including Field Epidemiologists
- Health and Environmental Testing Laboratory
- District and Tribal Liaisons

Maine Department of Public Safety - Maine Emergency Medical Services

Maine Department of Defense, Veterans and Emergency Management - MEMA

Maine State Police

Maine Funeral Home Directors

Maine Department of Corrections

Guidance was obtained and input was sought from various Maine experts including:

Attorney General's Office

Maine Department of Environmental Protection

Maine, DHHS, Department of Licensing and Regulatory Services

Maine, DHHS, Department of Multicultural Affairs

Maine Hospital Association

Maine Primary Care Association

Bangor Public Health

Portland Public Health

Southern Maine Healthcare Coalition

Central Maine Healthcare Coalition

Northeastern Maine Healthcare Coalition

Maine Ebola Response Plan

Executive Summary

The 2014 Ebola epidemic was the largest in history, affecting multiple countries in West Africa primarily Liberia, Guinea and Sierra Leone. As of October 2, 2015 a total of 28,444 (suspected, probable and confirmed) cases of Ebola and 11, 311 deaths were reported globally. In the United States, two imported cases, including one death, and two locally acquired cases in healthcare workers were reported in 2014. Also, during this outbreak, six health workers and one journalist were infected with Ebola virus while in West Africa and transported to hospitals in the United States; one of the health care workers died. The U.S. CDC as well as preparedness and response partners took precautions to prevent additional cases of Ebola in the United States, and made preparations in the event of a possible occurrence of Ebola in the US.

In response to the global Ebola threat, DHHS/Maine CDC activated the Public Health Emergency Incident Command Center (PHICC) to Level 2, Partial Activation, in October 2014. The Maine CDC then convened a group of preparedness and response partners/stakeholders to develop the Maine Ebola Response Plan and prepare for the possible occurrence of a case of Ebola occurring in Maine based upon guidance from the U.S. CDC.

The Maine Ebola Response Plan is an Annex to the Maine CDC All Hazards Emergency Operations Plan and is comprised of a Base Plan and 12 Appendices. The Base Plan includes Planning Assumptions, and the Concept of Operations. The Plan is based on a regionalization model of response designed to minimize exposure using specialized teams of highly trained first responders, healthcare clinicians, law enforcement officers and funeral directors. The regionalized model for healthcare facilities is a tiered response model consisting of frontline health care facilities, assessment hospitals and treatment hospitals. Maine has four identified assessment hospitals, and does not have an identified treatment facility within the state. A confirmed Ebola patient would be transported to the regional Ebola Treatment Center, which is Massachusetts General Hospital.

The Plan delineates the primary response functions of the Maine CDC and the support response functions of the various response partners. The Appendices more specifically describe those roles and responsibilities.

Appendices to the ERP Base Plan include the following:

- A. State of Maine Regional Ebola Assessment, Care and Transport Plan (REACT)
- B. Guidance for Maine Healthcare Providers Caring for Possible or Known Ebola Patients
- C. Centers for Medicare and Medicaid Services (CMS): Emergency Medical Treatment and Labor Act (EMTALA) for Ebola
- D. Ebola Virus Disease Investigation Protocol
- E. Active Monitoring/Direct Active Monitoring Plan
- F. Health and Environmental Testing Laboratory (HETL) Ebola Plan
- G. Hazardous Waste Transport and Disposal, and Environmental Decontamination

H. Personal Protective Equipment

I. Public Communications

J. Law Enforcement Response Capability in an Infectious Disease Environment

K. Fatality Management Plan

L. Disaster Behavioral Health Resources

M. Infectious Disease Epidemiology Investigation Protocol Template

Maine Ebola Response Plan

I. Purpose, Scope, Situation, and Assumptions

A. Purpose and Scope

The purpose of the Maine Ebola Response Plan is to define the Public Health response to the occurrence of a suspected or confirmed Ebola case within the State of Maine. The Plan delineates the roles and responsibilities of the Maine Center for Disease Control and Prevention (Maine CDC), as well as the roles and responsibilities of Maine CDC's preparedness and response partners to ensure a fully coordinated, collaborative, efficient and effective response.

This Plan is applicable across all of Maine CDC; specifically referencing Infectious Disease Epidemiology, Medical Epidemiology, Health and Environmental Testing Laboratory (HETL), Public Health Emergency Preparedness (PHEP), District and Tribal Liaisons (DL), and Public Health Nurses (PHN), as well as Hospital Preparedness contractors from all three geographically designated Regional Resource Centers (RRC).

The overall functional objectives of the Ebola Response Plan include:

1. Early detection and containment
2. Public information
3. Active monitoring/direct active monitoring
4. Responder safety and health
5. Waste management and environmental decontamination

B. Situation Overview

1. Hazard Profile

- a. Ebola Virus Disease (EVD) is caused by infection with a virus of the family *Filoviridae*, genus *Ebolavirus*.
- b. Symptoms may include fever, headache, joint and muscle aches, weakness, diarrhea, vomiting, stomach pain and lack of appetite. In some patients, the symptoms may include a rash, red eyes, hiccups, cough, sore throat, chest pain, difficulty breathing, difficulty swallowing and bleeding inside and outside of the body.
- c. Transmission occurs through direct contact with the blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk and semen) of a person who is sick with Ebola, contact with an infected animal in the affected countries or exposure to objects (such as needles) that have been contaminated with infected secretions.
- d. An individual not exhibiting the symptoms of Ebola is not infectious to others.

2. Vulnerability Assessment

The vulnerability of Maine will be defined by the number of travelers entering the State from the outbreak country, and the current level of response preparedness.

C. Planning Assumptions

1. Epidemiological disease surveillance and outbreak investigation, contact tracing and monitoring of Ebola exposed persons would be required.
2. An Ebola case(s) occurring within the State of Maine will be considered a public health emergency.
3. The public will likely be apprehensive, frightened or anxious, and require information and reassurance.
4. The number of Ebola cases occurring in Maine will be relatively small.
5. A confirmed Ebola case will require containment to prevent further transmission.
6. Hospitals and other healthcare facilities will need an experienced, highly trained staff to care for an Ebola infected patient.
7. Critical access hospitals (CAH) in rural areas will not have the capacity to care for an Ebola infected patient for an extended period of time (hours to a few days).
8. The regionalized hospitalization of Ebola infected patients will best support the management and treatment of Ebola infected patients.
9. Hospitals will require an adequate supply of personal protective equipment (PPE) and a staff that is trained to proficiency according to U.S. CDC guidelines on the use of that PPE.
10. Care of the Ebola infected patient will generate a significant amount of the hazardous waste.
11. Exposed facilities and dwellings will require specialized decontamination by a licensed and trained hazardous waste cleaning company.
12. Persons in active monitoring and direct active monitoring (AM/DAM) will require supportive services to meet their basic needs.
13. The safe handling of human remains due to an Ebola-related death in a hospital setting should be conducted according to the U.S. CDC.
Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries <http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html>
14. Some persons may need housing arrangements during the period they are being monitored.
15. All specimens sent for Ebola real-time Polymerase Chain Reaction (PCR) testing must be vetted by Federal CDC and must be shipped and logged by the Health and Environmental Testing Laboratory (HETL).
16. The Health and Environmental Testing Laboratory does not currently test for Ebola virus using an approved Laboratory Response Network-Biological (LRN-B) Ebola real-time PCR test.

II. Concept of Operations

- A. The Response would be initiated as outlined in the Maine CDC Emergency Operations Plan (EOP). The Incident Response Team (IRT) would be convened and the Public Health Emergency Operations Center (PHEOC) will be activated to partial or full activation.
- B. Incident Command Structure (ICS) will be implemented.
- C. External partners will be notified and informed of the situation initially, and on an ongoing basis. Situation reports will be provided on a daily basis.
- D. Communications with the public will be closely coordinated to ensure consistent and factual information. A variety of methods will be implemented to reach all sectors of the public. (See **Maine CDC All Hazards EOP, Communications Annex**)

III. Organization and Assignment of Responsibilities

A. General

Maine CDC will work closely with partners to support a regional response to an Ebola event. The Maine CDC is prepared to partially or fully activate the PHEOC to provide the needed support, as well as to request assistance from response partners if State resources are insufficient to meet the previously unidentified medical surge needs.

1. Regionalization

The DHHS/Maine CDC regionalization model of care is consistent with the tiered system of healthcare response as recommended by the United States Center for Disease Control and Prevention (U.S. CDC).

Care of an Ebola patient requires specially trained, experienced staff, high level PPE, isolation facilities and waste management and decontamination capabilities. Maine's Response to managing Ebola is to regionalize the transportation and care of Ebola persons under investigation (PUI) by sending highly suspected or confirmed Ebola cases to specially designated hospitals.

a. Tiered Response

Participating facilities in the tiered response include acute care hospitals and other emergency care settings, including urgent care clinics.

Relative to Ebola, acute healthcare facilities can serve one (or possibly more) of three roles:

- Frontline healthcare facilities
- Ebola assessment hospitals
- Ebola treatment centers

Frontline healthcare facilities that are equipped to provide emergency care include hospital-based emergency departments (ED) and urgent care facilities.

Frontline health care facilities should be prepared to:

- Rapidly identify and triage patients with relevant exposure history and signs or symptoms compatible with Ebola.
- Immediately isolate any patient with relevant exposure history, and signs and symptoms compatible with Ebola and take appropriate steps to adequately protect staff caring for the patient, including appropriate use of PPE.
- Immediately notify the hospital/facility infection control program and the Maine CDC.
- Transfer the patient to a designated assessment hospital that will provide Ebola testing and care until an Ebola diagnosis is either confirmed or ruled out.
- Provide proper PPE and a staff trained to proficiency according to U.S. CDC guidelines to care for a patient up to 12-24 hours.

Assessment hospitals are facilities prepared to receive and isolate PUIs for Ebola as do the frontline facilities. Further they are prepared to provide care for the patient until the diagnosis of Ebola can be confirmed or ruled out and until discharge or transfer is completed. Assessment hospitals are further prepared to:

- Coordinate Ebola testing which will involve transferring specimens to HETL.
- Provide proper PPE and a staff trained to proficiency according to U.S. CDC guidelines to care for a patient (with possible severe symptoms of vomiting, copious diarrhea or obvious bleeding) for up to 4-5 days.

Treatment centers are hospitals that plan to care for and manage a patient with confirmed Ebola for the duration of the patient's illness. The treatment hospital must meet the minimum criteria including infection control capacity, physical infrastructure, staffing resources, PPE supplies, waste management processes, worker safety training, environmental services and laboratory set up.

To create a regionalized, coordinated and networked approach the Maine Department of Health and Human Services has designated four healthcare facilities across the State as assessment hospitals that can successfully manage PUIs or confirmed cases of Ebola until an Ebola diagnosis is ruled out, or while awaiting transfer to an Ebola treatment hospital. Maine currently does not have a designated Ebola treatment hospital. Patients with confirmed Ebola will be transported to either a regionally designated Ebola treatment hospital or to a nationally designated Ebola treatment hospital. All healthcare facilities in Maine are expected to be able to quickly identify a PUI and take immediate action to isolate the person and protect facility staff with proper PPE.

See [Interim Guidance for US Hospital Preparedness for Patients with Possible or Confirmed Ebola Virus Disease: A Framework for a Tiered Approach](#) for more information on hospital roles.

All Maine hospital-based emergency departments and other urgent care facilities should be prepared to be a frontline facility.

The four designated Maine Ebola assessment hospitals, with a combined total of up to eight beds available, are:

- Central Maine Medical Center, Lewiston up to two rooms
- Eastern Maine Medical Center, Bangor up to two rooms
- Maine General Medical Center, Augusta up to two rooms
- Maine Medical Center, Portland up to two rooms

b. Regionalization Process

Public Safety Access Points (PSAP) (911 dispatch centers) are trained to identify possible Ebola cases. If a caller has Ebola symptoms and a travel history to an affected country, dispatch will then contact a secondary telephone triage center to assess risk. Based on the secondary triage, the patient may be transported either to a local hospital or to an assessment hospital for care. Transport will be completed by a specially designated transport team of responders in a specially equipped ambulance. **(See Appendix A)**

Both law enforcement (LE) and funeral directors have prepared Ebola Response Plans that are also based on the regionalization concept by resourcing and preparing specially prepared regional teams to work with individuals with suspected or confirmed Ebola. **(See Appendix J and Appendix K)**

2. Emergency Medical Treatment and Labor Act (EMTALA) requirements and implications relations to Ebola

The Centers for Medicare and Medicaid Services (CMS) released guidance to address concerns around the ability of hospitals or critical access hospitals to fulfill their EMTALA requirements during the Ebola response. EMTALA requires Medicare-participating hospitals and CAHs that have a dedicated emergency department to, at a minimum:

- Provide a medical screening examination (MSE) to every individual who comes to the ED, for examination or treatment for a medical condition, to determine if they have an emergency medical condition (EMC); and
- Provide necessary stabilizing treatment for individuals with an EMC within the hospital's capability and capacity; and
- Provide for transfers of individuals with EMCs, when appropriate.

According to the guidance, every hospital or critical access hospital with a dedicated emergency department is required to conduct an appropriate MSE of all individuals who come to the ED, including individuals who are suspected of having been exposed to Ebola, and regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate Ebola screening criteria when applicable, to immediately isolate individuals who meet the screening criteria to be a potential Ebola case, to contact their State public health officials to determine if Ebola testing is needed, and, when a decision to test is made, to provide treatment to the individual, using appropriate isolation precautions, until a determination is made whether the individual has Ebola.

The guidance further states in the case of individuals who have Ebola, hospitals and CAHs are expected to consider current guidance of public health officials (Maine Ebola Response Plan) in determining whether they have the capability to provide appropriate isolation required for stabilizing treatment and/or to accept appropriate transfers. In the event of any EMTALA complaints alleging inappropriate transfers or refusal to accept appropriate transfers, CMS will take into consideration the public health guidance in effect at the time.

The full guidance is included under **Appendix C**.

B. Organization

Various programs within the Maine CDC will have public health responsibilities to ensure the successful response to an Ebola event. Those Maine CDC Divisions/Programs/staff involved in support of the medical surge event include Public Health Emergency Preparedness, Infectious Disease (ID) Epidemiology, the Health and Environmental Testing Laboratory, the District and Tribal Liaisons, and Public Health Nursing.

C. Assignment of Responsibility

1. Primary Functions

The Maine CDC divisions/programs/staff involved in a public health Ebola response will assume the following responsibilities within the framework of ICS:

a. Public Health Emergency Preparedness (PHEP) will:

- Facilitate the activation of the PHEOC
- Coordinate the public health Ebola response
- Deploy supplies and equipment from the Maine CDC cache as needed
- Provide risk communications to the general public and to vulnerable populations
- Provide information from the U.S. CDC to clinicians and healthcare facilities

- Coordinate the response with all response partners
- Recommend a declaration of a public health emergency as appropriate
- Maintain situational awareness

b. ID Epidemiology will: (See Appendix D and Appendix E)

- i. Provide disease surveillance, case investigation, contact tracing and active and direct active monitoring
- ii. Provide clinical guidance to clinicians
- iii. Provide infection control guidelines to healthcare facilities
- iv. Monitor contacts and travelers from Ebola affected countries
- v. Report monitoring progress to Federal CDC

c. Health and Environmental Testing Laboratory will: (See Appendix F)

- i. Receive samples from health care facilities and forward them to the U.S. CDC or the assigned regional laboratory in Massachusetts for testing

d. Disaster Behavioral Health (DBH) will: (See Appendix L)

- i. Provide information and guidance to reduce public panic and stress and to recommend healthy coping mechanisms
- ii. Provide guidance for responders and health care workers

e. District and Tribal Liaisons (DLs) will: (See Appendix E)

- i. Work collaboratively with the RRCs to provide coordination of resources
- ii. Provide situational awareness to the State PHEOC
- iii. Provide liaison between the Maine CDC and local partners
- iv. Oversee and support the public health response locally
- v. Coordinate supportive assistance to individuals in active or direct active monitoring (AM/DAM)
- vi. Provide active monitoring in the event that the field epidemiologist (epi) is unavailable
- vii. Provide risk communications and information to district public health partners and municipal local health officers (LHOs)

2. Support Functions

a. Regional Resource Centers (RRCs) will:

- i. Ensure the accessibility of health and mental/ behavioral health services through activation of the resources of the regional Health Care Coalition (HCC) as needed
- ii. Obtain and report real time regional situational information including bed availability to the PHEOC

- iii. Serve as liaison between the Maine CDC and the local Healthcare Coalition partners including health care providers, EMS and behavioral health providers
- iv. Support regional resource management such as PPE and isolation equipment
- v. Coordinate training and exercises specific to Ebola
- vi. Support fatality management

The decision to initiate a regional Alternative Care Site (ACS) will originate with the RRC HCC according to HCC pre-determined trigger points.

b. Portland and Bangor City Health Departments

Portland Public Health (PPH) and Bangor Public Health (BPH) are local partners who would work closely with the Maine CDC Division of Infectious Disease and the DLs in supporting the local Ebola response.

c. Maine Emergency Management Agency (MEMA) (See Appendix J and Appendix K)

MEMA will be collaborating with Maine CDC on waste management, decontamination, fatality management and security issues using law enforcement resources and other logistical support.

d. County Emergency Management Agencies (CEMAs)

The County EMAs will be providing local logistical support in coordination with the Regional Resource Center and the DLs, as needed.

e. Chief Medical Examiner (CME) (See Appendix K)

The Chief Medical Examiner will oversee the handling of human remains in accordance with State and federal guidelines.

f. Maine Chapter of the American Red Cross (ARC) (See Appendix D)

The ARC, through MEMA, will assist Maine CDC in supporting persons that are being monitored by providing food, and other basic supplies

g. Hospitals (See Appendix A and Appendix B)

All hospitals will prepare staff to care for a possible Ebola case by obtaining adequate amounts of recommended PPE and training staff to proficiency on PPE according to U.S. CDC guidelines, as well as other infection control measures. The hospital staff will be vigilantly screening for Ebola suspected cases and will immediately isolate any patient that is suspected of being an Ebola case. The

hospital may admit the patient for a short stay, or may transfer the patient to a state designated Ebola assessment hospital or to a regional/national Ebola designated treatment hospital. (See **Appendix A: Ebola Regionalization Plan**)

h. Federally Qualified Health Centers (FQHC) (See Appendix A and Appendix B)

FQHCs will vigilantly screen for Ebola suspected cases, will immediately isolate a suspected case and will follow their infection control and transport protocol. (See **Appendix A**)

i. Northern New England Poison Center (NNEPC)

The NNEPC will provide Maine CDC's after hours on-call 24/7 coverage for clinical reporting of suspected Ebola cases.

j. Department of Transportation (DOT)

The DOT will provide transportation for medical materiel statewide.

k. Department of Environmental Protection (DEP) (See Appendix G)

The DEP will provide guidance on the proper treatment and disposal of contaminated solid and liquid waste.

l. Department of Education (DOE)

The DOE will ensure relevant public health information will be provided to schools, parents and students.

m. Maine National Guard (MENG)

The MENG will be utilized for logistical transport and mobile medical resources, if required.

n. Law Enforcement: Local Law Enforcement, Sheriffs and Maine State Police (MSP) (See Appendix J)

- i. Law enforcement regional response team will coordinate with EMS regional team to provide security during transportation.
- ii. Law enforcement will provide security for epidemiologists, DLs, and PHNs who actively monitor returning travelers as necessary.
- iii. Law enforcement will provide investigative support to ensure continuous contact with travelers under monitoring.

o. Emergency Medical Services (EMS) (See Appendix A)

Local EMS will assess and if applicable, will provide transport of suspected cases of Ebola to a healthcare facility. EMS has obtained proper PPE and has trained its responders on the donning and doffing PPE. Designated ambulances have been stripped down and designated as Ebola transport vehicles to facilitate decontamination of the vehicles.

p. Maine Funeral Directors (MFD) (See Appendix K)

Funeral directors are responsible for ensuring the proper handling and cremation of individuals that may expire due to Ebola.

q. 2-1-1 Maine (See Appendix I)

If the number of calls from the public exceeds Maine CDC's capacity to respond to the public, Maine CDC will activate its MOU with 2-1-1, for 2-1-1 Maine to establish a call center to manage the calls. Maine CDC will provide 2-1-1 Maine with talking points and will update the talking points as the situation changes.

IV. Authority, Command Responsibilities

A. Authority to Initiate Actions

The laws of the State of Maine, confer upon the Commissioner of the Maine DHHS the power to distribute the functions and duties of the Department including public health functions to the various Offices in order to integrate the work properly and to promote the most effective and efficient administration of the Department. The Maine CDC, the public health authority within the State, would lead the public health response.

B. Command Responsibility for Specific Actions

The Maine CDC Public Health Emergency Operations Center will manage and centrally coordinate response and recovery operations including:

1. Operations: Epidemiology will coordinate and conduct disease surveillance, case identification, contact tracing, traveler monitoring.
2. Logistics: Logistics will coordinate with relevant response partners regarding communications, hazardous waste removal, environmental decontamination, a State cache of PPE, and will assist the Red Cross by working to obtain necessary supplies to meet the needs of travelers being monitored.

V. Information, Collection and Dissemination

A. Information Collection

Information at the local level will be obtained/ collected by way of the RRCs, DLs, ID epidemiology, and others to include current situation, resources available, resources needed, and challenges.

B. Information Dissemination

Information will be disseminated from the Maine CDC to response partners via daily conference calls, Situation Reports, emails, Health Alert Network (HAN) alerts and the Maine CDC website.

VI. Communication and Confidentiality

A. Communications

Maine CDC is the State's lead public health agency, with primary responsibility for policy development and technical expertise regarding public health issues. As such, Maine CDC is responsible for developing, directing, and coordinating health-related communications to response partners and to the general public, during an emergency with public health implications. (See Appendix I)

When indicated, Maine CDC will be in close contact with its federal partners, the U.S. CDC and the Assistant Secretary for Preparedness and Response (ASPR). Maine CDC will provide situational information from the State to the U.S. CDC and ASPR. In turn, information received by the Maine CDC from the U.S. CDC and ASPR will be communicated back to State, regional and local partners.

The Maine CDC Public Information Officer (PIO) will collaborate and coordinate the dissemination of press releases, media interviews, websites and social media to inform the general public regarding health issues with other agency PIOs and initiate a Joint Information Center (JIC), if indicated. If the call volume exceeds the Department's capacity to respond to the public's concern, the Department will activate its MOU with 2-1-1 Maine to manage the public call center.

The Maine Health Alert Network (HAN) will be used to distribute critical information to Maine CDC health care partners, disaster support response partners and to vulnerable populations statewide.

The Maine CDC has developed multiple redundant communication methods by which to communicate with response and recovery partners and the public. For more detailed information on the Maine CDC communications function and capability, see the Communications Functional Annex to the Maine CDC All Hazards Emergency Operations Plan.

B. Confidentiality

All staff involved, paid and volunteer, in managing an outbreak have the responsibility of maintaining confidentiality of the individuals involved in the outbreak. Only the Chief Health Officer has the authority to release identifying information and will provide any such approval in writing. Identifying information will not be released unless authorized by the Health Officer and needed to properly conduct the outbreak investigation, to manage an outbreak and to protect the public's health.

Maine CDC staff members are required to complete annual compliance training, which includes relevant privacy and security laws and regulations. While outbreak investigations and outbreak management are Maine CDC functions and are Health Information Portability and Accountability Act (HIPAA) exempt, protected health information will only be released on order of the Chief Health Officer.

Community volunteers brought in to assist with the outbreak on a short term, emergency basis will receive brief training on privacy and security. This training will be documented using a sign-in sheet with volunteer names and signatures. Volunteers will also sign Maine DHHS confidentiality agreement for vendors.

VII. Administration, Finance and Logistics

A. Administration

The PHEOC Planning Section Chief is responsible for collecting and compiling all event documentation including the Incident Action Plans and all completed Incident Command Structure forms. These official records serve to document the response and recovery process of the Maine CDC and provide an historical record as well as form the basis for cost recovery, and identification of insurance needs and will guide mitigation strategies.

B. Finance

Each Maine CDC Division Director / Program Manager will submit reports/ledgers to the Maine CDC PHEOC Finance Section Chief relating to their department's expenditures and obligations during the emergency situation as prescribed by the Department of Emergency Management and Homeland Security. All original documents will be forwarded to the Planning Section Chief for the official record. A financial report will be compiled, analyzed and submitted to the Department of Health and Human Services (DHHS) for possible reimbursement following the event.

When local and State resources prove to be inadequate during emergency operations, requests should be made to obtain assistance from the Region I Emergency Coordinator and other agencies in accordance with existing mutual aid agreements and understandings including the Emergency Management Assistance Compact (EMAC) and Interstate Emergency Management Assistance Compact (IEMAC), or any real-time emergency negotiated agreements.

C. Logistics

Maine CDC has identified and addressed a number of logistical challenges specific to Ebola response, namely the availability and use of personal protective equipment and waste management (i.e. Category A waste management).

Maine CDC relies upon U.S. CDC guidance to determine the appropriate selection and usage of PPE for Ebola response. Based on U.S. CDC guidance, Maine CDC has purchased a State Cache of PPE to be used in response to Ebola. Additionally, Maine CDC has a defined process for requesting PPE from the USCDC, should the State Cache be depleted (or if it's anticipated to be depleted). **(See Appendix H)**

Collaborative work between the U.S. CDC and U.S. DOT has defined a number of caveats for the proper collection, transport and disposal of Ebola-contaminated waste. Based on the guidance provided by U.S. CDC and U.S. DOT, Maine CDC has established partnerships within State government and the private sector to define the processes required to address the need for Ebola waste management. **(See Appendix G)**

VIII. Plan Development and Maintenance

A. Plan Development

The Ebola Response Plan, an Annex to the Maine CDC All Hazards Emergency Operations Plan, was developed by the PHEP staff in close coordination and cooperation with internal response partners including Epidemiology, HETL, the DLs, and designated DHHS staff; and other response partners including but not limited to the RRCs, EMS, MEMA, DOT, DEP, and State Police.

B. Maintenance

The Plan will be reviewed by the Maine CDC Emergency Preparedness Committee during the annual review of the Maine CDC All Hazards EOP. The Plan will be updated to reflect lessons learned as they emerge from After Action Report/ Improvement Plans following real events or planned training exercises. If suggested changes to the Plan are drafted, these suggested changes will be discussed internally and vetted as indicated by significant changes. Any agreed upon changes will be added to the Plan as a DRAFT. Once the DRAFT is finalized and approved, a copy of the Plan will be distributed to various response partners and stakeholders for review and comment.

The PHEP staff will ensure that the Plan is reviewed by the stakeholders and appropriate subject matter experts a minimum of every three years. The building block training/ exercise approach will be used during this three-year time frame with internal/external stakeholders, to culminate by year three with a full scale exercise.

This plan can be used for emerging infectious diseases (EIDs) never before seen in Maine, such as other viral hemorrhagic fevers caused by the following virus families; arenaviruses, filoviruses, bunya viruses, and flaviviruses.

IX. Authorities and References

A. Legal Authority

1. The statutory procedures for the processing of public health measures are established in Title 22 M.R.S.A. Chapter 250, Subchapter II.
2. The statutory procedures for the processing of emergency management measures are established in Title 37-B, Chapter 13.

B. References

1. Maine CDC All Hazards Emergency Operations Plan, October, 2014
2. Seattle and King County Public Health, Isolation and Quarantine Response Plan, v4.1, September 2014

C. Resource Links:

1. Disaster Behavioral Health Website:
<http://www.mainedisasterbehavioralhealth.com/resourcespublichealth/>
2. U.S. CDC guidance documents: <http://www.cdc.gov/vhf/ebola/index.html>

Appendix A

State of Maine Regional Ebola Assessment, Care and Transport Plan (REACT)

Preface

The Maine Ebola Response Plan assumes an Ebola case occurring within the State of Maine would be considered a public health emergency.

Maine Center for Disease Control and Prevention (Maine CDC), in coordination with Federal CDC, will have situational awareness of known travelers from Ebola affected countries arriving within our State. Maine CDC infectious disease field epidemiologists will actively monitor known travelers from Ebola affected countries during the 21-day incubation period. A confirmed Ebola case would require containment to prevent transmission within the community and the healthcare system.

All hospitals and other healthcare facilities need to be prepared with staff trained to proficiency according to U.S. CDC guidelines and proper facilities, supplies and equipment to care for a suspected Ebola patient. Critical access hospitals in rural areas need to be prepared for short term care, but may not have the capacity to provide care for a suspected or confirmed Ebola patient for an extended period of time. The Maine Ebola Response Plan supports the regionalization of healthcare systems, Emergency Medical Services (EMS), law enforcement and mortuary care response planning to best support the management of suspected or actual Ebola patients.

Overview of Regionalization of Ebola Care

Regionalization refers to consolidating or confining the care of Ebola patients within the state to a few specially designated hospitals based on the premise that this model would be the most effective and efficient method of treating Ebola patients, containing the disease and use of resources.

Components of Maine's regionalization model include:

- Updated protocols and screening tools to be used by the 911 Public Safety Answering Points (PSAPs) that are evidence- based and aligned with the U.S. CDC guidelines;
- The addition of a secondary triage to further assess the status of the suspected Ebola patient;
- Regional ambulance teams with experienced staff who have advanced training, proper and adequate personal protective equipment (PPE), and a designated ambulance with appropriate barrier protection; and
- The designation of four regional assessment hospitals that have special facilities, proper and adequate PPE, and trained, experienced staff to care for Ebola patients.

The following document and algorithm detail how the regionalization concept would be operationalized.

State of Maine Regional Ebola Assessment, Care and Transport Plan

The purpose of this document is to describe the process for responding to 911 calls from the public that modifies our current system in a manner that both responds to the specific needs of an Ebola patient and provides a template for other emerging infectious diseases. EMS personnel, along with other emergency services staff, have a vital role in responding to requests for help, triaging patients and providing emergency treatment to patients. Unlike patient care in the controlled environment of a hospital or other fixed medical facility, pre-hospital care is typically provided in an uncontrolled setting. This setting is often confined to a very small space and frequently requires rapid decision-making and life-saving interventions based on limited information. EMS personnel are frequently unable to determine the patient history before having to administer emergency care.

Coordination among 9-1-1 PSAPs, the EMS system, healthcare facilities and the public health system is important when responding to cases with suspected Ebola. All 911 calls are answered by PSAPs that are licensed by Maine EMS and are required to have Emergency Medical Dispatch (EMD) provided for every medical call. Emergency medical dispatchers are licensed by Maine EMS (Department of Public Safety) and required to perform EMD in accordance with the protocols approved by the Board of EMS and the state EMS medical director. These protocols and the accompanying software are developed by the International Academy of Emergency Dispatch (IAED), are evidence based, and are used by EMS services throughout the US and around the world.

In response to concerns about Ebola and other emerging infectious diseases, the IAED protocols have been updated to align with U.S. CDC guidance. The update adds a surveillance tool that is incorporated into the dispatcher's questions. This surveillance tool includes the U.S. CDC guidelines for temperature and other signs and symptoms consistent with Ebola. All Maine PSAPs and EMD centers were notified on October 29, 2014 to update their software and card sets with the Emerging Infectious Disease (EID) surveillance questions.

The Process

The process is initiated by a call to 911. The call could be initiated from a variety of sources including a clinician at an outpatient facility, a law enforcement officer, or individual traveler that is under active and direct active monitoring by the Maine CDC.

For patients who have a medical emergency, but do not answer in the affirmative to the EMD surveillance tool:

- Dispatch would notify the local EMS service just as they do for other emergency calls.

- If the patient did not meet the criteria for concern, the dispatcher will deploy the local EMS agency and indicate “EID negative.”

For patients who answer in the affirmative to the EMD surveillance tool:

- Local EMS will be dispatched and advised that the EMD surveillance tool was “EID positive” or “EID inconclusive.”
- While maintaining a six foot or more distance from the patient, the local EMS agency will conduct an on-scene assessment with Online Medical Control (OLMC) at the local hospital. The secondary telephone triage will be provided by a person with clinical training to ask additional questions and to ascertain if the patient meets the EVD criteria for concern. If the secondary triage determines that the patient is EID negative, transport to the local hospital will take place per standard protocol.
- If secondary triage determines that the patient requires immediate transportation to a local hospital, local EMS on-site will provide transport after donning the appropriate PPE.
- If the patient requires transport, but not immediately, OLMC will contact the regional assessment hospital transfer coordinator and Maine CDC in order to coordinate patient transfer by a regional EMS transport service to a regional assessment hospital.

Regional Hospital Transfers

When the patient is to be transported to a regional assessment hospital, the patient’s condition will determine whether this happens by the local EMS service or, preferably, by a regional ambulance service. Regional EMS transport service providers have a designated ambulance with appropriate barrier protection (e.g. isolation pods) and staffed with experienced providers who have advanced training and adequate PPE to respond and transport the patient.

Patients awaiting transport by a regional EMS transport service:

Local EMS will continue to monitor patient status to ensure there is no significant change in the patient’s condition. If there is a change in status, local EMS may be called to treat and transport the patient to a local hospital and the regional EMS transport service would meet the patient at the local hospital. Once the patient is stabilized, the regional EMS transport service would transfer the patient to the designated assessment facility.

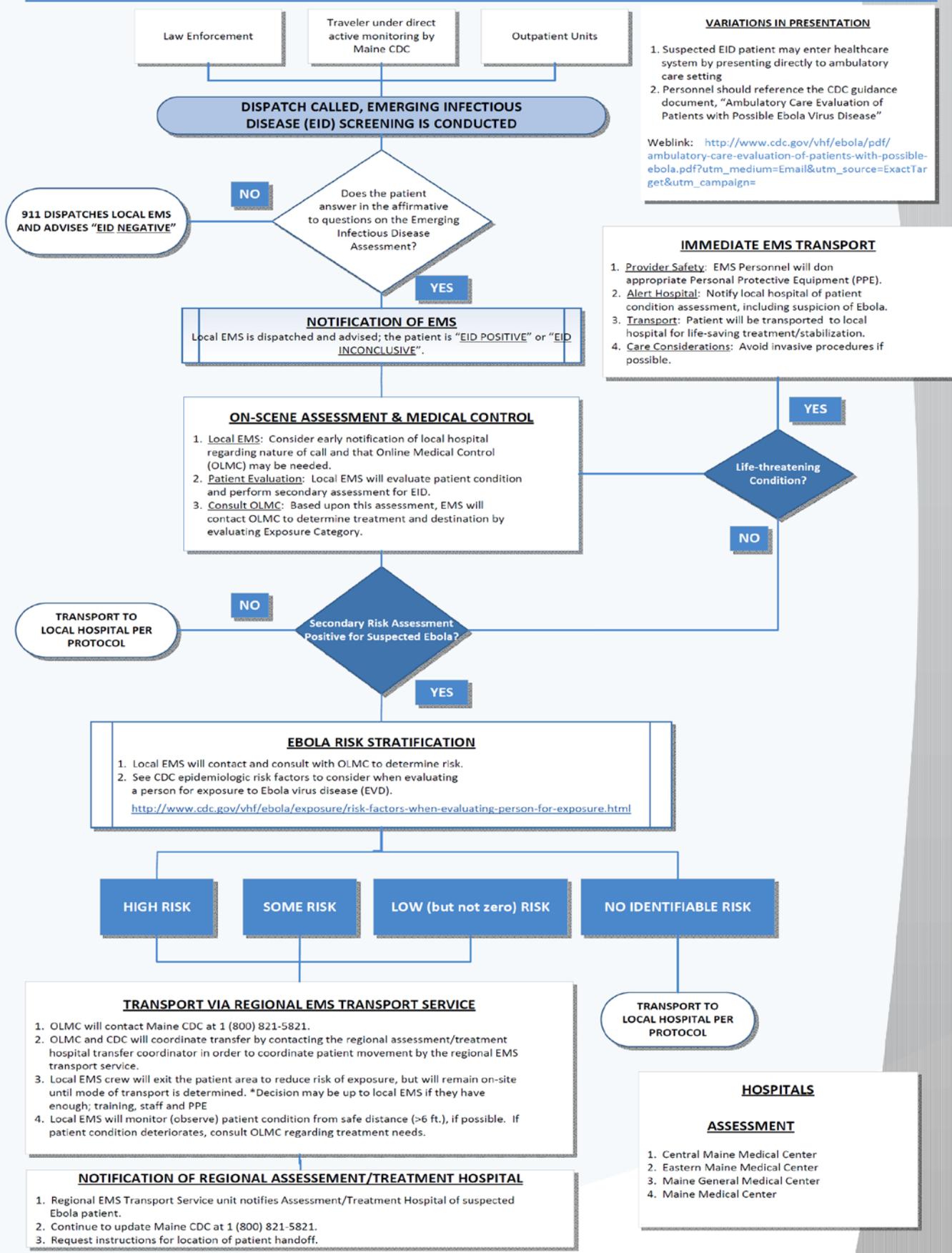
Transport to a Treatment Hospital

Once the patient in an assessment hospital is confirmed to have Ebola, arrangements will be made in conjunction with Maine CDC and U.S. CDC to transport the patient to a designated

treatment hospital, via the designated regional EMS transport service, for treatment for the duration of their illness.



State of Maine Regional Ebola Assessment, Care and Transport (REACT) Plan



Regional Emergency Medical Service Commitment

January 22, 2015

This confirms the willingness of _____ to participate as a Regional EMS Transport Service in the Maine Regional Ebola Assessment, Care & Transport (REACT) Plan. The REACT plan is based on establishing specialty transport teams that have the training and resources to provide pre-hospital assessment, care and transport of Ebola patients to one of four identified regional referral hospitals. The REACT plan can be downloaded at:

<http://www.maine.gov/dhhs/mecdc/infectious-disease/epi/zoonotic/ebola/documents/Maine-Regional-Ebola-Assessment-Care-and-Transport-Plan.docx>

The decision to activate a Regional EMS Transport Service to transport an individual suspected of having Ebola or with another emerging infectious disease to a regional referral hospital will occur following a consultation between local On Line Medical Control (OLMC), a Maine Center for Disease Control and Prevention (CDC) Epidemiologist, and the regional referral hospital. The regional EMS units should make a reasonable effort to respond within 2 hours of receiving the request.

Personal Protective Equipment

The Regional EMS Transport Service must ensure that their transport staff have received proper and adequate Personal Protective Equipment (PPE) training, ensure that their EMS personnel wear PPE, and follow proper procedures for putting on and taking off (donning and doffing) PPE as described in: [Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in US Hospitals, Including Procedures for Putting On \(Donning\) and Removing \(Doffing\)](#).

The Maine CDC has purchased a State Cache of PPE, based on current recommendations from the U.S. CDC (please note that the Maine CDC PPE cache does not utilize PAPRs consistent with the federal CDC's PPE recommendations). The Maine CDC will forward-deploy a portion of the State Cache to each regional referral hospital to resupply any PPE used by a Regional EMS Transport Service to transport an individual with a confirmed or suspected case of Ebola. If a Regional EMS Transport Service does not have the initial PPE necessary to respond to a confirmed or suspected case of Ebola, they should contact their regional referral hospital and/or the Maine CDC Logistics Section Chief at 207-557-1606.

Decontamination guidance: Maine CDC encourages Regional EMS Transport Services to coordinate with the regional referral hospital if a plan is not already in place.

Maine CDC staff will work closely with the Regional EMS Transport Service to assure that resources are available to maintain readiness and response to the best of our ability, so that no single Regional EMS Transport Service carries the burden of this planned response.

Liability:

Pursuant to this document and in accordance with M.R.S.A. Title 37B section 784A, the State of Maine provides liability insurance and worker's compensation to those trained and certified as Emergency Management Response Team (EMRT) Members when they are performing assigned duties directly related to preparation for, response to, or recovery from an authorized activation pursuant to this document.

For purposes of this agreement, “EMRT Member” is defined as Regional EMS Transport Service employees whose name and credentials have been provided and approved by Maine EMS. Liability insurance and worker’s compensation coverage shall be extended to those individuals and/or team when activated and approved by the Director of MEMA and/or the Director’s designee. The activation of a Regional EMS Transport Service will be initiated by Maine DHHS/CDC and Maine EMS whenever a traveler under active or direct active monitoring becomes symptomatic during their 21 day monitoring period. The Director of MEMA and/or the Director’s designee will be notified and approve/activate the Regional EMS Transport Team. If during an authorized emergency response or training activity, an individual is injured or thought to be injured, the first priority will be the safety and well-being of the team member. As soon as possible, the MEMA Duty Officer will be notified and within 24 hours of the injury a written “First Report of Injury” will be submitted to MEMA (see Attachment to this Agreement). It is understood that a Regional EMS Transport Service member engaged in a response pursuant to this document may be determined to have been exposed to the Ebola virus. As a result, that service member may be subject to active or direct active monitoring in accordance with the Maine DHHS/CDC guidelines.

The Team further agrees to indemnify MEMA, Maine DHHS/CDC, and Maine EMS and hold them harmless from any third party claims that may arise from the equipment provided pursuant to this agreement, including all losses, damages, and expenses, such as reasonable attorney’s fees and defense costs, related to any such third party claims. Such limitation of liability is to be made known to and binding upon any party receiving equipment pursuant to this agreement.

Nothing contained herein is intended to waive the defenses and immunities available to MEMA, the Team, Maine DHHS/CDC, or Maine EMS with respect to third parties under provisions of law, including, but not limited to, the defenses and immunities provided under the Maine Tort Claims Act, 14 MRSA 8101, et seq.

Your signature below will serve as written confirmation of your commitment to supporting Maine’s public health as a Regional EMS service provider. Thank you for your collaboration and preparedness efforts.

Authorized Service Representative (printed)

Date: _____

Authorized Service Representative (signature)

Maine EMS (signature)

Date: _____

REGIONAL REFERRAL HOSPITAL COMMITMENT
January 6, 2015

On behalf of the people of Maine, please accept my appreciation for your partnership and leadership to address the state's response to the emergent public health concern, Ebola Virus Disease. Preparedness for a public health emergency takes time, thoughtful planning and training hours, and ultimately, the capability to provide necessary and critical health care services.

Maine's Ebola Response Plan represents the evolving and cumulative work of many partners, including, but not limited to the Maine Department of Health and Human Services, in particular, its Center for Disease Control and Prevention, as well as the Department of Labor, the Department of Environmental Protection, Regional Resource Centers, Maine Emergency Management, Maine Emergency Medical Services, hospitals, health care providers and community leaders. As the lead agency in public health emergency, Maine DHHS has identified its Maine CDC office to coordinate the planning, operations, logistics and communication efforts.

This letter confirms the willingness of the following hospitals to participate as Regional Referral Hospitals as part of the Maine Ebola Response Plan. Participation as a Regional Referral Hospital is based on the understanding that all facilities are presently at varying states of readiness, but are in the process of making necessary preparations in order to be able to safely care for patients with EVD for limited periods of time. As partners in this process, Maine DHHS also acknowledges that participation is contingent upon the availability of a nationally-designated Ebola treatment center located out of state and Maine hospitals can only care for patients with EVD to the extent that this can be done appropriately and safely, and until transfer can be arranged to a more specialized facility. Additionally, participation is based on the understanding that healthcare workers caring for patients with EVD in Maine hospitals will adhere to monitoring protocols and work restrictions based solely on recommendations from the United States Centers for Disease Control and Prevention.

In addition, the Department, in conjunction with its partners at Emergency Medical Services, is confident that the network of emergency medical transporters are equipped with the skills and training to transport a confirmed or suspected case to and from these Regional Referral Hospitals. The Department further recognizes that the capacity of Regional Referral Hospitals may be changed depending on the surge and demand for services.

The commitment and capacity levels of the Regional Referral Hospitals are presently as follows:

Central Maine Medical Center, Lewiston	2 rooms
Eastern Maine Medical Center, Bangor	2 rooms
MaineGeneral Medical Center, Augusta	2 rooms
Maine Medical Center, Portland	2 rooms

DHHS CDC staff will work closely with all Regional Referral Hospitals to assure that resources are available to maintain readiness and response, as well as to the best of our ability, that no one Regional Referral Hospital carries the burden of the planned response.

Your signature below and email response in the affirmative will serve as written confirmation of your commitment to supporting Maine's public health as a Regional Referral Hospital. Thank you for your collaboration and preparedness efforts.

Sincerely,



Mary C. Mayhew
Commissioner

Tina Legere, President
Central Maine Medical Center

Deborah C. Johnson, RN, President and Chief Executive Officer
Eastern Maine Medical Center

Chuck Hays, President and Chief Executive Officer
MaineGeneral Medical Center

Richard Petersen, President and Chief Executive Officer
Maine Medical Center

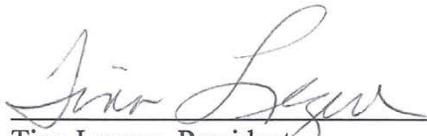
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Mary C. Mayhew
Commissioner



Tina Legere, President
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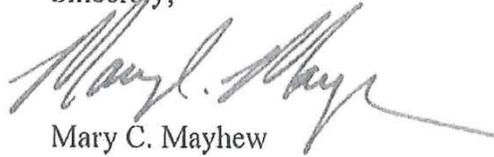
Chuck Hays, President and Chief Executive Officer
MaineGeneral Medical Center

Richard Petersen, President and Chief Executive Officer
Maine Medical Center

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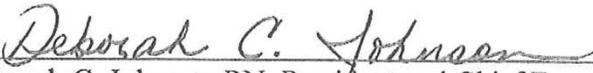
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Mary C. Mayhew
Commissioner

Tina Legere, President
Central Maine Medical Center



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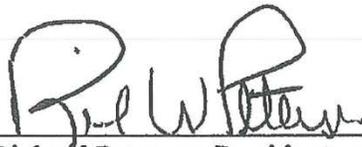


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Chuck Hays, President and Chief Executive Officer
MaineGeneral Medical Center



Richard Petersen, President and Chief Executive Officer
Maine Medical Center

Appendix B

Guidance for Maine Healthcare Providers Caring for Possible or Known Ebola Patients

The following guidance for healthcare professionals and healthcare facilities in Maine caring for patients with known or suspected Ebola hemorrhagic fever is based on the US Centers for Disease Control and Prevention Guidelines and the Emory Healthcare Ebola Preparedness Protocols. It is understood that the knowledge base about the Ebola virus is continually developing, and this information may require updates and/or state-based variation on a case-by-case basis.

The Department of Health and Human Services, Maine Center for Disease Control and Prevention (Maine CDC) explicitly recognizes the following assumptions:

- 1) Due to the national screening at targeted airports, the Maine CDC will be advised that an individual is traveling to Maine from the affected areas and, therefore, will be able to place the traveler under active or direct active monitoring immediately upon his/her arrival in Maine.
 - a. The Maine CDC will advise local EMS and hospital(s) of the traveler's location and monitoring status as appropriate.
- 2) All Maine healthcare facilities must be prepared to safely receive, isolate and assess patients who may have Ebola. The Maine CDC will assist a receiving facility to safely transport the patient to the appropriate Maine assessment hospital, or regionally designated facility as soon as reasonably possible. In the event that a patient tests positive for Ebola, Maine CDC will notify the U.S. CDC, who will in turn activate a response team within 24 hours to provide on-site guidance regarding treatment management protocol.
- 3) The Maine CDC acknowledges that:
 - a. The process of caring for a patient who *may* have Ebola is as challenging as the process of caring for a patient with confirmed Ebola.
 - i. A minimum of three staff are required to care for these patients at all times, each working in a different risk zone: hot zone (direct care), warm zone (indirect care), and cold zone (indirect support to staff providing patient care). Due to the burden of protective personal equipment (PPE), it is estimated that hot zone healthcare workers can work only up to a maximum of four hours at a time.

- ii. It is advised that facilities have dedicated Ebola teams comprised of a sufficient number of experienced and well-trained volunteer staff to care for these patients until a safe and medically appropriate transfer is arranged to a regional assessment hospital, or nationally designated hospital. In the event that a patient tests positive for Ebola, Maine CDC will notify the U.S. CDC, who will in turn activate a response team within 24 hours to provide on-site guidance regarding treatment management protocol.
 - iii. PPE usage should be implemented by volunteers who are highly trained in the donning and doffing process. A buddy system should be utilized to monitor and assist in the case of any breaches of PPE and to ensure no skin is exposed.
 - iv. Due to the need for appropriate isolation space, staffing and PPE, caring for these patients may rapidly deplete any healthcare facility's capacity to remain operational.
 - v. Caring for these patients may increase anxiety in the local population and in the hospital itself. This anxiety may result in employee/consumer avoidance of the staff caring for the patient as well as the facility itself.
- b. In recognition of the challenges outlined above, the Maine CDC expects to immediately transfer any patients who present with symptoms of Ebola to a Maine regional assessment hospital, capacity permitting.
- i. Any healthcare facility that receives a patient who present with symptoms of Ebola should immediately contact the Maine CDC Infectious Disease Reporting and Consultation Line at 1-800-821-5821 for assistance. No transfers should be arranged prior to notification of the Maine CDC and the State field epidemiology team. Discussions regarding patient care should be between physicians. All testing for Ebola must be approved first by the U.S. CDC through the Maine CDC team.
 - ii. All specimen samples for Ebola testing must be sent first to the Maine CDC Health and Environmental Testing Laboratory (HETL). HETL will then ship the sample(s) to the regional testing laboratory following U.S. CDC specimen transport protocol.
 - iii. The four Maine Regional Assessment Hospitals, with a combined total of up to eight beds available, are:

1. Central Maine Medical Center, Lewiston up to two rooms
2. Eastern Maine Medical Center, Bangor up to two rooms
3. Maine General Medical Center, Augusta up to two rooms
4. Maine Medical Center, Portland up to two rooms

Guidelines for Healthcare Workers

For the purposes of risk of exposure to Ebola, regardless of country, direct patient contact includes doctors, nurses, physician assistants and other healthcare staff, as well as ambulance personnel, burial team members and morticians. In addition, others who enter into the treatment areas where Ebola patients are being cared for (such as observers) would be considered to potentially have patient contact and be at risk. Clinical laboratory workers who use appropriate PPE and follow biosafety precautions, are not considered to have an elevated risk of exposure to Ebola, i.e., are considered to be in the low (but not zero) risk category. However, if an individual has had a known exposure or needle stick, this individual then becomes high risk and in need of direct active monitoring by Maine CDC and/or the affected hospital. Laboratory workers in Biosafety Level 4 facilities are considered to have no identifiable risk.

The high toll of Ebola virus infections among healthcare workers providing direct care to Ebola patients in countries with widespread transmission (Guinea, Liberia, Sierra Leone) suggests that there are multiple potential sources of exposure to Ebola virus in these countries, including unrecognized breaches in PPE, inadequate decontamination procedures, exposure in patient triage areas, and unknown exposures in the community. Due to this higher risk, healthcare workers who provide direct patient care in Ebola affected countries are classified in the some risk category, for which additional precautions may be recommended upon their arrival in the United States. Healthcare workers who have no direct patient contact and no entry into active patient management areas, including epidemiologists, contact tracers and airport screeners, are not considered to have an elevated risk of exposure to Ebola, [i.e., are considered to be in the low (but not zero) risk category.]

Active and Direct Active Monitoring

Active monitoring means that the Maine CDC assumes responsibility for establishing regular communication with potentially exposed individuals, including checking daily to assess for the presence or absence of symptoms and fever, rather than relying solely on individuals to self-monitor and report symptoms if they develop. Direct active monitoring means the Maine CDC conducts active monitoring through direct observation. The purpose of active (or direct active) monitoring is to ensure that, if individuals with epidemiologic risk factors become ill, they are

identified as soon as possible after symptom onset so they can be rapidly isolated and evaluated. Active (or direct active) monitoring could be conducted on a voluntary basis or compelled by legal order. Active (or direct active) monitoring and prompt follow up should continue and be uninterrupted if the person travels out of the jurisdiction.

Active monitoring should consist of daily reporting of two temperature checks spaced at least 6 hours apart and symptoms consistent with Ebola (which may include any one of the following: severe headache, fatigue, muscle pain, weakness, diarrhea, vomiting, abdominal pain or unexplained hemorrhage) by the individual to designated Maine CDC infectious disease epidemiologists (via disease reporting line at 1-800-821-5821) who will in turn immediately notify the Maine CDC Director and the State field epidemiology team. If there are any symptoms that manifest or the individual becomes febrile without other attributable etiologies, the DHHS Commissioner will be notified and U.S. CDC consulted. Temperature should be measured using a Food and Drug Administration-regulated thermometer (e.g. oral, tympanic or noncontact). If the individual under monitoring does not have a thermometer or did not receive one at the airport upon entry screening to the United States, Maine CDC will provide one as soon as possible. Initial symptoms can be as nonspecific as fatigue. Clinical criteria for required medical evaluation according to exposure level have been defined, and should result in immediate isolation and evaluation. Medical evaluation may be recommended for lower temperatures or nonspecific symptoms based on exposure level and clinical presentation.

Direct active monitoring, means a representative from the Maine CDC will directly observe the individual via an in-person visit, Skype, or Facetime at least once daily to review symptom status and monitor temperature; a second follow up per day may be conducted by telephone, FaceTime or Skype in lieu of a second direct observation. Direct active monitoring should include discussion and approval by the Department, of plans to work, travel, take public transportation or be present in congregate locations. Depending on the nature and duration of these activities, they may be permitted if the individual has been consistent with direct active monitoring (including recording and reporting of a second temperature reading each day), has a normal temperature and no symptoms whatsoever and can ensure uninterrupted direct active monitoring by the Maine CDC. Travel to another state or country may be permitted upon approval by the Director of the Maine CDC (or designee) and their counterpart in the state being visited, with uninterrupted direct active monitoring. Restrictions may be imposed if there is not adherence to direct active monitoring.

For healthcare workers under direct active monitoring, the Maine CDC can delegate the responsibility for direct active monitoring to the healthcare facility's occupational health program or the hospital epidemiologist upon mutual agreement that the facility understands the active monitoring system and is able to follow this individual for the remainder of their 21-day period. Facilities may conduct direct active monitoring by performing fever checks on entry or

exit from the Ebola treatment unit and facilitate reporting during days when potentially exposed healthcare workers are not working. The occupational health program or hospital epidemiologist would report twice daily to the Maine CDC (which could be by e-mail), with at least six hours between each assessment. If the healthcare worker is not at the facility for at least six hours, the second daily report will be as directed by the Maine CDC.

Low (but not zero risk)

Healthcare workers who provide care to Ebola patients in U.S. facilities while wearing appropriate PPE and with no known breaches in infection control are considered to have low (but not zero) risk of exposure because of the possibility of unrecognized breaches in infection control and should have direct active monitoring. As long as these healthcare workers have direct active monitoring and are asymptomatic, they can continue to work in hospitals and other patient care settings. As long as direct active monitoring continues uninterrupted, review and approval of work, travel, use of public transportation and attendance at congregate events are not indicated for such healthcare workers.

For a healthcare worker treating an Ebola patient in Maine who wore the recommended PPE and did not have any breaches in protocol, interstate and international travel may be allowed. The Maine CDC would need to continue direct active monitoring uninterrupted during the travel period.

It is important to note that if symptoms of Ebola do develop while the person is outside of the country, they will not be allowed to return to the United States except by air ambulance.

Some countries may have policies that would not allow someone who has cared for an Ebola patient to enter the country during the 21-day monitoring period. Healthcare workers who are being monitored for Ebola and have been approved to travel by the Maine CDC, should also check with the embassy of their destination country prior to travel for appropriate arrangements of uninterrupted active monitoring twice daily separated by at least six hours. U.S. CDC may be notified to assist in these notifications and arrangements.

Some Risk or High Risk

Healthcare workers taking care of an Ebola patient in a Maine facility who have a known breach in infection control practices will be classified into the “high risk” or “some risk” category based on the significance and severity of the actual infection control breach in question and will be subject to direct active monitoring and other restrictions consistent with US guidelines, such as travel restrictions, home monitoring, and controlled movement depending on the risk level

identified. These potential restrictions will last until 21 days after the last potential unprotected exposure and will be made under the public health authority of the Maine CDC.

High Risk

Healthcare workers taking care of Ebola patients in a U.S. facility where another healthcare worker has been diagnosed with confirmed Ebola without an identified breach in infection control are considered to have a higher level of potential exposure (exposure level: high risk). A similar determination would be made if an infection control breach is identified retrospectively during investigation of a confirmed case of Ebola in a healthcare worker. These individuals would be subject to restrictions, including controlled movement and the potential use of public health orders, until 21 days after the last potential unprotected exposure.

In U.S. a healthcare facilities where an unidentified breach in infection control has occurred, assessment of infection control practices in the facility, remediation of any identified deficiencies, and training of healthcare workers in appropriate infection control practices should be conducted with assistance from the Maine CDC Healthcare Associated Infections (HAI) Coordinator: 1-800-821-5821 or disease.reporting@maine.gov. Following remediation and training, asymptomatic, potentially exposed healthcare workers may be allowed to continue to take care of Ebola patients, but care of other patients should be restricted. For these healthcare workers, the last potential unprotected exposure is considered to be the last contact with the Ebola patient prior to remediation and training; at 21 days after the last unprotected exposure, they would return to the low (but not zero) risk category under direct active monitoring. Healthcare workers whose first Ebola patient care activities occur after remediation and training are considered to be in the low (but not zero) risk category.

Hospital Employee Health Monitoring

All employees involved in direct patient care or with indirect or potential exposure (such as those handling specimens or waste) are required to complete symptom surveys and temperature checks twice daily.

Healthcare Facility Monitoring of Exposure Incidents

Every Maine healthcare facility must have a plan to rapidly identify and manage an Ebola exposure incident, which will include notification of the Maine CDC at: 1-800-821-5821. All employees with potential or definite exposure to Ebola virus will be immediately evaluated by the appropriate physician, preferably an infectious disease physician.

- All employees who have recently cared for a patient with Ebola and experience symptoms of an acute infectious disease (e.g., fever, cough, new rash, nausea, vomiting, diarrhea, night sweats) should be evaluated immediately, placed in isolation, and started on an Ebola “rule-out” process in consultation with the Maine CDC.

Environmental Infection Control in Hospitals for Ebola Virus

See also: <http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html>

Ebola virus is transmitted through direct contact with blood or body fluids/substances (e.g., urine, saliva, sweat, feces, vomit, breast milk, and semen) of an infected person with symptoms or through exposure to objects (such as needles or hard surfaces) that have been contaminated with infected blood or body fluids. There is conflicting evidence about the role of the environment in transmission. Limited laboratory studies under favorable conditions indicate that Ebola virus can remain viable on solid surfaces, with viable viral particle concentrations falling slowly over several days.

Given the low infectious dose required and the potential of high viral loads in the blood of ill patients, higher levels of precaution are warranted to reduce the potential risk posed by contaminated surfaces in the patient care environment.

As part of the care of patients who are persons under investigation (PUI), or with probable or confirmed Ebola virus infections, hospitals are recommended to:

- **Be sure healthcare workers and other staff in contact with the patient wear recommended PPE** to protect against direct skin and mucous membrane exposure of cleaning chemicals, contamination, and splashes or splatters during environmental cleaning and disinfection activities. If reusable heavy-duty gloves are used for cleaning and disinfecting, they should be disinfected and kept in the room or anteroom.
- U.S. CDC recommends staff members use standard, contact, and droplet precautions to care for a PUI or patient with confirmed EVD.
- Staff members might need to take additional infection control steps if a PUI or patient with confirmed EVD has other conditions or illnesses, such as tuberculosis, or requires care involving aerosol-generating procedures such as intubation or chest compressions.
- Healthcare personnel can be exposed to Ebola virus by touching a patient’s body fluids, contaminated medical supplies and equipment or contaminated environmental surfaces. Splashes to unprotected mucous membranes (for example, the eyes, nose, or mouth) are particularly hazardous.

- Procedures that can increase environmental contamination with infectious material or create aerosols should be minimized, such as Bilevel Positive Airway Pressure (BiPAP), bronchoscopy, sputum induction, intubation and extubation and open suctioning of airway.
- Seasoned healthcare professionals must be trained repetitively in the proper use of PPE including methodical, safe removal with a monitored buddy system to prevent contaminating themselves or others in the process. Additionally, there should be a sign-in sheet for everyone entering the donning and doffing area for patient care.
- The Do Not Resuscitate (DNR) preference should be discussed with the patient (if possible) and the family.
- Contaminated equipment, supplies and patient care items must be disposed of appropriately, in accordance with the facility's contract for disposal of Category A waste, which follows the US Department of Transportation Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Information regarding waste management by the primary Category A Waste Disposal vendor in Maine is available on the Maine Ebola website.
- **Use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus** (e.g., norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces in rooms of patients with suspected or confirmed Ebola virus infection, i.e. bleach solution.
- **Avoid contamination of reusable porous surfaces that cannot be made single use.** Use only a mattress and pillow with impermeable plastic or other covering that can be disposed of. Do not place patients with suspected or confirmed Ebola virus infection in carpeted rooms. Remove all upholstered furniture and decorative curtains from patient rooms before use.
- **Routine cleaning and disinfection of the PPE doffing area.** Routine cleaning of the PPE doffing area should be performed at least once per day and after the doffing of grossly contaminated PPE. Cleaning should be performed by a healthcare worker wearing clean PPE. An EPA-registered hospital disinfectant with label claims against non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, and poliovirus) should be used for disinfection. When cleaning and disinfection are complete, the HCW should carefully doff PPE (with a buddy system for monitoring the donning and doffing of PPE being imperative) and perform hand hygiene.

- To reduce staff exposure to potentially contaminated textiles (cloth products) while laundering, **discard all linens**, fluid-permeable pillows or mattresses, and textile privacy curtains into the waste stream and dispose of appropriately in accordance with the facility's contract for Category A waste disposal which follows the US Department of Transportation Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180).
- **The Ebola virus is classified as a Category A infectious substance** by and regulated by the US Department of Transportation's (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Ebola is also a Risk Group 4 infectious agent as defined by the American Biological Safety Association (ABSA). Any item transported offsite for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes laboratory samples from the patient's body fluids, medical equipment, sharps, linens and used healthcare products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used personal protective equipment (gowns, masks, gloves, goggles, face shields, respirators, booties, etc.) or byproducts of cleaning contaminated or suspected of being contaminated with a Category A infectious substance.

Appendix C

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Survey and Certification Group

Ref: S&C: 15-10-Hospitals

DATE: November 21, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications
Related to Ebola Virus Disease (Ebola)

Memorandum Summary

- ***Ebola and EMTALA requirements:*** This Memorandum conveys information useful in responding to inquiries from hospitals concerning implications of Ebola for their compliance with EMTALA.
- ***EMTALA Screening Obligation:*** Every hospital or critical access hospital (CAH) with a dedicated emergency department (ED) is required to conduct an appropriate medical screening examination (MSE) of all individuals who come to the ED, including individuals who are suspected of having been exposed to Ebola, and regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate Ebola screening criteria when applicable, to immediately isolate individuals who meet the screening criteria to be a potential Ebola case, to contact their state or local public health officials to determine if Ebola testing is needed, and, when a decision to test is made, to provide treatment to the individual, using appropriate isolation precautions, until a determination is made whether the individual has Ebola.
- ***EMTALA Stabilization, Transfer & Recipient Hospital Obligations:*** In the case of individuals who have Ebola, hospitals and CAHs are expected to consider current guidance of public health officials in determining whether they have the capability to provide appropriate isolation required for stabilizing treatment and/or to accept appropriate transfers. In the event of any EMTALA complaints alleging inappropriate transfers or refusal to accept appropriate transfers, CMS will take into consideration the public health guidance in effect at the time.
- ***Centers for Disease Control and Prevention (CDC) Website:*** CMS strongly urges State Survey Agencies (SAs), hospitals and CAHs to monitor the CDC website at <http://www.cdc.gov/vhf/ebola/> for the most current guidance and information concerning Ebola identification, treatment, and precautions to prevent the spread of the disease, as well as their State public health website.

Background

Due to increasing public concerns with Ebola, CMS is receiving inquiries from the hospital industry concerning implications for their compliance with EMTALA. Concerns center around the ability of hospitals and CAHs to fulfill their EMTALA screening obligations while minimizing the risk of exposure from Ebola infected individuals to others in the ED, including healthcare workers, and the isolation requirements for Ebola. In addition, we have also received questions about the applicability of EMTALA stabilization, transfer and recipient hospital obligations in the case of individuals who are found to have met the screening criteria for possible Ebola disease or who have been determined to have Ebola.

EMTALA requires Medicare-participating hospitals and CAHs that have a dedicated emergency department to, at a minimum:

- Provide an MSE to every individual who comes to the ED, for examination or treatment for a medical condition, to determine if they have an emergency medical condition (EMC); and
- Provide necessary stabilizing treatment for individuals with an EMC within the hospital's capability and capacity; and
- Provide for transfers of individuals with EMCs, when appropriate.

In addition, all Medicare-participating hospitals with specialized capabilities are required to accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities an individual requires for stabilization as well as the capacity to treat these individuals. This recipient hospital obligation applies regardless of whether the hospital has a dedicated emergency department.

EMTALA Obligations When Screening Suggests Possible Ebola

It may be the case that hospitals, emergency medical services (EMS), and their State or local public health officials develop protocols for bringing individuals who meet criteria for a suspected case of Ebola only to hospitals that have been designated to handle potential or confirmed cases of Ebola. These pre-hospital arrangements do not present any conflict with EMTALA. This is the case even if the ambulance carrying the individual is owned and operated by a hospital other than the designated hospital, so long as the ambulance is operating in accordance with a community wide EMS protocol.

On the other hand, if an individual comes to an ED of a hospital or CAH, as the term "comes to the emergency department" is defined in the regulation at §489.24(b), either by ambulance or as a walk-in, the hospital must provide the individual with an appropriate MSE. We emphasize that it is a violation of EMTALA for hospitals and CAHs with EDs to use signage that presents barriers to individuals who may have been exposed to Ebola from coming to the ED, or to otherwise refuse to provide an appropriate MSE to anyone who has come to the ED for examination or treatment of a medical condition. However, use of signage designed to help direct individuals to various locations on the hospital property, as that term is defined in the regulation at §489.24(b), for their MSE would be acceptable.

If during the MSE the hospital or CAH concludes, consistent with accepted standards of practice for Ebola screening, that an individual who has come to its ED may be a possible Ebola case, the hospital or CAH is expected to isolate the patient immediately. Although levels of services provided by EDs vary greatly across the country, it is CMS' expectation that all hospitals and CAHs are able to, within their capability, provide MSEs and initiate stabilizing treatment, while maintaining the isolation requirements for Ebola and coordinating with their State or local public health officials, who will in turn arrange coordination, as necessary, with the CDC.

At the time of the drafting of this memo, CDC's screening guidance called for hospitals and CAHs to contact their State or local public health officials when they have a case of suspected Ebola. According to that guidance, the State or local public health officials, together with the hospital, will make a determination as to whether Ebola testing of the individual is required.

- If it is determined that Ebola testing is not required, the hospital or CAH is expected to complete its MSE in accordance with accepted standards of practice and to take appropriate actions, depending on whether or not the individual has an EMC.
- If it is determined that Ebola testing is required, the hospital or CAH is expected to maintain the individual in isolation, providing treatment within its capability for the individual's symptoms as needed, until it has the test results or if, prior to test results, there is a determination by the responsible public health authorities that the case presents a strong probability of Ebola.
- If the individual tests negative for Ebola, the hospital or CAH is expected to complete its MSE in accordance with accepted standards of practice and to take appropriate actions, depending on whether or not the individual has an EMC.
- If the individual tests positive for Ebola, or the hospital together with state or local public health officials otherwise conclude that the individual likely has Ebola, even prior to obtaining test results, the hospital or CAH is expected to comply with the most recent State or local public health guidance in determining whether it has the capability to provide stabilizing treatment on site, or whether to initiate an appropriate transfer, in accordance with §489.24(e), to a hospital which has the capability to provide the required stabilizing treatment.

We appreciate the work of public health authorities, the Centers for Disease Control and Prevention (CDC) and hospitals to develop specialized capabilities to treat patients with Ebola. However, the existence of hospitals with specialized capabilities does not relieve any other hospital or CAH of its obligation to provide an appropriate medical screening examination, or fulfill any other EMTALA requirement relevant to the situation.

Other Enforcement Considerations

Should CMS receive complaints alleging either inappropriate transfers by a sending hospital or refusal of a recipient hospital to accept an appropriate transfer, it will take into consideration the State or local public health direction and designations of hospitals as Ebola treatment centers at the time of the alleged noncompliance concerning where Ebola treatment should be provided. It will also take into consideration any clinical considerations specific to the individual case(s).

Surveyors and managers responsible for EMTALA enforcement are expected to be aware of the flexibilities hospitals are afforded under EMTALA and to assess incoming EMTALA complaints accordingly in determining whether an on-site investigation is required. They are also expected to keep these flexibilities in mind when assessing hospital compliance with EMTALA during a survey.

Consistent with their obligations under the hospital and CAH Conditions of Participation (CoPs) §482.42 and §485.635(a)(3)(vi), hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of Ebola. Since the Ebola virus is transmitted via droplets, strict adherence to droplet and contact isolation precautions must be followed. The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance. CMS recognizes the difficulties securing the recommended personal protective equipment (PPE) required for training and patient care that may be present in some circumstances at the time of this Memorandum.

The US Department of Labor Occupational Health and Safety Administration (OSHA) has also provided guidance on worker protection related to Ebola at <https://www.osha.gov/SLTC/ebola/> . Hospitals and CAHs are expected under their respective CoPs at §482.11(a) and §485.608(a) to comply with OSHA requirements, but CMS and state surveyors acting on its behalf do not assess compliance with requirements of other Federal agencies.

Latest CDC Guidance

The most up-to-date guidance regarding screening, testing, treatment, isolation, and other Ebola-related topics can be found on the CDC website at <http://www.cdc.gov/vhf/ebola/index.html> . Hospitals and CAHs are strongly urged to monitor this site as well as their State public health website and follow recommended guidelines and acceptable standards of practice. (See also S&C 15-02: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-02.pdf>) SAs are also encouraged to monitor the CDC and their state public health websites for up-to-date information.

Questions about this document should be addressed to hospitalSCG@cms.hhs.gov.

Effective Date: The information contained in this letter should be shared with all survey and certification staff, their managers, and the state/Regional Office training coordinators immediately.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

EMTALA Obligations & Ebola Virus Disease (EVD) Question and Answer Document

Note: For the purpose of this document, the term “hospital” includes all types of Medicare- participating hospitals and critical access hospitals (CAHs)

A. Patient Insurance/Payor Status:

A.1. Is a Medicare-participating hospital required to provide EMTALA-mandated screening and stabilizing treatment for non-Medicare beneficiaries with likely or confirmed EVD?

EMTALA applies to all individuals who come to the dedicated emergency department (ED) of a Medicare-participating hospital, regardless of type or presence of insurance coverage or ability to pay. Further, Medicare-participating hospitals with specialized capabilities are required within the limits of their capability and capacity to accept appropriate transfers of individuals protected under EMTALA from other hospitals, without regard to insurance or ability to pay.

B. Specialized Capabilities

B.1. EMTALA requires that hospitals with specialized capabilities to treat EVD accept appropriate transfers of individuals who require those services, if they have capacity to provide them. In the event of an EMTALA complaint related to an inappropriate transfer and/or a refusal of a recipient hospital to accept an appropriate transfer, how will CMS determine whether a hospital had the “specialized capabilities” with respect to EVD required by the individual?

If the responsible State or local public health officials have designated or otherwise formally identified the hospital as an EVD treatment facility, or if the hospital has held itself out to the public as qualified to treat EVD patients, then the hospital might be considered to have specialized capabilities to treat EVD. In an area where no hospitals have been designated or self- identified as EVD treatment centers, in the event of an EMTALA complaint alleging either an inappropriate transfer by a hospital that could have stabilized an individual with EVD, or refusal by a recipient hospital to accept an appropriate transfer, CMS would conduct a case-specific review to determine whether the hospitals in question had the capability and capacity to provide the treatment necessary to stabilize an individual with EVD.

B.2: Do the CDC’s recommendations for State and local public health officials and hospitals to employ a tiered framework for designation of hospitals in relation to EVD conflict with hospital obligations under EMTALA?

No. The CDC’s interim guidance recommending that State and local public health officials and hospitals employ a tiered framework for designating hospitals for the screening, assessment and treatment of potential EVD-infected patients does not conflict with EMTALA. The CDC released interim guidance recommendations on December 2, 2014 suggesting three categories of designation of hospitals with respect to EVD:

1. Frontline Healthcare Facilities
2. Ebola Assessment Hospitals
3. Ebola Treatment Hospitals

Specific details regarding this framework and the expectations for EBV assessment and treatment for hospitals in each category are available at the following link: <http://www.cdc.gov/vhf/ebola/hcp/us-hospital-preparedness.html>

This guidance presumes that hospitals at any of these levels would be expected to screen, isolate and begin stabilizing treatment, as necessary, of any individual who presents to the ED with possible EVD symptoms. The guidance also calls for hospitals to immediately contact their State and local health departments to coordinate ongoing care of individuals suspected to have EVD, including when transfers to higher levels of care are appropriate. This guidance is consistent with the EMTALA requirements for screening, stabilization and appropriate transfers.

See also the related CDC guidance recommendations for preparing hospitals in each tier:

<http://www.cdc.gov/vhf/ebola/hcp/preparing-frontline-healthcare-facilities.html>

<http://www.cdc.gov/vhf/ebola/hcp/preparing-ebola-assessment-hospitals.html>

<http://www.cdc.gov/vhf/ebola/hcp/preparing-ebola-treatment-centers.html>

B.3: If a hospital that does not have the specialized capabilities associated with a designated Ebola Assessment or Treatment Center has provided an appropriate medical screening examination to an individual who has come to its ED and concluded the individual meets the criteria to be considered a suspected case of EVD, how does it know where to make a transfer that would be appropriate under EMTALA?

A list of current designated Ebola Treatment Centers is updated weekly by the CDC and may be found at <http://www.cdc.gov/vhf/ebola/hcp/current-treatment-centers.html>. However, first and foremost, hospitals should be working with their State and local public health officials and be aware of the Ebola response plan within their region. They should work with these public health officials to assure the implementation of the regional plan, including facilitating appropriate transfers. The CDC is working with States and hospitals to assure that every “Frontline Healthcare Facility” would be able to make appropriate transfers of individuals with suspected or confirmed EBV in a timely fashion to a hospital with the requisite specialized capabilities for further assessment or treatment.

However, it is a State public health agency decision whether or not to adopt the CDC’s recommended tiered hospital EVD response framework, and to make designations of specific hospitals accordingly. Further, if a State has not made any designations of Ebola Assessment or Treatment Centers within the State, this does not mean that every hospital in that State would automatically be considered a “Frontline Healthcare Facility” for EMTALA purposes. In the event of a complaint that a transfer of an individual suspected of having EVD was inappropriate, CMS would follow its standard EMTALA investigation procedures and consider the specific facts of the case, informed by the

available guidance from the CDC as well as any regional Ebola response plans and/or State designations of hospitals, when determining whether a violation of EMTALA had occurred.

B.4: Are hospitals required to accept transfers of patients with suspected or confirmed EVD from small or rural hospitals that don't have negative pressure rooms or other capabilities to care for patients with EVD?

Hospitals with capacity and the specialized capabilities needed for stabilizing treatment are required to accept appropriate transfers from hospitals without the necessary capabilities. Hospitals should coordinate with their State/local public health officials regarding appropriate placement of individuals who meet specified EVD assessment criteria, and the most current standards of practice for treating individuals with confirmed EVD infection status.

As in any case concerning a hospital's EMTALA obligations with respect to transfers of individuals, CMS would evaluate the capabilities and capacity of both the referring and recipient hospitals in order to determine whether a violation has occurred. Among other things, we would take into account the CDC's recommendations at the time of the event in question in assessing whether a hospital had the requisite capabilities and capacity. We note that the CDC's recommendations focus on factors such as the individual's recent travel history and presenting signs and symptoms in differentiating the types of capabilities hospitals should have to screen and treat that individual. The presence or absence of negative pressure rooms would not be the sole determining factor, and in some cases all that would be required would be a private room.

See the CDC website for the most current infection prevention and control recommendations for hospital patients with suspected or known EVD:

<http://www.cdc.gov/vhf/hcp/infection-prevention-and-control-recommendations.html>

B.5: If a State has, consistent with the CDC recommendations, designated hospitals according to their capabilities to handle differing levels of suspected or confirmed cases of EVD, does this affect a hospital's EMTALA obligations with respect to transfers from out of the State?

No. Hospitals with specialized capabilities and the capacity to provide the necessary stabilizing treatment required by an individual protected under EMTALA may not refuse an appropriate transfer from a referring hospital within the boundaries of the United States.

C. Screening Examinations and Stabilizing Treatment Requirements

C.1: What are the EMTALA requirements for hospitals in regard to screening and treating individuals with possible EVD?

The EMTALA requirements for hospitals are the same for individuals with possible EVD symptoms as all other possible emergency medical conditions (EMCs):

- Provide an appropriate Medical Screening Exam (MSE) to every individual who

- comes to the Emergency Department (ED) for examination or treatment of a medical condition, to determine if they have an emergency medical condition (EMC); and
- Provide necessary stabilizing treatment for individuals with an EMC within the hospital's capability and capacity; and
 - Provide for appropriate transfers of individuals with EMCs if the hospital lacks the capability to stabilize them.

Specific to EVD, hospitals are encouraged to follow the CDC guidance for appropriate isolation procedures to minimize the risk of cross-contamination to other patients, visitors, and healthcare workers. For example, the CDC publishes and updates accepted national standards of infection control practice for EVD. Hospitals should consult the latest CDC guidance and coordinate with State/local public health authorities for guidance related to ongoing care and treatment of patients with EVD.

C.2: Are all hospitals expected to screen and treat individuals with possible EVD symptoms?

Yes, all hospitals are expected, at a minimum to screen, isolate, and begin stabilizing treatment, as appropriate, for any individual with possible EVD symptoms. Hospitals should coordinate with their State/local public health authorities regarding ongoing care and treatment, including when it is appropriate to transfer individuals to hospitals with specialized capabilities and capacity to provide further assessment and/or stabilizing treatment for suspected or confirmed EVD.

C.3: If a hospital does not have Intensive Care Unit (ICU) capabilities is it required to screen and, when appropriate, initiate stabilizing treatment for individuals with suspected or confirmed EVD?

Yes. The lack of ICU capabilities does not exempt a hospital from performing an MSE and initiating stabilizing treatment for individuals with known or suspected EVD who come to the hospital's ED seeking examination or treatment. Qualified medical personnel in hospitals that conduct the screening examination should be aware of the criteria for initial EVD screening and should apply such screening when appropriate. Note that the CDC guidance for preparing "frontline" hospitals, i.e., those hospitals in the lowest tier of the EVD framework, indicates that they should be able to do the following:

- "Rapidly identify and triage [patients with relevant exposure history AND signs or symptoms \(http://www.cdc.gov/vhf/ebola/hcp/case-definition.html\)](http://www.cdc.gov/vhf/ebola/hcp/case-definition.html) compatible with EVD as outlined in CDC's guidance for Emergency Department Evaluation and Management for Patients Who Present with Possible Ebola Virus Disease([http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible- ebola.html](http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html)).
- Immediately isolate any patient with relevant exposure history and signs or symptoms compatible with EVD and take appropriate steps to adequately protect staff caring for the patient, including appropriate use of personal protective equipment (PPE) as outlined in CDC's guidance for [Emergency Department Evaluation and Management of Patients with Possible Ebola Virus](#)

[Disease\(<http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html>\)](http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html).

- Immediately notify the hospital/facility infection control program, other appropriate facility staff, and the state and local public health agencies that a patient has been identified who has relevant exposure AND signs or symptoms compatible with EVD; discuss level of risk, clinical and epidemiologic factors, alternative diagnoses, plan for EVD testing, plan for possible patient transfer to another facility, and further care.
- Ensure there is no delay in the care for these patients by being prepared to test, manage, and treat alternative etiologies of febrile illness (e.g., malaria in travelers) as clinically indicated.”

C.4: May hospitals refuse to allow individuals with suspected cases of EVD into their ED if other nearby hospitals have been designated as Ebola Assessment Hospitals or Ebola Treatment Centers?

No. For every individual who “comes to the emergency department,” as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical condition, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination. Qualified medical personnel in hospitals that conduct the screening examination should be aware of the criteria for initial EVD screening and should apply such screening when appropriate. Hospitals that refuse to screen an individual who comes to their emergency department would likely be found to have violated EMTALA, regardless of presenting signs, symptoms, and possible diagnoses.

C.5: Are all hospitals expected to have Personal Protective Equipment (PPE) and other equipment/facilities to screen and take care of suspected or confirmed EVD patients, even on a temporary basis until transferred?

There are no requirements established under EMTALA for hospitals to have specific PPE or equipment/facilities. Consistent with their obligations under the hospital and CAH Conditions of Participation (CoPs) at §482.42 and §485.635(a)(3)(vi), hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of EVD. Ebola is transmitted through direct contact with blood or body fluids of a person who is sick with Ebola; the virus is not transmitted through the air (like measles virus). However, large droplets (splashes or sprays) of respiratory or other secretions from a person who is sick with Ebola could be infectious, and therefore specific precautions are recommended for use in healthcare settings to prevent the transmission of Ebola from patients to healthcare personnel and other patients or family members. The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance.

CMS anticipates that many State and local public health authorities will employ the tiered hospital approach recommended by the CDC in their planning for potential EVD cases. That framework envisions that hospitals would have differing needs for PPE and

specialized equipment or facilities, based on their designated status under the tiered hospital approach.

C.6: May hospitals decline to perform an MSE on an individual who comes to their ED with potential or suspected EVD due to a lack of PPE or specialized equipment/facilities?

No. For every individual who “comes to the emergency department,” as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical condition, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination. Qualified medical personnel in hospitals that conduct the screening examination must be aware of the criteria for initial EVD screening and apply such screening when appropriate. Hospitals that refuse to screen an individual who comes to their emergency department would likely be found to have violated EMTALA, regardless of presenting signs, symptoms, and possible diagnoses.

C.7: May a physician who is present in the hospital conduct the MSE through the use of telemedicine equipment in lieu of physically being in the same exam room as the patient?

The use of audio, video and other telehealth equipment by an on-site physician to perform medical screening examinations is not specifically prohibited under EMTALA. However, the hospital is still obligated to perform an appropriate medical screening examination to determine the presence or absence of an emergency medical condition. In investigating any complaints related to this, the appropriateness of an examination using this type of equipment would be determined based on the specific facts of each individual case, including the clinical signs and symptoms of the individual at the time of presentation. If an in-person or hands-on examination is necessary, use of equipment alone would not meet the EMTALA requirements for an appropriate screening examination.

Further, when the screening examination indicates an individual has an emergency medical condition, hospitals are required to provide stabilizing treatment within their capability/capacity prior to making an appropriate transfer. We recognize that not every hospital will have the same capabilities with regard to EVD, and that transfers of individuals who meet the criteria for suspected EVD to other hospitals, based on current State public health guidance, may be appropriate. But prior to the transfer, it is difficult to envision that the individual’s care needs could be met via remote technology alone. Again, the individual facts of any case would be reviewed to determine what the individual’s care needs were prior to transfer and what the hospital was capable of providing.

C.8: Will CMS issue EMTALA waivers for hospitals related to EVD?

The statute governing EMTALA waivers sets a high threshold for issuing such waivers and also limits the nature and duration of an EMTALA waiver. At this time the requirements for CMS to issue EMTALA waivers have not been met (i.e., issuance of a Presidential disaster declaration and a Secretary’s declaration of a public health emergency). See Survey and Certification policy memorandum SC-10-05, issued November 6, 2009, for more information on EMTALA waivers:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter10_05.pdf

C.9: What about ambulances operating under emergency medical services (EMS) systems – are they subject to EMTALA?

Only ambulances that are owned and operated by a hospital are subject to EMTALA. Otherwise EMS services are considered pre-hospital care that is outside the scope of EMTALA. Public health officials, EMS systems and hospitals are free to develop protocols governing where EMS should transport individuals for emergency care. This includes developing protocols specific to individuals who meet criteria to be considered suspected cases of EVD.

Even in the case of ambulances that are owned and operated by a hospital, it is permissible to transport an individual to a different hospital for screening and treatment, so long as they are operating in accordance with a communitywide EMS protocol, or they are operating under the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

C.10: May hospitals turn away an EMS ambulance that comes to the “wrong” hospital ED and send it to another hospital that has been designated to assess or treat suspected or confirmed cases of EVD?

No. For every individual who “comes to the emergency department,” as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical conditions, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination for every individual who comes to the hospital’s emergency department. Qualified medical personnel in hospitals that conduct the screening examination must be aware of the criteria for initial EVD screening and apply such screening when appropriate. Further, if an individual meets the initial screening criteria for possible EVD, hospitals are expected to isolate them and begin stabilizing treatment of symptoms.

C.11: May hospitals set up alternative screening sites within the hospital to screen possible EVD patients, even if they don’t have an EMTALA waiver?

Yes, hospitals have flexibilities to set up alternative screening sites at other parts of the hospital, both on- and off-campus. See, for example, Survey and Certification policy memorandum SC- 09-52, issued August 14, 2009, for guidance related to influenza that may also be informative for other types of situations:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter09_52.pdf

However, absent an EMTALA waiver issued by CMS pursuant to a declaration of a public health emergency, hospitals may not direct an individual who has already come to their on-site emergency department to any off-campus location for screening.

C 11(a): What constitutes an alternative hospital location? For instance, can this include a tarped-off area of another room, a room constructed in the ambulance bay, or the room previously used as the decontamination room?

Hospitals have flexibilities under EMTALA to determine alternative locations outside the ED but within the hospital for screening examinations of individuals potentially exposed to or infected with EVD. Survey and Certification policy memorandum SC 09-52, issued August 14, 2009, provided guidance for handling a surge in demand for ED services related to the H1N1 influenza virus, and may be helpful in other situations:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter09_52.pdf

C11(b): Do the Life Safety Code (LSC) requirements under the hospital or critical access hospital Conditions of Participation apply to alternative care sites?

Since alternative care sites are expected to be within the hospital, they would be expected to meet LSC requirements.

However, there may be situations where temporary examination areas are set up. The following information on alternative care sites from the CMS emergency preparedness website may be helpful:

If compliance issues come up in such localized situations where no applicable section 1135 waiver [for declared public health emergencies] is available, CMS focuses on fundamentals, such as assuring medical and nursing staff have proper credentials and, in the case of medical staff, have privileges; assuring that care is safe, that patients' rights are protected and that medical records with sufficient information to promote safe care are maintained. Additionally, for facilities subject to the Life Safety Code (LSC), past experience has demonstrated that many facilities, even when functioning in a degraded status, or in the case of the establishment of alternative care sites, may continue to meet the LSC by implementing reasonable and prudent measures. For example, there were several hospitals that were damaged by Hurricane Katrina which continued to comply with the LSC by implementing reasonable and prudent measures, and therefore were able to continue operations in a degraded but safe environment for weeks or months until repairs could be completed.

The fact sheet on alternative care sites is available at this link:

<https://www.cms.gov/About-CMS/Agency-Information/H1N1/downloads/AlternativeCareSiteFactSheet.pdf>

C.11(c): Can alternative sites include outbuildings on the campus or use of tents in the parking lot?

Alternative screening sites may be located in other buildings on the campus of a hospital or in tents in the parking lot, as long as they are determined to be an appropriate setting for medical screening activities and meet the clinical requirements of the individuals referred to that setting.

However, we note the following from the CDC’s guidance for frontline healthcare facilities: “State and local public health departments are actively monitoring persons with a recognized EVD exposure risk within the last 21 days (CDC’s [Interim US Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure \(http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html\)](http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html)). Therefore, these persons will be directed to designated facilities for evaluation if they become ill, making it unlikely that patients with unrecognized EVD disease will present to a frontline healthcare facility without warning. However, it is also possible that patients with unrecognized EVD will present to a frontline healthcare facility unannounced, or rarely, patients may be temporarily referred to frontline healthcare facilities when it is not feasible to refer to an Ebola assessment hospital or treatment center (e.g. based on distance, bed availability, or other considerations).”

Given the unlikelihood that persons with a recognized EVD exposure will present to a hospital that has not been designated for EVD assessment or treatment, it may be misguided for hospitals to be contemplating measures more suitable to handling a surge in the volume of ED patients, such as setting up tents in the parking lot. This is particularly the case when such arrangements may expose individuals to inclement weather conditions.

C.11(d): What would be an acceptable alternative location on campus? Must the location currently exist as a part of the certified facility?

The location must be part of the certified hospital. If it is not currently part of the certified hospital, then the hospital must take steps to add the location as a new practice location of the hospital.

C.11(e): What type of approval process needs to be in place for a hospital to use an alternative location?

CMS does not require any approval process to use an alternative screening location that is already part of the certified hospital. If the hospital is adding a practice location, it must file a Form 855A with its Medicare Administrative Contractor to advise it of this action. The hospital is not required to obtain prior approval from CMS in order to bill Medicare for services at the added location. There is also no requirement for all added locations to be surveyed for compliance with the Medicare Hospital Conditions of Participation, but CMS retains the discretion to require a survey in individual cases.

States may have licensure requirements for prior approval of any additional practice locations, so hospitals are encouraged to consult with their State licensure authority on any applicable State requirements.

C.11(f): In the past when there have been disasters that resulted in ED surges alternative locations needed to be submitted and approved by State licensure authorities and also by CMS. Does this hold true for alternative locations for screening of potential EVD patients?

See answer to the prior question. As stated, CMS does not require prior approval for hospitals that are adding a practice location. Hospitals should consult with their State licensure authority on any applicable State requirements.

D. Patient Rights

D.1: What action should the hospital take if an individual who meets the screening criteria for suspected EVD wants to leave the hospital against medical advice?

Hospitals do not have authority to prevent the individual from leaving against medical advice. However, State or local public health authorities may have such authority under State or local law, and hospitals should coordinate with their local authorities on the appropriate way to handle an individual suspected of having EVD who wants to leave the hospital environment.

Note that there is an EMTALA requirement at §489.24(d)(3) for a hospital to take all reasonable steps to secure the individual's written informed refusal (or that of the individual's representative) of further medical examination or treatment that the hospital has offered.

D.2: What should the hospital do if a patient who has been deemed likely to have Ebola refuses to be transferred to a designated EVD treatment facility or other facility with the capabilities to treat this condition?

Hospitals do not have authority to compel the patient to accept a transfer. However, State or local public health authorities may have authority under State or local law to address such situations, and hospitals should coordinate with their local authorities on the appropriate way to handle an individual deemed likely to have EVD who refuses to be transferred to another hospital that has the specialized EVD capabilities the individual needs and which the referring hospital lacks.

Note that there is an EMTALA requirement at §489.24(d)(5) for a hospital to take all reasonable steps to secure the individual's written informed refusal (or that of the individual's representative) of an appropriate transfer. The written document must indicate that the individual has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal.

E. Enforcement

E.1: What will CMS do when a survey reveals that a hospital is not following nationally recognized guidelines regarding EVD infection control processes?

EMTALA does not establish requirements for infection control practices. However, consistent with their obligations under the hospital and CAH Medicare CoPs at §482.42 and §485.635(a)(3)(vi), hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of EVD. Ebola is transmitted through direct contact with blood or body fluids of a person who is sick with Ebola; the virus is not transmitted through the air (like measles virus). However, large droplets (splashes or sprays) of respiratory or other secretions from a person who is sick with Ebola could be infectious, and therefore specific precautions are recommended for use in healthcare settings to prevent the transmission of Ebola from patients to healthcare personnel and

other patients or family members. The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance. Hospitals may be cited for deficiencies under the CoPs related to failure to follow accepted infection prevention and control standards of practice.

E.2: How will CMS handle complaints about violations of EMTALA related to transfers/attempts to transfer individuals suspected or confirmed as having EVD?

If CMS receives complaints alleging either inappropriate transfers by a referring hospital or refusal of a recipient hospital to accept an appropriate transfer, the agency will consider the following (along with other factors) when making a determination of whether violations of EMTALA have occurred:

- The individual's clinical condition at the time of presentation to the referring hospital and at the time of the transfer request;
- The capabilities of the referring hospital, including whether State or local public health authorities have designated it as having specialized capabilities related to EVD, and the hospital's capacity at the time of the transfer request;
- The screening and treatment activities performed by the referring hospital for the individual;
- Whether the request for transfer was consistent with any nationally recognized guidelines in effect at the time of the transfer request for EVD screening, assessment, or treatment, including guidance about transfer for further assessment or treatment of suspected or confirmed EVD; and
- The capabilities of the recipient hospital, including whether State or local public health authorities have designated it as having specialized capabilities related to EVD and the recipient hospital's capacity at the time of the transfer request.

Appendix D



Maine Department of Health & Human Services
Center for Disease Control and Prevention

Ebola Virus Disease

Investigation Protocol

Dr. Sheila G. Pinette

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Director, Maine CDC

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Effective Date

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Reporting Requirements

Ebola virus falls under Viral Hemorrhagic Fever on Maine's Notifiable Conditions List and is required to be reported immediately by telephone upon recognition or strong suspicion of disease.

Case Definition

Clinical Description

Acute onset of symptoms including fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal pain, or unexplained internal or external hemorrhaging.

Symptoms may appear anywhere from 2 to 21 days after exposure to the Ebola virus, but 8-10 days is most common.

Laboratory Criteria for Diagnosis

Laboratory findings diagnostic for Ebola may include leukopenia frequently in conjunction with lymphopenia which is followed by elevated neutrophils. Platelet counts are often decreased in the 50,000 to 100,000 range. Amylase may be elevated, as well as hepatic transaminases with aspartate aminotransferase (AST) exceeding alanine aminotransferase (ALT). Proteinuria may be present. Prothrombin (PT) and partial thromboplastin times (PTT) are prolonged and fibrin degradation products (FDP) are elevated, consistent with disseminated intravascular coagulation (DIC).

Case Classification

A Person Under Investigation (PUI) is considered as someone who has both consistent symptoms and risk factors as follows:

1) Elevated body temperature or subjective fever or symptoms, including severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage; **AND**

2) An epidemiologic risk factor within the 21 days before the onset of symptoms.

Confirmed: A case with laboratory-confirmed diagnostic evidence of Ebola virus infection.

Epidemiologic Risk Factors:

High risk includes any of the following:

- Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of a person with Ebola while the person was symptomatic
- Exposure to the blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, and semen) of a person with Ebola while the person was symptomatic without appropriate personal protective equipment (PPE)
- Processing blood or body fluids of a person with Ebola while the person was symptomatic without appropriate PPE or standard biosafety precautions
- Direct contact with a dead body without appropriate PPE in a country with widespread Ebola virus transmission
- Having lived in the immediate household and provided direct care to a person with Ebola while the person was symptomatic

Some risk includes any of the following:

- In countries with widespread Ebola virus transmission:
 - Direct contact while using appropriate PPE with a person with Ebola while the person was symptomatic or with the person's body fluids
 - Any direct patient care in other healthcare settings
- Close contact in households, healthcare facilities, or community settings with a person with Ebola while the person was symptomatic
 - Close contact is defined as being for a prolonged period of time while not wearing appropriate PPE within approximately 3 feet (1 meter) of a person with Ebola while the person was symptomatic

Low (but not zero) risk includes any of the following:

- Having been in a country with widespread Ebola virus transmission within the past 21 days and having had no known exposures
- Having brief direct contact (e.g., shaking hands) while not wearing appropriate PPE, with a person with Ebola while the person was in the early stage of disease
- Brief proximity, such as being in the same room for a brief period of time, with a person with Ebola while the person was symptomatic
- In countries without widespread Ebola virus transmission: direct contact while using appropriate PPE with a person with Ebola while the person was symptomatic
- Traveled on an aircraft with a person with Ebola while the person was symptomatic

No identifiable risk includes:

- Contact with an asymptomatic person who had contact with a person with Ebola
- Contact with a person with Ebola before the person developed symptoms
- Having been more than 21 days previously in a country with widespread Ebola virus transmission

- Having been in a country without widespread Ebola virus transmission and not having any other exposures as defined above
- Aircraft or ship crew members who remain on or in the immediate vicinity of the conveyance and have no direct contact with anyone from the community during the entire time that the conveyance is present in a country with widespread Ebola virus transmission

Laboratory Testing Services Available

Providers seeking to test a suspect case must contact Maine CDC for consultation and shipping authorization. Currently, testing can be performed at the Massachusetts State Laboratory Institute and federal CDC in Atlanta. No specimen will be accepted without prior consultation. **(Appendix F 1.)** Specimens will not be tested at HETL but should be sent to HETL to ensure routing instructions and packaging is correct. **(Appendix F 2.)**

The CDC's *Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Patients with Suspected Infection with Ebola* should be consulted. **(Attachment 1)**

Purpose of Surveillance and Reporting

- To identify potential cases, isolate them, and prevent the spread of the viral infection.
- To understand trends in transmission of Ebola infection, including symptoms, risk factors, and travel history.
- To collect data useful to target prevention efforts at affected populations.
- To provide case management guidance to hospitals.

Case Investigation

- If Maine CDC receives a call from or report of a symptomatic individual with consistent risk factors requiring transport to a hospital, then:
 - The responding epidemiologist should advise the individual to immediately call 911 to arrange for transport via EMS to the nearest Ebola assessment hospital.
 - Epidemiologist will call Medical Epidemiologist On-Call (MEOC) for consultation and inform MEOC of situation and details gathered at the time. MEOC will notify Maine CDC Director. Maine CDC Director will coordinate with Ebola assessment hospital as appropriate.
 - Epidemiologist will coordinate a conference call using ID Epi conference line as necessary. Federal CDC will be consulted as needed.
 - If after-hours notification or report is received, then after-hours on-call epidemiologist (AHOC) will notify Program Manager or Field Epidemiologist Supervisor to make sure after-hours calls are either transferred to another available epidemiologist or another epidemiologist can take over the suspect investigation duties.
- Case investigation should be initiated immediately after report to minimize risk to caregivers and contacts and completed within 48 hours. Open an Ebola hemorrhagic fever investigation in NEDSS.

- The investigator should ensure the patient is in isolation at a hospital in a single room with a private bathroom.
- Recommend proper PPE as appropriate.
- Complete federal CDC Person Under Investigation (PUI) Form in collaboration with the attending physician and infection preventionist at the hospital caring for the patient.
- Utilize the CDC Decision Tree to determine the need for consultation and testing.
- Notify MEOC, Epi On-Call (EOC), AHOC, subject matter expert (SME), Division Director, and Program Manager. MEOC will ensure Maine CDC Director is notified.
- Program Manager or SME will notify Public Health Emergency Preparedness (PHEP) about suspect case to prepare for possible Public Health Emergency Operations Center (PHEOC) activation.
- Subject matter expert, in conjunction with medical epidemiologist, will notify the federal Centers for Disease Control and Prevention-Emergency Operations Center at 770-488-7100 to alert them to the case and note guidance and assistance they may be able to provide. If testing is approved, discuss with federal CDC and Massachusetts public health regarding where the specimen will be tested. Verify correct Ebola contact for testing laboratory to ensure proper notification to federal CDC or Massachusetts when shipping specimens.
- For laboratory specimen submission, follow federal CDC guidelines as well as Maine guidelines. Coordinate with HETL to make sure specimen destination is known and that HETL makes arrangements for intake and shipping.
- Complete notification to federal CDC via NEDSS.
- The ID Epi Outbreak SOP should be used as a guide in activating a team and assigning roles and responsibilities.
- If confirmed, Program Manager, Division Director, or MEOC will notify appropriate internal state partners.
- If confirmed, complete federal CDC Case Investigation Form.
- Coordinate with federal CDC response team.
- Begin contact tracing of any family members, friends, or others who may have had contact with the patient while symptomatic. Complete Contact Tracing Form and enter information into contact spreadsheet on S Drive.
- Based on the level of these contacts' exposure risk (see Epidemiologic Risk Factors on page 2), perform direct active monitoring or active monitoring of these contacts to monitor for Ebola-like symptoms for 21 days following exposure. Enter this daily monitoring data on the Ebola Contact Tracking Log. Active monitoring should be performed by following the Active Monitoring SOP.
- Maintain close contact with attending physician, infection preventionist(s) and nursing staff on use of effective PPE and progress of patient until a subsequent sample from the patient tests negative for Ebola by PCR.

Recommendations for Control of Case and Contacts

Recommendations for Case

The CDC's *Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in US Hospitals* should be followed and is available in the attachments section.

There is no immunization for Ebola at this time.

There is no approved treatment available for Ebola at this time. Clinical management should focus on supportive care of complications (e.g. hypovolemia, electrolyte abnormalities, refractory shock, hypoxia, hemorrhage, septic shock, multi-organ failure, DIC). Several investigational therapeutics for Ebola are in development. For more information about availability and access, contact the FDA or federal CDC.

It is believed that a person remains infectious for approximately 10 days after cessation of symptoms, and would only be considered non-infectious upon obtaining a negative PCR test for Ebola. However, because Ebola can stay in semen after recovery, men should abstain from sex (including oral sex) for three months. If abstinence is not possible, condoms may help prevent the spread of Ebola.

Recommendations for Symptomatic Contacts

The CDC's *Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in US Hospitals* should be adhered to for following symptomatic contacts. Symptomatic contacts should be referred to hospital for care.

Recommendations for Asymptomatic Contacts

Asymptomatic contacts should be monitored for fever and other symptoms of Ebola and seek medical attention should symptoms appear.

Exclusions

Case

If an adult or child has an Ebola infection, the patient should be in isolation at a hospital and excluded from all activities until PCR negative.

Symptomatic Contacts

If an adult or child were identified as a symptomatic contact, they should be in isolation at a hospital until ruled in or out as a case.

Asymptomatic Contacts

Asymptomatic contacts will be assigned risk categories by using Epidemiologic Risk Factors on page 2 and Maine CDC and federal CDC guidance. Follow the Active Monitoring SOP for instructions on both active and direct active monitoring exclusions and quarantine.

Managing Special Situations: Schools, Daycares, Healthcare Settings

Recommendations for Schools and Daycare Centers

The institution should follow federal CDC Ebola guidance for schools and universities for those returning from affected countries or exposed to Ebola infected individuals. The institution should also follow their standard protocol for a child or worker presenting with general symptoms of illness (e.g. fever, muscle pain, abdominal pain, severe headache, vomiting, and diarrhea). If a family member of someone being monitored is in daycare, consult with MEOC to provide appropriate guidance.

Recommendations for Healthcare Settings

Healthcare providers should be alert for and evaluate suspected patients for Ebola who have both clinical symptoms and epidemiologic risk factors within the last 3 weeks (21 days) before onset of symptoms. Federal CDC guidance documents, including EMS guidelines and ambulatory care guidelines, are available.

References

See the following references for clinical information including identification, description of infectious agent, occurrence, reservoir, mode of transmission, incubation period, period of communicability, susceptibility, and further clinical information.

- Heymann, David L., MD. *Control of Communicable Diseases Manual*. 19th ed. Washington, DC: American Public Health Association, 2008, p. 204-207.
- Due to the changing nature of Ebola outbreaks, consult attached links (**Attachment 1**) to federal CDC guidance for the latest information. Subject matter expert will review and update links if new information becomes available or links change.
- Federal CDC Ebola website <http://www.cdc.gov/vhf/ebola/index.html>

Attachments

1. Links to federal CDC Guidance Documents
2. Ebola Virus Disease Fact Sheet
3. School Health Manual

Attachment 1

Ebola Virus Disease – Links to (federal) CDC Guidance Documents

Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in U.S. Hospitals

<http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html>

Ebola Virus Disease Information for Clinicians in U.S. Healthcare Settings

<http://www.cdc.gov/vhf/ebola/hcp/clinician-information-us-healthcare-settings.html>

Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Patients with Suspected Infection with Ebola Virus Disease

<http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html>

Interim Guidance about Ebola Infection for Airline Crews, Cleaning Personnel, and Cargo Personnel

<http://www.cdc.gov/quarantine/air/managing-sick-travelers/ebola-guidance-airlines.html>

Advice for Colleges, Universities, and Students about Ebola in West Africa

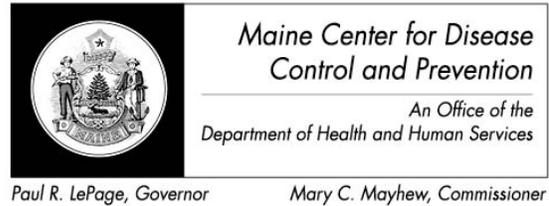
<http://wwwnc.cdc.gov/travel/page/advice-for-colleges-universities-and-students-about-ebola-in-west-africa>

Interim Guidance for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PSAPs) for Management of Patients with Known or Suspected Ebola Virus Disease in the United States

<http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html>

Ebola Virus Disease

Fact Sheet



What is Ebola?

Ebola is caused by a virus. There are four known types of the virus that can infect humans.

How is it spread?

It is spread through direct contact with the blood, sweat, vomit, feces and other body fluids of an ill person. It can also be spread through contact with an ill animal in the affected countries or exposure to needles or other objects contaminated with the virus.

Individuals exposed can develop symptoms 2 to 21 days after exposure. Patients infected with Ebola who are not showing symptoms are not infectious.

What are the symptoms?

Symptoms usually include: fever, headache, joint and muscle aches, weakness, diarrhea, vomiting, stomach pain, and lack of appetite.

In some patients, the symptoms may include: a rash, red eyes, hiccups, cough, sore throat, chest pain, difficulty breathing, difficulty swallowing, and bleeding inside and outside of the body.

How do I know if I have Ebola?

Ebola is only found through a lab test. Your doctor will order the necessary lab test.

How is it treated?

There is no approved treatment for the disease. Doctors will treat the symptoms and monitor the patient.

Are there long term consequences?

Due to how rarely the disease has occurred, little is known about long term effects of having Ebola.

Can I get Ebola again?

Once a patient has been treated and has recovered, they are likely to be immune to the type of Ebola they were infected with. However, the patient may still be able to become infected with other types of the virus.

How can it be prevented?

The best way to prevent Ebola is to avoid direct contact with blood and other body fluids of those ill with Ebola.

When traveling to affected countries, avoid contact with bats or monkeys, do not participate in funeral rites there and avoid hospitals where Ebola patients are being treated.

Where is Ebola found?

Currently, Ebola is only found naturally in certain areas of Africa.

For an updated list of affected countries, visit <http://www.cdc.gov/vhf/ebola/outbreaks/index.html>

Where can I get more information?

For more information contact your healthcare provider or local health center. You can also contact the Maine Center for Disease Control and Prevention by calling 1-800-821-5821 or visiting www.maine.gov/idepi. The federal Centers for Disease Control and Prevention website for Ebola <http://www.cdc.gov/vhf/ebola/> is another great source of information about the disease.

Attachment 3

School Health Manual Ebola Virus Disease

Definition:

Ebola is caused by a virus in the family *Filoviridae*, genus *Ebolavirus*.

Signs and symptoms:

Symptoms may include fever, headache, joint and muscle aches, weakness, diarrhea, vomiting, stomach pain, and lack of appetite. In some patients, the symptoms may include: a rash, red eyes, hiccups, cough, sore throat, chest pain, difficulty breathing, difficulty swallowing, and bleeding inside and outside of the body.

Transmission:

Transmission is usually through direct contact with the blood, sweat, emesis, feces and other body secretions of an infected person, contact with an infected animal in the affected countries, or exposure to objects (such as needles) that have been contaminated with infected secretions. Patients with Ebola Virus Disease who are not showing symptoms are not infectious.

Diagnosis:

Ebola Virus Disease is diagnosed by clinical symptoms and laboratory tests.

Role of the School Nurse:

Prevention

- Provide education to students and staff regarding good hand washing with soap and water
- Avoid contact with bodily fluids of ill students.
- When students plan to travel internationally, review guidance for destination countries.

Treatment Recommendations

- If symptoms are noted, the child should be referred to a healthcare provider.
- Standard treatment is limited to supportive therapy in a hospital.

Exclusions

- Any students with Ebola will be hospitalized and would be excluded from school. The provider and Maine CDC will provide recommendations on individual students' return.

Reporting Requirements

- Ebola is a reportable disease – report immediately to 1-800-821-5821

Resources:

- Maine CDC Ebola website: <http://www.maine.gov/ebola>
- Federal CDC Ebola website <http://www.cdc.gov/vhf/ebola/>

Appendix E

Ebola Monitoring Policy for Travelers from Ebola Affected Countries

The Maine Department of Health and Human Services' Center for Disease Control and Prevention continues daily post-arrival monitoring of travelers to Maine whose travel originated in Ebola affected countries pursuant to the United States Centers for Disease Control and Prevention guidelines.

Maine CDC has established protocols for the monitoring of any individual who returns to Maine after traveling from an Ebola affected country based on guidelines of the U.S. CDC. There are four basic risk categories of travelers based on levels of exposure. This policy may be updated as guidelines change and the outbreak evolves.

- **High Risk**

- direct contact with body fluids, from a person sick with Ebola who is showing symptoms (including but not limited to fever, severe headache, vomiting, diarrhea, abdominal pain, or unexplained bruising or bleeding) through:
 - a needle stick
 - splashes to eyes, nose, or mouth
 - getting body fluids directly on skin
- touching a dead body while in a country with a large Ebola outbreak or a small outbreak that may be hard to control without wearing recommended personal protective equipment (PPE) or not wearing PPE correctly
- both living with and taking care of a person sick with Ebola

- **Some Risk**

- close contact with a person sick with Ebola such as in a household, healthcare facility, or the community (without wearing PPE). Close contact means being within 3 feet of the person sick with Ebola for a long time.
- in a country with a large Ebola outbreak or a small outbreak that may be hard to control
 - direct contact with a person sick with Ebola (such as in a hospital) while wearing PPE correctly
 - direct patient care in any other healthcare setting

- **Low (but not zero) Risk**

- having been in a country with a large Ebola outbreak or a small outbreak that may be hard to control within the past 21 days, with no known exposure (such as NO direct contact with body fluids from a person sick with Ebola)

- being in the same room for a brief period of time with a person sick with Ebola
 - brief direct contact, like shaking hands, with someone sick with Ebola
 - direct contact with a person sick with Ebola in a country where there have been Ebola cases, but no large Ebola outbreak or small outbreak that may be hard to control while wearing PPE correctly
 - travel on an airplane with a person sick with Ebola
- **No Risk— assuming there are no other risk factors from the other risk levels, examples in the No risk level include:**
 - having contact with a healthy person who had contact with a person sick with Ebola
 - having contact with a person sick with Ebola before he or she had any symptoms
 - having left a country with a large Ebola outbreak or a small outbreak that may be hard to control MORE than 21 days ago and has not been sick with Ebola since leaving that country
 - having been in a country where there have been Ebola cases, but no large Ebola outbreak or small outbreak that may be hard to control
 - being an aircraft or ship crew member who did not leave the plane or ship or the area close by and who did not have direct contact with anyone from the community while in a country with a large Ebola outbreak or small outbreak that may be hard to control

Maine CDC will perform monitoring on all individuals Maine CDC categorizes as in the low, some, or high risk categories. This means monitored individuals must take their temperature twice daily, watch themselves for symptoms, and immediately contact Maine CDC if they have a fever or other symptoms. Monitoring must take place until 21 days after the last possible exposure and can occur on a voluntary basis or be required by public health order as needed.

This monitoring may take two forms:

- **Active monitoring** means that Maine CDC epidemiologists or other public health workers are responsible for checking at least once a day to see if those in these risk levels have a fever or other symptoms of Ebola.
 - **Direct active monitoring** means that epidemiologists or other public health workers will make a direct observation at least once a day to see if people have a fever or other symptoms. An example of direct observation is an in-person visit.

If anyone under monitoring displays symptoms consistent with Ebola, medical evaluation and isolation of the individual will be performed in order to protect the health of the patient and the public. Protocols may be utilized for EMS transport to the nearest appropriate medical facility. This may involve Ebola testing if there is a strong suspicion of the disease after consultation among medical providers, Maine CDC, and U.S. CDC and other diseases have been ruled out. Isolation will aid in ensuring that proper precautions are taken in order to prevent transmission of

Ebola or other infectious diseases to health care workers involved in the evaluation and care of the individual.

The following table summarizes the public health actions that may be taken for those in the respective risk categories:

Exposure Category	Public Health Actions
High Risk	<ul style="list-style-type: none"> • Direct active monitoring • Maine CDC will ensure, through public health orders as necessary, the following minimum restrictions: <ul style="list-style-type: none"> ○ Controlled movement: exclusion from all long-distance and local public conveyances (aircraft, ship, train, bus and subway) ○ Exclusion from public places (e.g., shopping centers, movie theaters), and congregate gatherings ○ Exclusion from workplaces for the duration of the public health order, unless approved by Maine CDC (telework is permitted) • Non-congregate public activities while maintaining a 3-foot distance from others may be permitted (e.g., jogging in a park) • Federal public health travel restrictions (Do Not Board) will be implemented to enforce controlled movement • If travel is allowed, individuals are subject to controlled movement <ul style="list-style-type: none"> ○ Travel by noncommercial conveyances only ○ Coordinated with public health authorities at both origin and destination ○ Uninterrupted direct active monitoring
Some Risk	<ul style="list-style-type: none"> • Direct active monitoring • Maine CDC, based on a specific assessment of the individual’s situation, will determine whether additional restrictions are appropriate, including: <ul style="list-style-type: none"> ○ Controlled movement: exclusion from long-distance commercial conveyances (aircraft, ship, train, bus) or local public conveyances (e.g., bus, subway) ○ Exclusion from public places (e.g., shopping centers, movie theaters), and congregate gatherings ○ Exclusion from workplaces for the duration of a public health order, unless approved by Maine CDC (telework is permitted) • If the above restrictions are applied, non-congregate public activities while maintaining a 3-foot distance from others may be permitted (e.g., jogging in a park)

	<ul style="list-style-type: none"> • Other activities should be assessed as needs and circumstances change to determine whether these activities may be undertaken • Any travel will be coordinated with Maine CDC to ensure uninterrupted direct active monitoring • Federal public health travel restrictions (Do Not Board) may be implemented based on an assessment of the particular circumstance <ul style="list-style-type: none"> ○ For travelers arriving in the United States, implementation of federal public health travel restrictions would occur after the traveler reaches the final destination of the itinerary
<p>Low (But Not Zero) Risk</p>	<ul style="list-style-type: none"> • No restrictions on travel, work, public conveyances, or congregate gatherings • Direct active monitoring for: <ul style="list-style-type: none"> ○ U.S.-based healthcare workers caring for symptomatic Ebola patients while wearing appropriate PPE ○ Travelers on an aircraft with, and sitting within 3 feet of, a person with Ebola • Active monitoring for all others in this category

Maine CDC will seek to make monitoring of individuals as least intrusive as possible while protecting the health of the public by following the newest guidance on public health actions from the U.S. CDC, either as listed above or as amended by U.S. CDC or Maine CDC.

The Maine CDC will coordinate care services such as food and assistance with partners as needed for travelers who may be under movement restrictions.

U.S. CDC References:

<http://www.cdc.gov/vhf/ebola/exposure/monitoring-symptoms-controlling-movement.html>

<http://www.cdc.gov/vhf/ebola/hcp/monitoring-and-movement-of-persons-with-exposure.html>

Monitoring Form for Travelers with Potential Exposure to Ebola Virus Disease

Local Health Jurisdiction:		Epidemiologist:	
Contact IDs	Maine CDC_ID:	Federal CDC_ID:	
Name	Last:	First:	Middle Initial:
Demographics	DOB:	Age:	<input type="checkbox"/> Years <input type="checkbox"/> Months
Local Address	Street:	Apartment:	
	City:	State:	Zip code: County:
Permanent Address			
Responsible Person	<input type="checkbox"/> Self <input type="checkbox"/> Other (give name and relationship): _____		
Phone Number of Recent Traveler	Home: (____) ____-_____ Cell: (____) ____-_____	Email Address of Recent Traveler	
Phone Number of Emergency Contact	Home: (____) ____-_____ Cell: (____) ____-_____	Email Address of Emergency Contact	
Relation of Emergency Contact to Traveler	<input type="checkbox"/> Household Contact <input type="checkbox"/> Family, non-household <input type="checkbox"/> Co-worker <input type="checkbox"/> Lab Worker <input type="checkbox"/> Friend <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Other : _____		
Primary Care Physician	Name:	Phone: (____) ____-_____ Fax: (____) ____-_____	

Exposure Dates	Earliest: ____/____/____ Last: ____/____/____
Nature of Exposure (check all that apply)	<input type="checkbox"/> Exposed to Blood <input type="checkbox"/> Used PPE <input type="checkbox"/> Touched patient briefly <input type="checkbox"/> Direct patient care <input type="checkbox"/> Used PPE <input type="checkbox"/> Briefly near patient (within 3 feet) but did not touch <input type="checkbox"/> Laboratory work for patient <input type="checkbox"/> Needlestick <input type="checkbox"/> Touched body/funeral <input type="checkbox"/> Used PPE <input type="checkbox"/> Face splashed with fluids of patient <input type="checkbox"/> Household of patient <input type="checkbox"/> Passenger on flight or transport <input type="checkbox"/> Spent time in patient room <input type="checkbox"/> Other: _____
Exposure Type	<input type="checkbox"/> High Risk <input type="checkbox"/> Some Risk <input type="checkbox"/> Low Risk <input type="checkbox"/> No Known Exposure
Activity while under 21-day monitoring	<input type="checkbox"/> Home AM/DAM, excluded from work <input type="checkbox"/> No exclusion from work <input type="checkbox"/> Other: _____
Method of Monitoring	<input type="checkbox"/> Daily Visit in Person <input type="checkbox"/> Self-report daily via phone <input type="checkbox"/> Other: _____ Notes:
Symptom Watch	Start Date (day ____): ____/____/____ End Date (day 21): ____/____/____
Instructions for self- monitor or public health monitoring	Temperature checks should be at least 6 hours apart. Persons under controlled movement should be told not to use any commercial conveyances (bus, airplane, etc.) and check with the field epidemiologist if they are planning to do any other travel.

Additional Patient Notes	
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Travelers with Potential Exposure to Ebola Virus Disease: Screening Questions

In the last 21 days did you have any of the following exposures?

Y N

- Exposed to blood or other body fluids (feces, vomit, urine, saliva, blood, etc.) of a person sick with Ebola including contaminated objects or surfaces such as bedding or clothing

If yes, what body fluid(s)? _____

If yes, what personal protective equipment (PPE) was used? _____

- Provided direct care to anybody with Ebola at home or in health care setting including bathing, feeding, helping to the bathroom

If yes, what PPE was used? _____

- Did laboratory work on blood or other body fluids of an Ebola patient

If yes, what PPE was used? _____

- Directly touched dead bodies including at a funeral or burial rite

If yes, what PPE was used? _____

- Lived in same household as person sick with Ebola, shared a bathroom, or slept in the same room

- Spent at least one hour in the same room (within 3 feet) of a person sick with Ebola

If yes, what PPE was used? _____

- Touched a person sick with Ebola even briefly (shook hands, hugged, kissed, etc.)

If yes, what PPE was used? _____

- Had casual contact with a patient such as a brief interaction (talking or briefly being in same room) without directly touching patient

If yes, what PPE was used? _____

- Had a needle stick with blood from a person sick with Ebola

- Had your face splashed with any body fluid (diarrhea, vomit, etc.) from a person sick with Ebola

IF YES TO ANY OF THE ABOVE QUESTIONS, CONTACT MAINE CENTER FOR DISEASE CONTROL AT 1-800-821-5821 IMMEDIATELY

Traveler under symptom watch: _____ Telephone: (____) _____ - _____

Address: _____ Supervisor: _____

- 1) For Telephone and ask if the person is feeling well. If the person cannot be reached, contact your supervisor.
- 2) If the person is ill when telephoned, ask for a temperature reading. Contact your supervisor.
- 3) For a fever, there should be concern if the reading is >100.4 F (38.0 C)
- 4) Confirm the date and time of the next phone call.

Day number (after last contact)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21																						
Date																																											
Time AM																																											
Temperature AM	°F																																										
Time PM																																											
Temperature PM	°F																																										
	A M	P M																																									
Malaise ¹																																											
Muscle pain																																											
Headache																																											
Sore throat																																											

Day	Call Log/Notes
1	
2	
3	
4	
5	
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7	
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9	
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11	
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15	
16	

17	
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21	

Active Monitoring/Direct Active Monitoring (AM/DAM): Traveler Support Services

A. Command and Control

Maine CDC, through the activation of the Public Health Emergency Operations Center (PHEOC), will be the lead agency in coordinating the local and State public health response to an outbreak situation including AM/DAM of individuals or groups.

B. Activation of Plan

This plan will be activated by the Maine CDC PHEOC to provide services to persons in AM/DAM.

C. Concept of Operations

In order to ensure the basic needs of a person in active monitoring or direct active monitoring (AM/DAM) are met, several general personal care assessment questions have been added to the epidemiologists' intake questionnaire.

- Infectious disease epidemiology staff will administer the personal care screening questions. In the event that ID field epis have reached critical capacity, public health nursing staff will administer the screening questionnaire.
- If the traveler responds “yes” to one of the questions, the district liaison for that District will serve as Case Manager to ensure basic living needs are met.
- Infectious disease epidemiology staff will submit the traveler response/s to the personal care assessment questions to the designated DL to further assess the need for basic living support and need for resources.
- The DL will notify PHEP director or designee regarding resources needed to support the traveler during monitoring.
- The PHEP Logistics Chief will work to obtain the needed resources to support the personal care needs of the traveler during the monitoring period.

D. Responder Health and Safety

Those tasked with implementing this plan will be interacting directly with individuals or groups who are suspected of being infected or exposed face potential exposure to the disease themselves. In order to protect these workers PHEP will ensure responders are provided with required personal protective equipment (PPE), which may include face,

eyes, head and hand protection, depending on the response. Staff members who may need to use PPE will be trained by their respective agencies in advance of the implementation of this plan and training will be documented.

E. Access to Housing

It is assumed that in most instances in AM/DAM will be accommodated within their own homes. However, some instances of disease outbreak or suspected infection will affect individuals or groups who do not have access to housing. This may include members of the homeless communities as well as visitors to the area who are no longer able to stay in their hotels or with the friends and family who were accommodating their visit.

- If one or more individuals needs AM/DAM, but do not have adequate housing, DHHS/Maine CDC will utilize existing local hospitals, hotels and motels, rental homes, or nursing home resources to accommodate the individuals.
- If many members of the homeless community require AM/DAM, DHHS/Maine CDC will work with local shelters to designate one shelter to accommodate only those individuals.
- If a large group of people, e.g. tourists visiting Maine require AM/DAM, PHEOC will work with MEMA and the American Red Cross to determine where this group could be accommodated for an extended period of time.

F. Supportive Services

1.1 Personal Care

Persons in the State of Maine who are placed under AM/DAM will be supported by Maine CDC and its partners to the extent possible through means such as provision of temporary assistance, food and other necessities to maintain their households within their private residences or alternate care site during the 21-day monitoring period.

The State of Maine Emergency Management Agency has an existing Memorandum of Understanding (MOU) with Maine American Red Cross to coordinate mass care services during a pandemic health incident to include meals, shelter and health services, and MEMA will help to facilitate and implement the Red Cross MOU with Maine DHHS/CDC.

Maine DHHS/CDC is responsible for coordinating provision and access to the following basic support services such as:

- Food
- Water

- Medicines
- Medical care
- Laundry
- Waste
- Methods of communication

Initial Activation

1. Infectious disease epidemiology staff will be actively monitoring individuals and family members under AM/DAM on a daily basis. In the event the epidemiologists have reached critical capacity, public health nursing staff will provide active monitoring.
2. Infectious disease epidemiology staff will identify the non-prescription and prescription medications needs by working with individuals' health care health care providers, health insurance and local pharmacies; or referrals to Maine CDC Public Health Nurses (PHN).
3. Infectious disease epidemiology staff will identify the needs through a personal care screening:
 - a. Can you stay in this residence for the next 21 days?
 - b. Do you have a computer? Will you have internet access where you are staying?
 - c. Do you need transportation to medical appointments or need a drug prescription filled in the next 21 days?
 - d. Will you need help with grocery shopping, special meals or water for the next 21 days?
 - e. Do you need help to reach someone in your faith or spiritual community?
 - f. Do you need information on ways to cope with stress and how to relax?
 - g. Do you have other things you might need help with in the next 21 days?

When support services are needed, the Social Services Concept of Operations would be implemented at this time. **(See Concept of Operations)**

Ongoing Activation

1. The DLs will monitor ongoing needs and requests for supportive services on individuals under AM/DAM on a daily basis by telephone; iPads, other monitoring device, or in person monitoring.
2. DLs will provide written updates to PHEP regarding ongoing supportive services needs and adjustments.
3. PHEP will maintain regular communication with MEMA and American Red Cross Liaison to provide quality assurance, responder health and safety, and logistical

support to continue to provide supportive services to individuals and family members under AM/DAM.

1.2 Access to Communications

Persons within AM/DAM will be provided access to communications methods to support psycho-social needs. Examples of communication access may include distribution of pre-paid calling cards, iPads, cell phones, FM radios, reading materials, television services and Internet access. In addition, Maine DHHS will develop and translate materials as needed for those in AM/DAM and their family members.

1.3 Medical Care

As indicated, infectious disease epidemiology staff will conduct daily follow-up with non-symptomatic exposed individuals to assess for symptoms and needs for medical support services. Infectious disease epidemiology staff, in coordination with public health nursing staff, will identify access and functional needs such as; access/mobility arrangements, obtaining oxygen supplies, wheelchair battery re-charging, dialysis, prescription medications, etc. The Public Health Emergency Operations Center (PHEOC) may enlist the services of community agencies, i.e. Maine American Red Cross health services, visiting nurses, etc.

1.4 Behavioral/Mental Health Services

The Maine Disaster Behavioral Health Response Team will be activated by the PHEOC upon request from internal partners to coordinate behavioral/mental health and spiritual support to individuals in home AM/DAM and hospital isolation. The Behavioral Health Response Team will provide psychological first aid and other supportive services to responders, morgue staff, and medical and health care staff assigned to emergency operations. Behavioral health services, in coordination with community behavioral health providers, will be provided in appropriate languages, including sign language when indicated.

The Behavioral Health Response Team leaders will determine how to provide mental health support in AM/DAM where person-to-person contact is limited or restricted. This may include:

- Telephone calls from counselors or spiritual counselors, access to Maine's Access Teams and the National Disaster Distress Hotline
- Web-site communication
- Distribution of behavioral health supportive written materials
- Distribution of faith-based written materials

- Communication through television programs and radio talk shows
- Person-to-person contact with appropriate personal protective equipment and precautions to eliminate potential disease spread

1.5 Utility Services

Individuals and family members under AM/DAM orders will need to be maintained in safe and secure living arrangements. To the extent possible, the PHEOC will coordinate with MEMA, local emergency management agencies, local governments, and other community-based providers or public utilities to ensure ongoing provisions of basic utilities, such as water, power, waste management and heating/air conditioning to residences of persons under AM/DM.

1.6 Housing Services

The planning assumption for this Plan is that individuals and family members will be housed in their private residence. Exceptions will be reviewed for persons who are homeless, visitors from outside the State and individual private residences that do not meet the environmental health standards required by Maine CDC regulations.

The PHEOC will work with MEMA and Maine American Red Cross to identify alternate housing arrangements in:

- Hotels and motels
- College and school campus housing
- Private residences
- Healthcare centers, skilled nursing and long term care facilities

Financial assistance services for alternate housing arrangement would be arranged and coordinated by the PHEOC, MEMA and the DHHS Commissioner's Office.

1.7 Animal Care/Veterinary Services

Maine residents often maintain livestock and family pets. The animal care will be coordinated through MEMA who would activate in accordance with the Pets Evacuation and Standards Act (PETS), which ensures the care and management of furred or feathered family members. Community/County Animal Response Teams (CARTs) are specially trained to set up animal shelters, to provide care and feeding, to provide medication management and to provide access to veterinary services.

1.8 Additional Support Services

Additional support services may be requested and coordinated with DHHS/CDC, Department of Education, Maine Voluntary Organizations Active in Disaster, American Red Cross, Goodwill Industries, Salvation Army of New England and faith-based services, if possible, including:

- Caregivers/childcare
- Essential shopping for personal hygiene and other supplies
- Assistance with school alternate attendance arrangements
- Access to legal support when under AM/DAM

Appendix F

HETL EBOLA PLAN

Laboratory: Packaging and Transport of Specimens for Ebola Testing from Local Lab to HETL

November 10, 2014

Purpose:

To outline the process for packaging and transport of laboratory specimens for Ebola testing from a local laboratory to HETL.

Assumptions:

- Providers will consult with Maine CDC when determining the need to test a patient for Ebola.
- ALL LABORATORY SPECIMENS FOR EBOLA TESTING WILL NEED TO BE MOVED THROUGH THE MAINE CDC, HEALTH AND ENVIRONMENTAL TESTING LABORATORY (HETL).

Packaging:

All laboratory specimens for Ebola testing should be packaging according to DOT regulations for Category A biohazardous agents, regardless of the private or commercial status of the courier. This is to ensure personal and public safety. Local laboratories should verify that appropriate supplies are available and that trained staff is available to package specimens when needed.

Transport:

Each local laboratory should verify with their regular courier service if that courier service is willing to transport specimens for Ebola testing. The local laboratory will make the arrangements for transportation of the specimen from the local laboratory to HETL. It has been the practice of Maine CDC to help coordinate and assume the cost for transport specimens for emerging infectious disease/pathogens and for ASAP transport of those specimens. Below is a prioritized list of transport options.

1. Authorize courier to transport specimen promptly (same day, ASAP) to HETL (e.g. outbreak specimen). Verify which courier the Laboratory is planning to use. The two couriers we have used most frequently for this are listed below.
 - a. Uniship (848-7546) – covers Portland – north [does not have many drivers in south].
Authorize shipment with:
Charlie Richmond (Asst. Mgr) or Chip Blethen (Gen. Mgr)

Cell: 659-4735

Cell: 745-1030

crichmond@unishipcourier.com

cblethen@unishipcourier.com

2. State Police – Maine CDC has verified State Police are committed to helping with transport of specimens.
3. Use of willing volunteer and personal vehicle – *consider concerns with liability issues, specimen tampering, public perception, etc.*

Communication is an important piece of this process. When a specimen is ready to be shipped to HETL, the local laboratory should contact Maine CDC and inform them a specimen is in the queue for transport. Laboratories have been instructed to provide the estimated pick-up time and estimated arrival time at HETL. Maine CDC will then notify HETL that a specimen is coming.

Contact Information for HETL (including after hours and weekends)

Richard Danforth, Program Advisor/BT Coordinator

Work: 207-287-5679

Cell: 215-6106

Email: Richard.Danforth@maine.gov

Ken Pote, Lab Director

Work: 287-2703

Cell: 592-3751

Email: Ken.Pote@maine.gov

HETL EBOLA PLAN

Laboratory: Transport of Specimens for Ebola Testing from HETL to Boston or CDC

October 30, 2014

Purpose:

To outline the process for transport of laboratory specimens for Ebola testing from HETL to Boston or U.S. CDC.

Assumptions:

- ALL LABORATORY SPECIMENS FOR EBOLA TESTING WILL NEED TO BE MOVED THROUGH THE MAINE CDC, HEALTH AND ENVIRONMENTAL TESTING LABORATORY (HETL).
- Laboratories will contact the Laboratory Program Advisor/BT Coordinator Richard Danforth at HETL at 207-287-5679 or Richard.Danforth@maine.gov.
- All Ebola specimens are treated as Category A Risk Group 4 biohazardous material; even if Ebola has not been confirmed by laboratory testing.
- HETL will log the specimen in, determine to which testing laboratory the specimen will need to proceed (Boston or U.S. CDC), split the specimen – if needed, add the appropriate specimen submission form and arrange for transport of the specimen the testing laboratory.

Specimen Submission Forms:

1. U.S. CDC: Fill out and include both U.S. CDC Specimen Submission Forms
 - a. <http://www.cdc.gov/nceid/dhcpp/vspb/pdf/specimen-submission.pdf>
 - b. <http://www.cdc.gov/laboratory/specimen-submission/pdf/form-50-34.pdf>
2. Massachusetts: Fill out and include the Massachusetts Public Health Laboratory (MA PHL) Specimen requisition form
 - a. <http://www.mass.gov/eohhs/docs/dph/laboratory-sciences/general-submission-form.pdf>

Transport from HETL to Boston or U.S. CDC

1. HETL will use General Courier: 207-767-6004 or 800-698-5035, 385 Main Street, South Portland, Maine 04106 to send samples to Massachusetts
2. If HETL is granted emergency access to the U.S. CDC/DoD Ebola Real-Time PCR, World Courier will be used to fly split samples to U.S. CDC in Atlanta.
3. Addresses:
 - a. Atlanta: Centers for Disease Control and Prevention, ATTN STAT LAB: VSPB, UNIT #70, 1600 Clifton Road NE, Atlanta, GA 30333

- b. Massachusetts: MA PHL (William A. Hinton State Laboratory Institute), 305 South Street
Jamaica Plain, MA 02130

Weekend, after hours or holiday schedule to ensure timely packaging and transport of specimen (including backup for any planned or unplanned absence of key staff):

- 1. HETL would treat request as a bioterrorism (BT) event.
 - a. Lab director will receive the initial call from Disease Control
 - b. Lab director will contact one of the members on the Preparedness Rotation Call List

U.S. CDC, per their website states: “Do not ship for weekend delivery unless instructed by CDC:”

Interim Guidance Regarding Compliance with Select Agent Regulations for Laboratories Handling Patient Specimens Under Investigation or Confirmed for Ebola Virus Disease (EVD)

Last updated: January 27, 2015

Content source: Centers for Disease Control and Prevention

National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)

Division of High-Consequence Pathogens and Pathology (DHCPP)

Viral Special Pathogens Branch (VSPB)

1) Is Ebola virus a select agent?

Yes, Ebola virus is listed as a select agent. Biological agents that the US Department of Health and Human Services (HHS) has determined to have the potential to pose a severe threat to public health and safety, such as Ebola virus, are regulated under HHS Select Agent regulations (42 CFR Part 73). A current list of select agents and toxins also can be found on the Federal Select Agents Program's Select Agents and Toxins List. Ebola virus also is listed as a Tier 1 agent. A subset of select agents and toxins have been designated as Tier 1 because these biological agents and toxins present the greatest risk of deliberate misuse with significant potential for mass casualties or devastating effect to the economy, critical infrastructure, or public confidence, and pose a severe threat to public health and safety. Entities that possess, use, or transfer Tier 1 select agents and toxins must adhere to additional requirements detailed within the Select Agent Regulations.

2) Is genetic material from the Ebola virus regulated as a select agent?

No. Nucleic acids that cannot produce infectious forms of a select agent (such as from the Ebola virus) are not regulated as a select agent.

3) Is waste generated during delivery of care to patients with EVD subject to select agent regulations? (42 CFR Part 73)

As long as facilities treating patients with EVD follow CDC's Infection Prevention and Control Recommendations for Hospitalized Patients Under Investigation (PUIs) for Ebola Virus Disease (EVD) in US Hospitals or equivalent actions, waste generated during delivery of care to patients with EVD would not be subject to select agent regulations (see the exclusion provision 42 CFR § 73.3(d)(1)). However, this exclusion would not apply to any facility that intentionally collected or otherwise extracted the Ebola virus from waste generated during the delivery of patient care.

4) Are specimens collected from a PUI for EVD covered by the select agent regulations?

No, specimens would not be subject to federal select agent regulation until identified as containing Ebola virus by viral isolation.

- 5) How do select agent regulations apply to specimens that have tested positive by molecular methods?

Select agent regulations would not apply until the specimen that has tested presumptively positive using molecular methods has been proven to contain live-infectious Ebola virus by virus isolation.

Any specimens confirmed by virus isolation to contain live-infectious Ebola virus must be reported to DSAT immediately by telephone (404-718-2000), email (lrsat@cdc.gov), or FAX (404-718-2096) and be followed up with APHIS/CDC Form 4 within seven days of the initial report.

- 6) Are specimens from a PUI confirmed by viral isolation to contain Ebola virus covered by the select agent regulations?

Yes. If live-infectious Ebola virus is confirmed, any diagnostic or clinical specimens (blood, urine, tissue, and other body fluids) that are kept would be covered by the regulations and would have to be destroyed, decontaminated, or transferred to a registered select agent facility within seven days of notification that live-infectious Ebola virus was detected. Specimens collected but not kept, for example, blood collected for routine patient care and then decontaminated or destroyed after testing, are not subject to the regulations. Specimens taken after the patient is no longer infected with EVD are not subject to the select agent regulations.

- 7) Is the APHIS/CDC Form 2 required to transfer specimens from a patient confirmed by viral isolation to contain Ebola virus?

Yes, APHIS/CDC Form 2 would be required to request prior authorization for the transfer of the identified select agent.

- 8) Would the APHIS/CDC Form 4 need to be completed for reporting specimens confirmed by viral isolation to contain Ebola virus?

Yes. For reporting the isolation of Ebola virus from the clinical sample, only one APHIS/CDC Form 4 should be completed for each patient.

- 9) We have performed a nucleic acid extraction on a sample from a patient with confirmed EVD. Is the extracted nucleic acid covered by select agent regulations?

No. The nucleic acid of Ebola virus is not infectious; therefore, it is not a select agent.

- 10) What safety precautions should I use to perform routine medical testing for PUIs or patients with confirmed EVD?

Please refer to Interim Guidance for Specimen Collection, Transport, Testing, and Submission for People Under Investigation (PUIs) for Ebola Virus Disease (EVD) for guidance regarding safety precautions.

- 11) What should be done if there is a potential exposure to blood, body fluids and other infectious materials from a PUI for EVD?

Please refer to Infection Prevention and Control Recommendations for Hospitalized Patients Under Investigation (PUIs) for Ebola Virus Disease (EVD) in US Hospitals for guidance regarding occupational exposures.

12) If the patient with EVD has died as a result of virus, would the patient's body be considered a select agent?

No. The patient's body would not be considered a select agent. Select agents in their naturally occurring environment are not subject to the regulations. This includes a human that was naturally infected with a select agent.

Appendix G

Hazardous Waste Transport and Disposal, Wastewater Handling and Environmental Decontamination

A. Waste Management

Waste generated in the care of patients with known or suspected EVD is subject to procedures set forth by local state and Federal regulations. Basic principles for spills of blood and other potentially infectious materials are outlined in the US Occupational Safety and Health Administration (OSHA) Blood borne Pathogen standard, 29 C.F.R. 1910.1030. See <https://www.osha.gov/SLTC/bloodborne pathogens/index.html>.

Waste contaminated (or suspected to be contaminated) with Ebola virus is a Category A infectious substance regulated as a hazardous material under the US Department of Transportation's (DOT's) Hazardous Materials Regulations (HMR; 49 C.F.R., Parts 171-180). Requirements in the HMR apply to any material DOT determines is capable of posing an unreasonable risk to health, safety, and property when transported in commerce. For off-site commercial transport of Ebola-associated waste, strict compliance with the HMR is required. For more information on the HMR requirements see <http://phmsa.dot.gov/hazmat/transporting-infectious-substances>.

- If a person requires a variance to the HMR, that person must apply for a **Special Permit** under 49 CFR § 107.105. DOT may grant a special permit if the applicant can demonstrate that an alternative packaging will achieve a safety level that is: (1) at least equal to the safety level required under the HMR, or (2) consistent with the public interest if a required safety level does not exist.
- See <http://www.phmsa.dot.gov/hazmat/permits-approvals/special-permits>. DOT granted multiple special permits authorizing the transportation in commerce of certain Ebola-associated waste. See <http://phmsa.dot.gov/hazmat/packaging-of-ebola-contaminated-waste>.

Ebola-associated waste that has been appropriately incinerated, autoclaved, or otherwise inactivated is not infectious, does not pose a health risk and is not considered to be regulated medical waste or a hazardous material under Federal law. Therefore, such waste is no longer considered a Category A infectious substance and is not subject to the requirements of the HMR.

Additional guidance is available per the U.S. CDC, Ebola-Associated Waste Management <http://www.cdc.gov/vhf/ebola/hcp/medical-waste-management.html>

Maine CDC Division of Environmental Health and the Health and Environmental Testing Lab works in collaboration with partners in the Department of Environmental Protection, Maine Emergency Management Agency and the private sector to identify the processes for properly disposing of this hazardous medical waste.

Collection:

- Stericycle currently has a contract to pick up and transport medical waste for every hospital and most health centers in Maine. These contracts do not include Category A waste, but Stericycle has a simple contract amendment to provide this service.
- Stericycle has sent Category A waste packaging instructions to every hospital in Maine
- Two different containers are available from Stericycle:
 - Poly drum (55 gallon)
 - Corrugated container
- Containers arrive unmarked – if a patient is ruled out, containers can be marked per normal protocols and disposed of accordingly; if Ebola is confirmed the containers will be marked with Ebola. Average waste estimate (based on the cases in Texas) – (10) 55 gallon drums/patient/day
 - Additional PPE requirements may increase waste amounts
 - Better training and reduced staff exposure may lower waste amounts
- Stericycle recommends that facilities wait to order containers just-in-time (i.e. once they have confirmed an Ebola case (this will save the facility money and storage space)
 - Stericycle can get containers to facilities within 3 days of order; orders will be expedited if an Ebola case is confirmed
 - Other facilities have stored red bags in the suspected patient’s room until Ebola is confirmed or ruled out.
 - Maine CDC has purchased a small cache of containers from Stericycle to forward deploy to facilities with a suspected case of Ebola.

Transport:

- Stericycle has obtained US DOT Special Permit 16279, which allows for transport of Ebola waste. The special permit authorization for Stericycle expires March 31, 2017
 - Stericycle will re-apply for the permit as necessary
 - Stericycle has sent the current permit to every hospital
- Stericycle will provide a trailer onsite to store full containers at any facility with a confirmed Ebola case
 - Once the trailer is full, Stericycle will over pack the containers within an additional 95 gallon container for transport and disposal
 - Facilities do not need to purchase the 95 gallon containers

Disposal:

Stericycle will be incinerating Ebola waste and then transporting the ashes to an identified landfill.

B. Wastewater Handling

Handling and treatment requirements of feces and urine within health facilities:

- The key to controlling the hazard associated with the presence of the virus in the body fluids of infected individuals lies in the rigorous enforcement of protocols to separate and contain ALL body fluids (including feces and urine). Feces from suspected or confirmed Ebola cases must be treated as a biohazard and handled at a minimum. All direct human contact with feces should be avoided and full PPE should be worn by all workers handling feces. If the patient is unable to use a toilet, feces should be collected in a clean bedpan and immediately and carefully disposed of into a separate toilet. Full PPE should be worn at all times when handling fresh feces from Ebola cases and great care should be taken to avoid splashing.
- After collection and disposal of the feces from the bedpan, the bedpan should be rinsed with 0.5% chlorine solution to disinfect the pan, disposing of the rinse water in drains or a toilet. Depending on the dirtiness of the pan, it may need to be rinsed twice.
- If feces are on surfaces (linens, floor, etc.) they should be carefully removed and immediately disposed of in a toilet. Chlorine is an ineffective means to disinfect media containing large amounts of solid and dissolved organic matter. Therefore, there will be limited benefit to adding chlorine solution to fresh feces and, possibly, may introduce risks associated with splashing.

Recommendations for septic tanks and the off-site transportation of feces:

Septic or holding tanks should be designed to hold wastewater for as long as feasibly possible with a regular emptying schedule based on generated wastewater volumes. Full PPE should be worn at all times when handling or transporting feces off site and great care should be taken to avoid splashing. For crews, this includes pumping out tanks or unloading pumper trucks. After handling, and once there is no risk of further exposure, individuals should safely remove PPE before entering the transport vehicle.

Wastewater treatment:

There is no evidence to date that Ebola has been transmitted via sewerage systems, with or without wastewater treatment. As part of an integrated public health policy, wastewater carried in sewerage systems should ideally be treated in well-designed and well-managed centralized wastewater treatment works. Each stage of treatment (as well as retention time and dilution) results in further reduction of potential risk. Waste stabilization ponds (oxidation ponds or lagoons) are generally considered to be a wastewater treatment technology that is particularly well-suited to the destruction of pathogens as relatively long retention times (20 days or more) combined with sunlight, elevated pH levels and other factors serve to accelerate pathogen destruction.

Additional guidance is available per the U.S. CDC Interim Guidance for Managers and Workers Handling Untreated Sewage from Individuals with Ebola in the United States:

<http://www.cdc.gov/vhf/ebola/prevention/handling-sewage.html>

http://www.who.int/water_sanitation_health/WASH_and_Ebola.pdf?ua=1

C. Environmental Decontamination

Those facilities, residences, vehicles, etc. thought to be contaminated with bodily fluids from a person with Ebola will require a specialized decontamination process.

Level of cleaning and decontamination:

Once a person has been confirmed to have Ebola, the way to decontaminate the residence depends on the person's symptoms at the time they were in the residence:

- Cleaning by residents - If the person with Ebola **only had a fever** with no gastrointestinal (e.g., diarrhea, vomiting) or hemorrhagic (bleeding) symptoms while he or she was in the residence, the person should not be contaminating their environment. The remaining members of the residence can clean and launder as normal using detergent and/or disinfectant.
- Cleaning by contract company - If the person with Ebola had a fever **and** diarrhea, vomiting, and/or unexplained bleeding, public health and/or assigned authorities may need to contact a contract company who will assess the residence to determine the proper decontamination and disposal procedures. Remaining members of the residence should avoid contaminated rooms and areas until after the completion of the assessment and decontamination.

Contract companies that can conduct cleaning:

Companies with experience in cleaning biohazard and crime scenes can conduct the necessary cleaning. OSHA provides guidance for cleaning and decontaminating in non-healthcare settings. Any contract company conducting such work must comply with the State's Ebola policies and with OSHA standards for, among others that may apply, blood borne pathogens (29 CFR 1910.1030), personal protective equipment (PPE) (29 CFR 1910.132), respiratory protection (29 CFR 1910.134), and hazard communication (29 CFR 1910.1200) (e.g., for chemical hazards). In states that operate their own occupational safety and health programs, different or additional requirements may exist. MEMA has identified a list of potential vendors to assist with the decontamination of residences and other sites as necessary. MEMA will continue to follow up with these vendors to ensure willingness to provide this service.

Transport of waste:

- Transportation of Ebola-contaminated waste (i.e., materials that cannot be decontaminated and were in contact with the person with Ebola having fever **and**

diarrhea, vomiting and/or unexplained bleeding) must be packaged and transported in accordance with regulations on the transportation of Ebola contaminated items provided by the US Department of Transportation (DOT): [US DOT Hazardous Materials Regulation for Category A Infectious Substance](#). If a contract company is handling the waste, requirements in OSHA standards, including Blood borne Pathogens (29 CFR 1910.1030) may also apply.

- Stericycle can collect and transport waste resulting from the decontamination of residences and other sites (provided it is packed according to their procedures).

Additional guidance is available per the U.S. CDC, Interim Guidance for the US Residence Decontamination for Ebola Virus Disease (Ebola) and Removal of Contaminated Waste http://www.cdc.gov/vhf/ebola/hcp/residential-decontamination.html?utm_medium=Email&utm_source=ExactTarget&utm_campaign

Appendix H

Personal Protective Equipment

Personal protective equipment (PPE) is one of the most important mechanisms available to assist in controlling the Ebola disease. Without proper PPE, health care workers who come in contact with bodily fluids of an Ebola patient, become high risk of contracting the disease themselves and potentially spreading the disease to others. Healthcare workers must have access and adequate supply of the recommended PPE, and be thoroughly trained on the donning and doffing (i.e. putting on and removing) of that PPE to control the spread of the disease.

It is expected that healthcare facilities will obtain an adequate supply of proper PPE for their staff and train their staff to proficiency according to U.S. CDC guidelines in the use of that PPE. In the event that the local supply of PPE becomes depleted in caring for a patient with Ebola, the State will identify additional resources.

Guidance

The U.S. CDC has provided detailed guidance on the types of personal protective equipment to be used and on the processes for donning and doffing PPE for all healthcare workers caring for a suspected or confirmed patient with Ebola. The guidance reflects lessons learned from the recent experiences of US hospitals caring for Ebola patients and emphasizes the importance of **training, practice, competence, and observation** of healthcare workers in correct donning and doffing of PPE selected by the facility.

This guidance contains the following key principles:

1. Prior to working with Ebola patients, all healthcare workers involved in the care of Ebola patients must have received repeated training and have demonstrated competency in performing all Ebola-related infection control practices and procedures, and specifically in donning and doffing proper PPE.
2. While working in PPE, healthcare workers caring for Ebola patients should have no skin exposed.
3. The overall safe care of Ebola patients in a facility must be overseen by an onsite manager at all times, and each step of every PPE donning and doffing procedure must be supervised by a trained observer to ensure proper completion of established PPE protocols.

Guidance documents

Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in US Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)

<http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>

Ebola: Donning and Doffing of Personal Protective Equipment (PPE)

<http://www.medscape.com/viewarticle/833907>

State PPE Cache

Based on U.S. CDC guidelines and the PPE currently used at Maine healthcare facilities, Maine CDC has ordered a cache of PPE to support partners in response to suspected and/or confirmed Ebola patients in Maine. These partners include healthcare, emergency medical services, law enforcement, and others as needed.

PPE Inventory

- Powered air purifying respirators (PAPRs)
- Single-use (disposable) N95 respirators
- Single-use (disposable) surgical hoods
- Single-use (disposable) full face shields
- Single-use (disposable) fluid-resistant coveralls with integrated socks
- Single-use (disposable) nitrile examination gloves with extended cuffs
- Single-use (disposable), fluid-resistant or impermeable shoe covers
- Single-use (disposable), fluid-resistant or impermeable aprons

PPE Deployment

In order to ensure adequate PPE is available at the identified assessment and treatment hospitals and among identified first responders (e.g. EMS and law enforcement), Maine CDC will forward-deploy a standardized cache of PPE to these groups.

Upon notification that a traveler will be arriving in the State, Maine CDC will determine if additional healthcare facilities and first responders in the affected region require forward-deployment of PPE (e.g. hospitals, health centers, etc.).

If State Cache PPE is used by a healthcare facility, it is expected that the healthcare facility will resupply the PPE used once the normal supply chain is restored and PPE orders are fulfilled. This will allow Maine CDC to maintain this capability in the future.

PPE Distribution

Maine CDC collaborates with the Maine Department of Transportation and Maine Civil Air Patrol to distribute PPE as necessary throughout the State.

Strategic National Stockpile (federal cache)

The Strategic National Stockpile is a federal asset managed by the U.S. CDC's Division of the Strategic National Stockpile (U.S. CDC DSNS) that augments state supplies needed in response to severe public health emergencies.

The U.S. CDC DSNS is increasing the PPE available in SNS to assist states upon request:

- The PPE sent will support 4-5 days of patient care
- PPE will be shipped directly to healthcare facilities in need
- Shipping time depends on location , but will be 24 hours or less

Maine's Strategic National Stockpile Plan (Maine SNS Plan) describes how the State of Maine will request, receive, and distribute medical materials from the SNS. The Maine SNS Plan will be activated if the State PPE Cache is depleted, or is anticipated to become depleted, in response to an active case of Ebola.

Appendix I

Public Communications

Messaging Coordination, Validation, and Approval

Maine CDC is responsible for providing public health information to the general public that is relevant, timely, easy to understand and consistent with messaging from other response agencies.

All public-facing communications regarding Ebola that are referred to or developed by Maine CDC must first be reviewed and approved by the Department of Health and Human Services' Public Health Information Officer before being distributed.

Methods of Communication

In order to ensure that Ebola-related communications are disseminated as widely as possible, Maine CDC will distribute its messaging via multiple methods. These methods include:

- Posting information on Maine CDC's Ebola webpage (www.maine.gov/ebola), including Frequently Asked Questions (FAQs), factsheets, info-graphics, and links to resources produced by external organizations, such as the U.S. CDC.
- Posting on Maine CDC's blog (mainepublichealth.blogspot.com).
- Social media posts, including both Facebook (www.facebook.com/MaineCDC) and Twitter (@MEPublicHealth), linking to relevant resources.
- Press releases distributed to media agencies and posted on the Maine State Government News webpage (www.maine.gov/portal/government/state-news)
- Television and radio appearances.
- Dedicated press conferences.

Appendix J

State of Maine

Law Enforcement Response Capability in an Infectious Disease Environment

By Maj. Chris Grotton, Maine State Police

State LE Response Team:

Concept of Operations:

The Infectious Disease Law Enforcement Response Team (IDLERT) is a multi-jurisdictional team of officers located throughout the state. The Team Leader is responsible to train, develop, and maintain the team to mission-ready status. The Team Leader shall be the primary contact for team members, member agencies and state agencies regarding IDLERT activities.

Mission: The mission of the Infectious Disease Law Enforcement Response Team is to provide law enforcement services in an environment of known or suspected infectious disease, with the intent to enforce a lawful court order or other legal process and facilitate transfer to appropriate medical care facility.

Team training, deployment, and activities shall be conducted in accordance with policies and protocols established and approved by the State Police Team Leader.

The Team is organized under a Memorandum of Understanding, signed by all parties, outlining roles and responsibilities and clarifying legal authority, liability and worker's compensation coverages. In accordance with M.R.S.A. Title 37B section 784A, the State of Maine provides liability insurance and worker's compensation to those trained and certified Special Team volunteers when activated and approved by the Director of MEMA and/or the Director's designee and while they are performing assigned duties directly related to preparation for, response to or recovery from emergency operations.

IDLERT will integrate with identified EMS provider for regional transport of a symptomatic person. This will be a coordinated approach with Maine CDC, EMS provider, and identified hospital receiving patient.

Activation Protocols:

Request for activation must meet the following criteria;

- Identified need for law enforcement,
- Legal authority (consent or legal process), after a validated medical need or health emergency has been established with Maine CDC authority and input.

The activation and deployment of the Team must include, at a minimum;

- Obtain medical briefing by Maine CDC and other medical providers
- Coordination and integration with /EMS & designated hospital receiving patient
- Defined mission and role of the Team during the deployment

Response protocol

Callout process & requirements for deployment:

- CDC to contact MEMA duty officer to initiate callout
- Establish legal authority
- Obtain medical brief from Maine CDC
- Coordination with EMS & designated hospital
- Gather other relevant intelligence required to complete the mission
- Develop and execute plan in accordance with IDLERT protocol

Response protocol on scene:

- Tactical considerations and coordination with EMS regarding use of equipment and special considerations for the IDLERT.
- Refer to IDLERT protocol for approval to use of gear on duty belt and in conjunction with recommended PPE to keep risk for exposure of personal equipment to a minimum.
- Transport & decontamination process - accompany patient to designated hospital for security and decontamination of personnel and equipment.

Post-deployment considerations:

- Replace any consumed PPE and equipment
- In conjunction with Maine CDC guidance, assess need for:
 - Workers compensation exposure reporting
 - Medical assessment and screening
 - Follow up procedure which shall be contingent upon CDC classification based on exposure risk.

Team Training

Initial training to include:

- Team mission and protocols
- Briefing on Ebola Virus Disease/EID by Maine CDC
- Completion of medical screening questionnaire, fit testing for issued respirator.
- Training on PPE donning and doffing, decontamination procedures and protocols.
- EMS integration (Maine EMS, local service provider, regional EMS and hospital resources)

Agreement Between
Maine Emergency Management Agency
And
Participating Agencies - Infectious Disease Law Enforcement Response Team

Team Mission: The mission of the Infectious Disease Law Enforcement Response Team (IDLERT) is to provide law enforcement services in an environment of known or suspected emerging infectious diseases (EID), such as enforcing a lawful court order or other legal process to facilitate the transfer of a person to an appropriate medical care facility.

The Infectious Disease Law Enforcement Response Team will consist of law enforcement officers from participating agencies throughout Maine, acting at the direction of an assigned Team Leader. The Maine DHHS/Center for Disease Control (CDC) is party to this agreement and supports the Infectious Disease Law Enforcement Response Team. The participating agencies contributing officers to the Infectious Disease Law Enforcement Response Team (hereafter "the Team") and the Maine Emergency Management Agency (hereafter "MEMA") agree as follows:

Team Activation/Deployment Criteria: If requested by MEMA and approved by the Team Leader, the Team agree to respond to incidents within the State of Maine as follows:

Activation of the Team must meet the following criteria:

- Identified need for law enforcement, and
- Legal authority (consent or legal process)

The activation and deployment of the Team must include, at a minimum:

- Obtain medical brief (Maine DHHS/CDC and other medical providers)
- Coordination and integration w/BMS & designated hospital
- Defined mission and role of the Team during the deployment

Team training, deployment, and activities shall be conducted in accordance with policies and protocols established and approved by the Team Leader.

Team deployments shall be conducted utilizing the principles of the Incident Command System.

Equipment: Equipment and supplies deemed necessary for the execution of the mission shall be provided by Maine DHHS/CDC.

The Team will have possession and full use of the equipment, and will maintain and protect the equipment, including but not limited to routine testing, cleaning, inspection, and storage. The Team agrees to report to MEMA all defective, damaged, lost, used and obsolete equipment in a timely manner.

It is understood that the mission of the Team is dynamic and likely to evolve over time. This will require ongoing discussions and evaluation of equipment needs.

Training and Certification of Team: The Team will be based regionally throughout Maine. The Team shall maintain an active roster of sufficient personnel to accomplish the mission.

The Team is to be fully trained, to include any necessary certifications and demonstrated proficiency with applicable pieces of equipment.

Training shall be conducted in compliance with applicable regulations and industry recommendations. Training shall include, but not be limited to a full briefing on relevant infectious disease(s), training and demonstrated proficiency in Personal Protective Equipment procedures and decontamination, briefing and discussion on Team protocols, and integration with EMS and medical care providers as appropriate.

Liability: Pursuant to this document and in accordance with M.R.S.A. Title 37B section 784A, the State of Maine provides liability insurance and worker's compensation to those trained and certified Special Team volunteers when they are performing assigned duties directly related to preparation for, response to or recovery from an authorized activation pursuant to this document.

Liability insurance and workman's compensation coverage shall be extended to those individuals and/or team when activated and approved by the Director of MEMA and/or the Director's designee.

If during an authorized emergency response or training activity an individual is injured or thought to be injured the first priority will be the safety and well being of the team member. As medical assistance is being sought, the MEMA Duty Officer will be contacted and a verbal summary of the event will be provided. Additionally, if there are questions with regard to who may be covering the cost of the injury, it is the Team Leader or designated safety officers' responsibility to ensure the medical provider understands that this may be a workman's compensation claim under the umbrella of the State of Maine. Within 48 hours of the injury a written "First Report of Injury" will be submitted to MEMA (*see Attachment to this Agreement*).

It is understood by all parties that a Team member engaged in a response pursuant to this document may be determined to have been exposed to a virus or substance. As a result, that Team member may be subject to some level of monitoring in accordance with Maine DHHS/CDC guidelines.

The Team further agrees to indemnify MEMA and Maine DHHS/CDC and hold them harmless from and against any third party claims that may arise from the equipment provided pursuant to this agreement, including all losses, damages, and expenses, such as reasonable attorney's fees and defense costs, related to any such third party claims. And, such limitation of liability is to be made known to and binding upon any party receiving equipment pursuant to this agreement.

Nothing contained herein is intended to waive the defenses and immunities available to MEMA, the Team, or Maine DHHS/CDC with respect to third parties under provisions of any law, including, but not limited to, the defenses and immunities provided under the Maine Tort Claims Act, 14 MRSA 8101, et seq.

Third Party Beneficiaries: This agreement is for the benefit of the Team, MEMA, and Maine DHHS/CDC only, and is not intended to inure to the benefit of any third party, including but not limited to any particular municipality or group of emergency first responders.

Risk of Loss: The risk relating to any casualty loss or damage to any equipment under this agreement shall pass to the Team upon delivery of the equipment by MEMA to a location specified by MEMA. MEMA shall be responsible for inspection of the equipment for damage, defect or storage upon delivery. MEMA shall notify the Team when the equipment is available for pick-up and the Team shall arrange transportation to recover the equipment from MEMA.

Entire Agreement / Severability: This agreement constitutes the entire understanding between the parties hereto and supercedes all other oral or written communications between them that might exist in regard to the subject matter herein. This agreement may not be amended or modified except by a writing signed by both parties. If any portion of this agreement should be found unenforceable by a court of law, the parties intend that all other portions of the agreement shall remain in full force and effect.

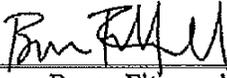
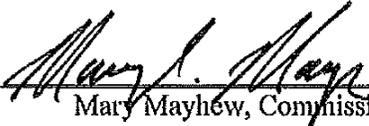
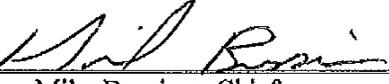
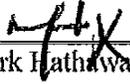
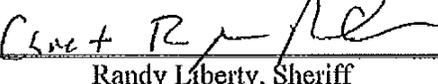
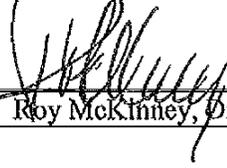
Withdrawal and Termination: The agencies represented by members assigned to the Team may withdraw from their participation in this agreement provided that it has given MEMA, and all other parties to this agreement, at least sixty (60) days notice of its intention to do so.

Term: This agreement will remain in full force and effect until November 05, 2017, and may be extended by the mutual agreement of the parties hereto, evidenced by a duly executed instrument to be attached hereto.

Amendment: This agreement may be modified or amended by mutual agreement of all parties hereto either by a duly executed written instrument to be attached hereto, or electronically via email affirmation and approval by MEMA and the agencies participating in the Team.

Effective Date: This agreement shall be effective when signed by the interested Parties designated below.

IN WITNESS WHEREOF, the Maine Emergency Management Agency and the Team, hereby execute this agreement and further acknowledge that each of the signatures below has been duly authorized to execute this agreement on behalf of the parties.

Maine Emergency Management Agency	
By:  Bruce Fitzgerald, Director	Dated: 11/24/14
Maine Dept. Health & Human Services/CDC	
By:  Mary Mayhew, Commissioner	Dated: 11/21/14
Maine State Police	
By:  Col. Robert A. Williams, Chief	Dated: 11/21/14
Lewiston Police Department	
By:  Mike Bussiere, Chief	Dated: 12-1-14
Bangor Police Department	
By:  Mark Hathaway, Chief	Dated: 11/28/14
Kennebec County Sheriff's Office <i>on behalf of:</i>	
By:  Randy Liberty, Sheriff	Dated: 11/25/14
Maine Drug Enforcement Agency	
By:  Roy McKinney, Director	Dated: 11/24/2014

Updated US CDC Guidance: Monitoring Symptoms and Controlling Movement to Stop Spread of Ebola (updated 10/27/14)

RISK LEVEL	RISK CRITERIA	PUBLIC HEALTH ACTION		
		Monitoring	Restricted Public Activities	Restricted Travel
HIGH Risk	Direct contact with infected body fluids (needle stick, splashes, fluids directly on skin)	Yes - Direct Active Monitoring	Yes	Yes
	Handling body fluids without PPE			
	Touching a dead body without PPE			
	Living with and caring for a symptomatic person			
SOME Risk	Close contact (within 3 feet) with person showing symptoms without PPE	Yes - Direct Active Monitoring	Case-by-case assessment	Case-by-case assessment
	In countries with widespread Ebola, direct contact with person showing symptoms with PPE			
LOW Risk (but not zero)	Having been in a country with widespread Ebola within the previous 21 days, and having no known exposure	Yes - Active Monitoring for some; Direct Active Monitoring for others	No	No
	Being in the same room for a brief period of time (without direct contact) with a person showing symptoms			
	Having brief skin contact with a person showing symptoms when the person was believed to be not very contagious			
	Direct contact with a person showing symptoms while wearing PPE			
	Travel on an airplane with a person showing symptoms			
NO Risk	Contact with a person who is NOT showing symptoms AFTER that person was in contact with a person with Ebola	No	No	No
	Contact with a person with Ebola BEFORE the person was showing symptoms			
	Having traveled to a country with Ebola outbreak MORE than 21 days ago			
	Having been in a country where there is no widespread Ebola transmission (e.g, United States) and having no other exposures to Ebola			

Definitions:	
Quarantine	Separates people who are not sick but carry some level of risk of contagion from other people who are not sick and not at risk
Isolation	Separates sick people who are confirmed to have a contagious disease from people who are not sick
Active Monitoring	Public health officials are responsible for checking at least once a day to see if people have a fever or other symptoms of Ebola
	People being monitored must take their temperature twice daily, watch themselves for symptoms, report as directed to public health officials, and immediately tell public health officials if they have a fever or other symptoms
	Active monitoring must take place until 21 days after the last possible exposure and can occur on a voluntary basis or be required by legal order
Direct Active Monitoring	Public health officials conduct active monitoring by directly observing the person being monitored
	Public health officials directly observe the individual at least once a day to review symptoms and check temperature, a second follow-up per day can be done by telephone Direct active monitoring should include discussion of plans to work, travel, take public transportation, or go to busy public places to determine whether these activities are allowed
Travel Restrictions	People must NOT travel by airplane, ship, or long distance bus or train, even if they are NOT sick
	People on travel restrictions might be allowed to travel by private plane or car as long as they continue to be monitored during travel
	Taking local public transport should be discussed with the local health department



**EMPLOYEE'S REPORT OF INJURY, EXPOSURE, or MEDICAL CONDITION
COMPLETE AND RETURN WITHIN 24 HOURS TO:**

NRSC, SHS #155, Augusta, ME 04333

Phone: Thomas Cotnoir 287-5046 or Carmen Welch 287-4997 -- Fax: 287-2216



1. Name:		2. Social Security #	
3. Home address: Include street, city/town, zip code		4. Date of birth	6. Home phone
		5. M <input type="checkbox"/> F <input type="checkbox"/>	7. Work phone
8. Department/Agency:		9. Job title	
10. Work location/crew - where accident happened:		11. Work hours: <u>Circle/Bold Off Days</u> Begin AM <input type="checkbox"/> PM <input type="checkbox"/> Sun Mon Tues Wed End: AM <input type="checkbox"/> PM <input type="checkbox"/> Thurs Fri Sat	
12. Supervisor's name:		13. Supervisor's phone:	
14. Date/time of injury Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/>		15. Date you first thought your medical condition had to do with your work <input type="checkbox"/> Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/>	
16. Date/time you reported your injury: Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/>		17. To whom did you report your injury?	
18. Did you seek treatment as a result of your injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		19. Who did you treat with?	
20. Who is your PCP (Primary Care Physician)?		21. Address:	
22. Did you lose time from work? Yes <input type="checkbox"/> No <input type="checkbox"/> Date returned to work?		23. Date(s) missed?	
24. Witnesses: Witnesses:		Work phone: Work phone:	
25. Nature of injury/illness (e.g., strain, sprain, fracture, cut, bruise, multiple injuries, etc.)			
26. Body part injured (e.g., head, ear, eye, face, arm, hand, shoulder, back, knee). Specify left/right/upper/lower:			
27. Injury Source (e.g., machinery, chemicals, vehicle, stairs, person, etc.)			
28. Describe fully <u>how and where</u> the injury occurred (e.g., Struck by...Fell from...Exposed to...etc.			
29. Have you ever had a similar injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what happened and when?		30. Who did you treat with for similar injury?	
32. Do you work for another employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you lost time from your other employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		31. Do you want to use <input type="checkbox"/> sick leave and/or <input type="checkbox"/> vacation leave if you miss work due to your injury?	
34. Signature of employee:		33. Name and address of second employer? Phone number:	
		35. Date you completed and returned this form:	

Appendix K

Fatality Management Plan

Primary Agencies:

- Office of the Chief Medical Examiner (CME)
- Department of Health and Human Services (DHHS)

Support Agencies:

- Department of Public Safety (DPS)
- Maine Emergency Management Agency (MEMA)

Public & Private Support:

- Tertiary health care facilities in which Ebola patients are assessed
- Funeral homes assigned to recover and transport remains of Ebola patients
- Crematoriums assigned to cremate remains of Ebola patients
- Maine Funeral Directors Response Team
- Maine Funeral Directors Association
- Other organizations providing ancillary services in support of fatality management (FM) of Ebola patients

I. PURPOSE, SCOPE, SITUATION & ASSUMPTIONS

A. Purpose

The purpose of this Plan is to serve as a State-level operational guide for coordinating fatality management (FM) of Ebola Virus Disease (EVD) decedents. It focuses on assigning responsibilities and coordinating the FM activities of public, private, private-non-profit, and voluntary entities. All FM activities will be in accordance with current U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries and additional guidance linked therein.

Disclaimer. The content of this Plan should not be interpreted to subsume, replace, detract from, or conflict with, authorities and responsibilities of the Office of the Chief Medical Examiner, Maine Department of Health and Human Services (DHHS), or other State and local agencies or private and private-non-profit organizations that support the implementation of this Plan, as specified by statute or regulation.

This Plan specifically addresses a State-level fatality management plan for fatalities or suspect fatalities resulting from EVD which may occur in the State of Maine, or which may occur outside of the State of Maine if final disposition of remains will be within the State of Maine.

Death care and emergency response standards and procedures that currently exist for health care facilities in which EVD patients expire, licensed funeral directors, Maine's Mortuary

Response Team, and crematories will remain in force unless superseded by information in this Plan.

B. Scope

This Plan applies to all primary, support, and public/private support agencies listed above, all licensed funeral directors and crematories in Maine and all other public, private, private-non-profit and voluntary partners that have a role in preparedness and response activities related to FM of Ebola patients.

C. Situation Overview

§851. Mass fatality plan, Title 37B, MRSA, outlines roles and responsibilities for the preparation and execution of “a plan for the recovery, identification and disposition of human remains in a disaster.”

Because of the highly lethal nature of EVD and the specialized training and procedures needed to handle human remains of Ebola patients in hospitals and mortuaries, one or more fatalities resulting from EVD will be considered a disaster for the purposes of this Plan. As such, the roles and responsibilities outlined in this Plan are an extension of those found in the Maine statute addressing a mass fatality plan.

Multiple fatalities resulting from EVD may necessitate state coordination of additional state and federal resources to augment state and local resources when appropriate.

See the Base Plan of the Ebola Response Plan for additional information on the overview of the situation.

D. Planning Assumptions

The following circumstances have been assumed to be true for planning purposes. Upon notification of a fatality resulting from Ebola, expeditious changes to the execution of this Plan will need to be made as the facts of the event become known.

1. EVD fatalities will occur in one of the pre-designated assessment hospitals in Maine.
2. Not more than one EVD fatality will occur in a 24 hour period.
3. Pre-designated EVD assessment hospitals, funeral homes (and associated transport operators) and crematories are equipped, staffed and trained to safely handle human remains of Ebola patients in accordance with current U.S. CDC guidance and this Plan.
4. Those who physically handle remains are at risk of blood borne or body fluid exposure requiring universal precautions and proper training for handling the deceased.
5. Human remains of an Ebola patient will be cremated unless objected to by the decedent’s next of kin.

6. Agencies and entities assigned responsibilities in this Plan will have established operating procedures specifying their support service actions and will be able to communicate and coordinate these actions in the event of an Ebola fatality to use available capabilities as effectively as possible.
7. Pre-designated funeral directors have coordinated with pre-designated assessment hospitals on the following points prior to the occurrence of an EVD fatality:
 - a. Transport route of human remains through the hospital.
 - b. Location of transport vehicle outside of the facility.
 - c. Equipment and supplies the funeral director and hospital will provide, respectively, for the preparation of human remains prior to transport.
8. Human remains of Ebola patients that are transported from out-of-state locations to the State of Maine for final disposition:
 - a. Will be prepared at the location of expiration for final disposition (cremains or hermetically sealed casket) in accordance with U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries, and
 - b. Will be handled and accounted for in the same manner as human remains for non-Ebola patients upon arrival to the State of Maine.

I. CONCEPT OF OPERATIONS

A. General

Goal and Objectives. The goal of this Plan is to ensure the safe, timely and appropriate handling of human remains of Ebola patients in Maine assessment hospitals and mortuaries until final disposition. In coordination with and support to local municipalities and FM partners, the State of Maine will accomplish this goal by maintaining the following FM objectives:

- Support the safe, timely and appropriate recovery of human remains
- Transport and prepare human remains for final disposition
- Handle decedents with dignity and respect
- Care for families of the deceased
- Support activities leading to determination of cause and manner of death
- Conduct proper release and/or final disposition of the remains
- Support tracking of physical decedent remains and corresponding case data.

This Plan will be activated upon one or more fatalities resulting from EVD.

Assessment & Treatment Hospitals. Four tertiary health care facilities in Maine are pre-designated for the assessment of suspect Ebola patients. Once a patient is confirmed with Ebola at one of these assessment hospitals, the patient will be transported to a pre-designated regional or national treatment hospital (both out-of-state). In the event an Ebola patient dies in

one of Maine's designated assessment hospitals, the remainder of this plan will go into effect. Names and locations of pre-designated assessment and treatment hospitals are found under separate cover.

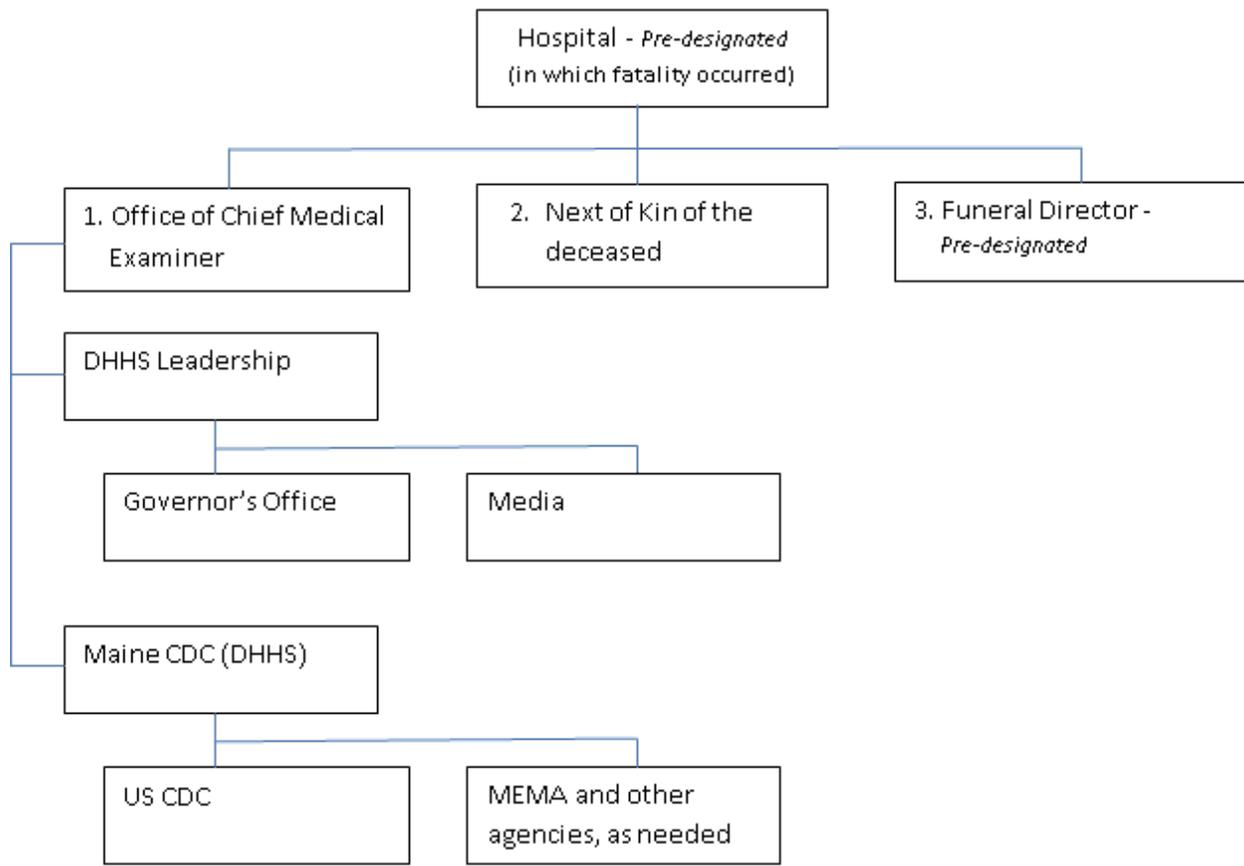
Primary and Alternate Funeral Directors. A funeral director located in Southern Maine is pre-designated for the recovery of human remains of Ebola patients. An alternate funeral director is pre-designated elsewhere in the State to support or serve in lieu of the primary funeral director should the need arise. Other members of the Maine Funeral Directors Response Team and/or Maine Funeral Directors Association will provide support to the primary and alternate funeral directors, as needed. Names and locations of the primary and alternate funeral directors are found under separate cover.

Primary and Alternate Crematoriums. A crematorium located in close proximity to the primary funeral director is pre-designated to receive and cremate human remains of Ebola patients. An alternate crematorium is pre-designated elsewhere in the State to support or serve in lieu of the primary crematorium should the need arise. Names and locations of the primary and alternate crematoriums are found under separate cover.

The activities that follow outline how agencies and organizations implicated in this Plan will conduct FM operations or be called upon to help support and coordinate safe handling of human remains of Ebola patients:

B. Notification (Alert & Warning)

Immediately after a fatality resulting from EVD, initial notifications will be made in accordance with the chart shown on the next page:



Response Actions

Ebola assessment hospital staff, funeral directors and crematorium staff that handle or assist in the handling of human remains of Ebola patients are expected to properly use personal protective equipment (PPE) and follow decontamination measures during every step of the process in accordance with U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries and with related guidance linked therein. **See paragraph IX. Authorities and References, for URL to the U.S. CDC guidance.**

HUMAN REMAINS (HR) RECOVERY OPERATIONS

1. After initial notifications, the assessment hospital in which the Ebola patient expired, will strictly follow procedures outlined in the U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries, which includes, but is not limited to the following:
 - a. Keep the decedent in the same room in which he/she expired and do not remove any medical devices or garments.
 - b. Prepare the room for mortuary recovery.
 - c. Prepare the decedent for transport from the hospital which includes triple bagging and sealing of the human remains (HR) with all medical devices and garments intact.

- d. Coordinate with the pre-designated funeral director for recovery of the decedent.
2. The pre-designated funeral director will coordinate with the hospital, next-of-kin, Chief Medical Examiner and the funeral director at the location of final disposition, and others as needed, to support activities leading to determination and documentation of cause of death and to conduct release of the remains and to track corresponding case data. On a case-by-case basis, the Chief Medical Examiner will consider waiving the standard 48 hour waiting period for release of the human remains in order to expedite recovery and transport of the remains and to minimize exposure of the HR to others.
3. Upon arrival of the funeral director to the hospital in which the Ebola patient expired, the funeral director will assume custody of the human remains from hospital staff in accordance with U.S. CDC Guidance for the Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries.
4. The funeral director and supporting funeral staff, with assistance from hospital staff, will escort the human remains of the Ebola patient along a pre-designated route through the hospital to an awaiting transport vehicle. Route of travel through the hospital must maximize discretion and minimize travel distance and exposure to hospital staff and patients.

MORGUE AND CREMATORIUM OPERATIONS

1. At no time is the HR to be placed in the hospital morgue, local morgue or temporary morgue unless the case load of human remains of Ebola patients exceeds the State's capacity to recover, transport and prepare them for final disposition. The Chief Medical Examiner in consultation with the Director of Maine CDC will be the sole approval authority for use of a morgue and only when conditions exceed capacity.
2. Upon recovering the HR from the hospital, the funeral director and supporting funeral staff and driver will transport the human remains of the Ebola patient along a pre-designated route to the pre-designated crematorium.
3. The HR will be cremated and placed in an appropriate container for final disposition.
4. In the event that the decedent's next of kin opts out of cremation after recommendations from the funeral director to do otherwise, the HR will be taken from the hospital to the funeral director's funeral home and immediately placed in a metal casket.

RELEASE OF HR/FINAL DISPOSITION

1. The pre-designated funeral director will coordinate with the funeral director from the location of final disposition to transfer cremains or the metal casket containing remains.

2. After cremation or placement of the HR in a metal casket, the contained HR is no longer considered a threat for transmission of Ebola to subsequent handlers of the HR.
3. Standard procedures used by funeral directors for transfer of non-Ebola HRs from one funeral director to another will be used after HR of Ebola patients have been cremated or placed in a metal casket.

OTHER CONSIDERATIONS

1. Remains of decedents must be handled with the utmost respect and care. Members of the hospital and mortuary team will ensure that all human remains are stored with dignity, prepared with professionalism and transported with consideration.
2. Other agencies must be involved when the human remains are foreign nationals or undocumented residents. Agencies include the US State department, foreign embassies, Immigration Nationalization Service and others as warranted. MEMA and Maine CDC are available to assist CME in contacting the appropriate authorities.
3. The cultural, religious and other characteristics of the HR and NOK should be carefully considered throughout EVD fatality management operations.

II. ASSIGNMENT OF RESPONSIBILITIES

A. Office of the Chief Medical Examiner

1. Provide consultation to MEMA for updates to this Plan.
2. Serve as incident commander and oversee implementation of this Plan in the event of a death resulting from EVD.
3. Coordinate with the Maine Funeral Directors Association and the Maine Funeral Directors Response Team and designate primary and alternate funeral directors and crematoriums needed to implement this Plan, which are in close proximity to the Ebola assessment hospitals. Provide names and locations of pre-designated organizations to Maine CDC.
4. Provide the pre-designated funeral directors and crematoriums with necessary equipment, supplies and training to implement this Plan.
5. Conduct death investigation, victim identification and death certification, per State and federal regulations.
6. Submit requests through Maine CDC to MEMA for use of volunteers in the implementation of this Plan to invoke protections afforded under Title 37B, MRSA.

7. In the event of State EOC activation for mass EVD fatality operations, submit requests for support to the State EOC for action.
8. Document all actions taken regarding HR in accordance with existing regulations and procedures.
9. Be prepared to accompany DHHS leadership during public messaging events to convey technical perspective regarding Ebola fatalities.

B. Commissioner, Department of Health and Human Services

1. Inform the Governor's office of EVD fatalities in Maine.
2. Coordinate with the Governor's office for all public messaging related to EVD fatalities. Names of the decedents should not be released until the Office of the Chief Medical Examiner indicates it is permissible and until after the next of kin have been notified.
3. In the event of multiple EVD fatalities necessitating the activation of the State EOC, provide representation to the State EOC's Joint Information Center (JIC) when requested by MEMA to coordinate public messaging.
4. Verify that pre-designated funeral directors and crematoriums are currently licensed and in good standing.
5. Ensure that mortuary and crematorium operations in support of this Plan are consistent with state and federal standards and licensing agreements.

C. Maine Center for Disease Control and Prevention

1. Provide consultation to MEMA for updates to this Plan.
2. Assist the Office of the Chief Medical Examiner with the necessary equipment, supplies and training for funeral directors and crematoriums to implement this Plan.
3. Provide the pre-designated assessment hospitals with the necessary equipment and supplies and facilitate training to implement this Plan.
4. Receive revisions of this Plan from MEMA and integrate them into the statewide Ebola Response Plan.
5. Facilitate training and exercise support to pre-designated assessment hospitals, funeral directors and crematoriums, upon request.
6. Be prepared to provide behavioral health professionals, social service organizations and religious leaders needed during the fatality management process.

7. Submit requests to MEMA for use of volunteers in the implementation of this Plan to invoke protections afforded under Title 37B, MRSA. Verify credentialing of medical volunteers through the Maine Responds program prior to submission of requests.
8. Ensure the Office of Vital Records issue registered death certificates and issue permits for burial, cremation and transportation as soon as possible.
9. Report EVD fatalities to U.S. CDC per their guidelines.
10. In the event of multiple EVD fatalities necessitating the activation of the State EOC:
 - a. Provide representation to the State EOC when requested by MEMA.
 - b. Establish and maintain communications with Office of the Chief Medical Examiner.
 - c. Serve as the primary point of contact in the State EOC for EVD fatality management activities.
 - d. Process requests for State assistance, as assigned.
 - e. Coordinate and prepare requests for federal assistance in conjunction with the DHHS Secretary's Operations Center, ASPR, US DHHS and the U.S. CDC Operations Center.

D. Department of Public Safety (Maine State Police and State EMS)

1. Be prepared to coordinate and/or provide law enforcement support to hospitals and funeral directors in need of security upon receiving a request from MEMA.
2. Be prepared to coordinate with local EMS organizations, to transport human remains of Ebola patients to pre-designated crematorium or funeral home.

E. Maine Emergency Management Agency

1. Update this Plan, as needed, in consultation with CME, Maine CDC, and other agencies and organizations implicated herein, per §851. Mass fatality plan, Title 37B, MRSA. Provide a copy of the final revised Plan to Maine CDC for integration into the statewide Ebola Response Plan, with copy furnished to CME.
2. Provide training and exercise support to the Office of the Chief Medical Examiner and the Maine CDC upon request.
3. Receive and act on requests from the Maine CDC for use of volunteers to assist with the implementation of this Plan.
4. Receive and act on requests from Maine CDC for general, non-medical support to EVD mass fatality operations.

5. Activate the State EOC for mass EVD casualties, if indicated, and coordinate the response per the State Emergency Operations Plan.
6. Submit and coordinate requests for federal assistance, as needed.

F. Pre-designated Assessment Hospitals

1. Coordinate with the pre-designated funeral director on the acquisition, storage, and use of mortuary supplies and equipment needed to prepare human remains in advance of an EVD fatality.
2. Pre-designate the route of travel from point of patient expiration to location of transport vehicle and provide route to the pre-designated funeral director and the Maine CDC in advance of an EVD fatality.
3. Handle human remains of Ebola patients in accordance with U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries and related guidance linked therein.
4. Submit requests for support on EVD fatality management operations to Maine CDC.

G. Pre-designated Funeral Directors

1. Provide consultation to MEMA for updates to this Plan.
2. Coordinate with the pre-designated assessment hospitals on the acquisition, storage and use of mortuary supplies and equipment needed to prepare human remains in advance of an EVD fatality.
3. Pre-designate the route of travel from pre-designated assessment hospitals to the crematorium and funeral home of the pre-designated funeral director and provide route to CME with copy furnished to the Maine CDC in advance of an EVD fatality.
4. Handle human remains of Ebola patients in accordance with U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries and related guidance linked therein.
5. Submit requests for support on EVD fatality management operations to CME.

H. Pre-designated Crematoriums

1. Handle human remains of Ebola patients in accordance with U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries and related guidance linked therein.

2. Submit requests for support on EVD fatality management operations to CME.

IV. DIRECTION, CONTROL & COORDINATION

- A. MEMA develops, coordinates and updates the Fatality Management Appendix to the Maine Ebola Response Plan.
- B. Office of the Chief Medical Examiner serves as the Incident Commander during implementation of this Plan.
- C. DHHS provides oversight and quality assurance of hospital, mortuary and crematorium operations in support of this Plan.
- D. MEMA authorizes use of volunteers in support of this Plan to invoke protections under Title 37B, MRSA.
- E. MEMA activates the State EOC in consultation with Maine CDC and CME if the volume and scope of EVD fatalities warrants activation.
- F. Agencies and organizations functioning under this Plan will retain operational control of their own resources.

V. INFORMATION COLLECTION, ANALYSIS & DISSEMINATION

The pre-designated funeral director will collect decedent information from the hospital in which the decedent expired and other sources as needed, and will disseminate said information as appropriate for the processing of human remains in accordance with standard protocols and procedures. The funeral director will immediately apprise the CME of any challenges that inhibit or delay this process.

VI. COMMUNICATIONS

1. Business Hours: Normal day-to-day business communications methods and contact information will be used to coordinate Ebola fatality management operations.
2. After business hours, weekends & holidays:
 - Office of the Chief Medical Examiner: Call State Police/9-1-1 dispatch center
 - Maine CDC: Call 207-821-5821
 - MEMA Duty Officer: Call 207-624-4400
3. Upon activation of the State EOC, communications used for normal day-to-day operations will be used and WebEOC will be used by all State agencies to document proceedings related to FM operations.

VII. ADMINISTRATION, FINANCE & LOGISTICS.

A. Administration.

Processing and administration of death certificates, identification and tracking of HR and other processes associated with fatality management will be in accordance with routine procedures and protocols established by the mortuary industry, State and federal regulations and the U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries.

B. Finance.

1. Memoranda of Agreement or support contracts for FM operations will be established by Maine CDC upon consultation with CME to ensure services are available and compensated for. Agreements may include HR recovery services; supplies, equipment and transportation for HR recovery; decontamination services; support personnel, technical assistance or subject matter experts; etc.
2. Full or partial funding is available by Maine CDC for:
 - PPE - for the assessment hospitals and funeral director and staff.
 - Travel Expenses - for mortuary team training and deployment.
 - Special equipment and supplies - used for recovery and preparation of HR of Ebola patients.
 - Decontamination services for transport vehicles
3. Costs for final preparation of human remains (i.e., cremation, etc.), funeral services and container used for final disposition (urn, casket, etc.) will be borne by NOK or decedent's estate.

Logistics.

Requests for supplies, equipment and funding specific to Ebola FM will be submitted to CME and/or Maine CDC for consideration.

VIII. PLAN DEVELOPMENT AND MAINTENANCE. Per Ebola Response Plan, Base Plan.

IX. AUTHORITIES AND REFERENCES

- A. U.S. CDC Guidance for Safe Handling of Human Remains of Ebola Patients in US Hospitals and Mortuaries and information via links therein: <http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html>
- B. Title 37B, MRSA.
- C. State of Maine licensing requirements for mortuary and cremation services.
- D. State of Maine Emergency Operations Plan.

III. ABBREVIATIONS & DEFINITIONS

A. Abbreviations

CDC	Centers for Disease Control and Prevention
CME	Chief Medical Examiner or Office of the Chief Medical Examiner
DPS	Department of Public Service
DHHS	Department of Health and Human Services
EOC	Emergency Operations Center
EVD	Ebola Virus Disease
FM	Fatality Management
HR	Human Remains of Ebola patient
MEMA	Maine Emergency Management Agency
MRSA	Maine Revised Statutes Annotated
NOK	Next of Kin
PPE	Personal Protective Equipment

Appendix L

Disaster Behavioral Health Resources

How do Infectious Disease Crisis Events Affect People?

Communities can be severely affected by Ebola disease in many ways. People are separated from their loved ones due to illness or death. Health workers need to deal with a high workload and a lot of stress. Those associated with Ebola can be vulnerable to social stigma, worsening their distress and isolation. Ultimately, whole communities may experience the fear and suffering that disease outbreaks often cause.

Although these events affect everyone in some way, people can experience a wide range of reactions. They can feel overwhelmed, confused or very uncertain about what is happening. They can feel fear and anxious, numb or detached. Some people may have mild reactions, whereas others may have more severe reactions. In general, how someone reacts depends on many factors, including

- The nature and severity of the event;
- Their experience with previous distressing events;
- The support they have in their life from others;
- Their physical health;
- Their personal and family history of mental health problems;
- Their cultural background and traditions;
- Their age, for example; children of different ages react differently than adults.

Children: Tips for Parents, Caregivers and Family Members to talk about Infectious Disease:

American Academy of Pediatrics. (2013, July). *Talking to children about tragedies and other news events*. Retrieved from <http://www.healthychildren.org/English/family-life/Media/Pages/Talking-To-Children-About-Tragedies-and-Other-News-Events.aspx> This webpage provides tips for alleviating stress in young children who may have experienced a traumatic event or who have heard about situations such as Ebola on television or online.

Children need help understanding what they hear about Ebola on the news or from their friends <http://www.cdc.gov/vhf/ebola/children/index.html>

Centers for Disease Control and Prevention. (2014). *Advice for colleges, universities, and students about Ebola in West Africa*. Retrieved from <http://wwwnc.cdc.gov/travel/page/advice-for-colleges-universities-and-students-about-ebola-in-west-africa> This webpage provides information for students who may have recently traveled abroad to countries affected by Ebola. It also gives insight into what a person can expect when returning home, such as what to monitor their health for and how to ensure the safety of others.

Adults Managing their Fears about Ebola and Infectious Diseases:

American Psychological Association. (n.d.). *Managing your fear about Ebola*. Retrieved from <http://www.apa.org/helpcenter/ebola-fear.aspx>

Centers for Disease Control and Prevention. (2014). **Maintain a healthy state of mind**. Retrieved from <http://www.bt.cdc.gov/preparedness/mind> This webpage gives information about managing stress and anxiety during a disaster or public health crisis for several different groups,

American Psychological Association. (2014, October). *As Ebola concerns mount, psychology offers guidance on health-risks communication*. Retrieved from <http://www.apa.org/news/press/releases/2014/10/health-communication.aspx> This article offers advice on communicating about Ebola and other public health crises. Not only does it give advice to parents on how to talk with children and teens about the Ebola outbreak, but it also provides detailed information to media and industry leaders who may be called upon to give interviews.

Healthcare Workers: Guidance for managing stress during an Infectious Disease Outbreak:

SAMHSA. (2005). *A guide to managing stress in crisis response professions* (HHS Publication No. SMA 4113). Retrieved from <http://store.samhsa.gov/shin/content//SMA05-4113/SMA05-4113.pdf> [PDF – 1.3 MB] This SAMHSA pocket guide provides first responders with information on signs and symptoms of stress and offers simple, practical techniques for minimizing stress responses prior to and during disaster response. parents, middle and high school students, and older adults.

Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health (NIOSH). (n.d.). *Traumatic incident stress: Information for emergency response workers* (HHS NIOSH Pub. No. 2002-107). Retrieved from <http://www.cdc.gov/niosh/mining/UserFiles/works/pdfs/2002-107.pdf> [PDF – 473 KB] This fact sheet provides an overview of stress that disaster responders may face as a consequence of traumatic incidents.

SAMHSA. (2014, September). *Tips for disaster responders: Understanding compassion fatigue* (HHS Publication No. SMA14-4869). Available at <http://store.samhsa.gov/product/Understanding-Compassion-Fatigue/SMA14-4869> This tip sheet explains the causes and signs of compassion fatigue, the burnout and secondary trauma a disaster response worker can experience. It offers self-care tips for coping with compassion fatigue and discusses compassion satisfaction as a protective tool.

Healthcare Workers: **“Listen, Protect and Connect”** building a Personal Resilience Plan for work-related exposure to traumatic events http://www.mainedisasterbehavioralhealth.com/wp-content/uploads/2014/03/APD_brochure-FinalUpdated.pdf

Appendix M

Infectious Disease Epidemiology Investigation Protocol Template



Maine Department of Health & Human Services
Maine Center for Disease Control and Prevention

Name of Disease

Investigation Protocol

State Epidemiologist

Effective Date

Review Date

Reporting Requirements

Consistent with Notifiable Conditions List (Reportable immediately or reportable within 48 hrs)

Case Definition

Clinical Description

Consistent with current CDC Clinical Case Definition

Laboratory Criteria for Diagnosis

Consistent with current CDC Laboratory Criteria for Diagnosis

Case Classification

Consistent with current CDC Case Classification for:

Suspect:

Probable:

Confirmed:

Laboratory Testing Services Available

Emphasis on testing available through the Health and Environmental Testing Laboratory. Include capacities (PFGE, etc) isolates related to this disease that are described in Notifiable Conditions List (Maine Reporting Rules) that should be submitted to HETL, and isolates that are requested for further testing by the CDC (or other federal agency).

Purpose of Surveillance and Reporting

- *Present in bullet format.*
- *Rationale for surveillance, reporting and investigation.*

Case Investigation

- *Present in bullet format*
- *Describe: expected timeline for initiation and completion of case investigation*
- *Describe forms, documents used to document investigation (include electronic options if they exist)*
- *Describe points of emphasis for the investigation (attempt to limit to 10-15)*

Recommendations for Control of Case and Contacts

Recommendations for Case

Describe isolation, immunization, treatment recommendations

Recommendations for Contacts

Describe contacts, precautions, prophylaxis recommendations

Exclusions

Case

Describe exclusions from school, workplace or sensitive occupation including timeframes and measures required to end exclusion (completion of treatment, demonstration of non-infected specimen(s), completion of prophylaxis, cessation of symptoms, etc.)

Symptomatic Contacts

Describe exclusions from school, workplace or sensitive occupation including timeframes and measures required to end exclusion (completion of treatment, demonstration of non-infected specimen(s), completion of prophylaxis, cessation of symptoms, etc.)

Asymptomatic Contacts

Describe exclusions from school, workplace or sensitive occupation including timeframes and measures required to end exclusion (completion of treatment, demonstration of non-infected specimen(s), completion of prophylaxis, cessation of symptoms, etc.)

Managing Special Situations: Schools, Daycares, Healthcare Settings

Recommendations for Schools

Describe in bullet format recommended control measures

Recommendations for Daycare Centers

Describe in bullet format recommended control measures

Recommendations for Healthcare Settings

Describe in bullet format recommended control measures

References

See the following references for clinical information including identification, description of infectious agent, occurrence, reservoir, mode of transmission, incubation period, period of communicability, susceptibility, and further clinical information.

- Committee on Infectious Diseases. *Red Book*, 2003 Report of the Committee on Infectious Diseases. ____ ed. Elk Grove Village, IL: American Academy of Pediatrics, (date).
- Teutsch, Steven M., Churchill, R. Elliott. *Principles and Practice of Public Health Surveillance*. ____ ed. New York, New York: Oxford University Press, Inc., (date).
- Heymann, David L., MD. *Control of Communicable Diseases Manual*. ____ ed. Washington, DC: American Public Health Association, (date).
- *Other documents (current references)*

Attachment(s)

1. Confidential Case Report, (for example)
2. Next attachment

Acronyms

ABSA	American Biological Safety Association
ACS	Alternate Care Site
AHOC	After Hours on Call Epidemiologist
ALS	Advanced Life Support
ALT	Alanine Aminotransferase
AM/DAM	Active Monitoring/ Direct Active Monitoring
APHIS/CDC	Animal and Plant Health Inspection Service/ Center for Disease Control
ARC	American Red Cross
ASAP	As Soon As Possible
ASPR	Assistant Secretary of Preparedness and Response
AST	Aspartate Aminotransferase
BiPAP	Bilevel Positive Airway Pressure
BLS	Basic Life Support
BPH	Bangor Public Health
BT	Bioterrorism
CAH	Critical Access Hospital
CART	County/Community Animal Response Team
CEMA	County Emergency Management Agency
CFR	Code of Federal Regulations
CME	Chief Medical Examiner
CMS	Centers for Medicare and Medicaid Services
CoP	Condition of Participation
DBH	Disaster Behavioral Health
DEP	Department of Environmental Protection
DHCPP	Division of High-Consequence Pathogens and Pathology
DHHS	Department of Health and Human Services
DIC	Disseminated Intravascular Coagulation
DL	District and Tribal Liaison
DNR	Do Not Resuscitate
DOE	Department of Education
DOT	Department of Transportation
DPS	Department of Public Safety
DSAT	Division of Select Agents and Toxins
ED	Emergency Department
EIDs	Emerging Infectious Diseases
EMAC	Emergency Management Assistance Compact
EMC	Emergency Medical Condition
EMD	Emergency Medical Dispatch
EMRT	Emergency Medical Response Team
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Epidemiologist on Call
EOP	Emergency Operations Plan
EPA	Environmental Protection Agency
epi	Epidemiologist
EVD	Ebola Virus Disease (Ebola)

FAQ	Frequently Asked Questions
FDA	Federal Drug Administration
FDP	Fibrin Degradation Products
FQHC	Federal Qualified Health Centers
FHD	Funeral Home Directors
FM	Fatality Management
HAI	Hospital Acquired Infections
HAN	Health Alert Network
HCC	Health Care Coalition
HCW	Health Care Worker
HETL	Health and Environmental Testing Laboratory
HIPAA	Health Information Portability and Accountability Act
HMR	Hazardous Materials Regulations
HR	Human Remains
IAED	International Academy of Emergency Dispatch
ICS	Incident Command Structure
ICU	Intensive Care Unit
ID	Infectious Disease
IDLERT	Infectious Disease Law Enforcement Response Team
IEMAC	Interstate Emergency Management Assistance Compact
IRT	Initial Response Team
JIC	Joint Information Center
LE	Law Enforcement
LHO	Local Health Officer
LRN-B	Laboratory Response Network- Biological
LSC	Life Safety Code
Maine CDC	Maine Center for Disease Control and Prevention
MA PHL	Massachusetts Public Health Laboratory
MEMA	Maine Emergency Management Agency
MENG	Maine National Guard
MEOC	Maine Epidemiologist on Call
MSE	Medical Screening Examination
MSP	Maine State Police
MOU	Memorandum of Understanding
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NEDSS	National Electronic Disease Surveillance System
NNEPC	Northern New England Poison Control
NOK	Next of Kin
OLMC	Online Medical Control
OSHA	Occupational Health and Safety Administration
PAPRS	Powered Air Purifying Respirators
PCR	Polymerase Chain Reaction
PETS	Pets Evacuation and Standards Act
PHEOC	Public Health Emergency Operations Center
PHEP	Public Health Emergency Preparedness
PHN	Public Health Nurse
PIO	Public Information Officer
PPE	Personal Protective Equipment
PPH	Portland Public Health

PSAP	Public Safety Answering Points
PT	Prothrombin
PTT	Partial Thromboplastin Times
PUI	Persons Under Investigation
REACT	Regional Ebola Assessment, Care and Transport
RRC	Regional Resource Centers
SA	Survey Agencies
SC	Survey and Certification
S Drive	Shared Drive
State EOC	State Emergency Operations Center
SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOP	Standard Operating Procedure
U.S. CDC	United States Centers for Disease Control and Prevention
VSPB	Viral Special Pathogens Branch
WebEOC	Web-based IT Platform