Indiana Department of Health

SPECIAL PATHOGENS STATE OPERATIONS PLAN

Indiana Department of Health

November 2022

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PROMULGATION STATEMENT

KRISTINA BOX, M.D., FACOG
STATE HEALTH COMMISSIONER
INDIANA DEPARTMENT OF HEALTH
SPECIAL PATHOGENS STATE OPERATIONS PLAN (SPSOP)
PROMULGATION

The primary role of government is to provide for the welfare of its citizens. The welfare and safety of citizens is never more threatened than during disasters. The goal of emergency management is to ensure that mitigation, preparedness, response, and recovery actions exist so that public welfare and safety are preserved.

The SPSOP provides a comprehensive framework for statewide emergency management during an infectious disease emergency. It addresses the roles and responsibilities of government organizations and provides a link to local, state, federal, and private organizations and resources that may be activated to address disasters and emergencies in the State of Indiana.

The SPSOP ensures consistency with current policy guidance and describes the interrelationship with other levels of government. The plan will continue to evolve, responding to lessons learned from actual disaster and emergency experiences, ongoing planning efforts, training and exercise activities, and federal guidance.

Therefore, in recognition of the public health emergency preparedness and response responsibilities of state government and with the authority vested in me as the State Health Commissioner of Indiana, I hereby promulgate the Special Pathogens State Operations Plan.

SIGNATURE PAGE

Kristina Box, M.D., FACOG, State Health Commissioner
Indiana Department of Health (IDOH)

Lindsay Weaver, M.D., FACEP, Chief Medical Officer
Indiana Department of Health (IDOH)

Eric Hawkins, M.S., State Epidemiologist & Director
Indiana Department of Health (IDOH)
Infectious Disease Epidemiology & Prevention Division

Megan Lytle, Director
Indiana Department of Health (IDOH)
Division of Emergency Preparedness

Derek Sebold, MPH, CPH, Planning & Preparedness Manager
Indiana Department of Health (IDOH)
Division of Emergency Preparedness

EXECUTIVE SUMMARY

In the past two decades, the world has encountered several special pathogens or high consequence infectious disease (HCID) outbreaks that have traveled from country to country. HCIDs are easily transmissible and highly fatal, and often not preventable through routine vaccination. HCIDs include viral hemorrhagic fevers (VHFs) like Ebola Virus Disease (EVD), Crimean Congo, Lassa and Marburg, as well as special respiratory infectious diseases such as highly pathogenic avian influenza, Middle Eastern Respiratory Syndrome coronavirus (MERS-CoV), severe acute respiratory syndrome (SARS), and, more recently, the novel coronavirus (COVID-19) global pandemic.

The introduction of a HCID into a population with little or no immunity could lead to an infectious disease emergency and quickly overwhelm healthcare systems. Patients affected by HCIDs usually develop severe symptoms and require a level of specialized care from trained frontline personnel (healthcare workers, first responders, etc.). In response to the 2014-2015 outbreak of EVD in West Africa and the risk of domestic cases from international travel, the United States developed a tiered approach to healthcare preparedness, which consisted of frontline, assessment, and treatment centers. Frontline centers include all locations that provide emergency care, including hospital-based emergency departments, critical access hospitals, and urgent care clinics. These frontline centers were tasked with quickly identifying and isolating potential EVD patients before a safe transfer to a treatment center could be arranged.

The COVID-19 pandemic uncovered many vulnerabilities in infectious disease emergency preparedness within the U.S. healthcare infrastructure and simultaneously reinforced the importance of special pathogen readiness capabilities. Current preparedness efforts focus on a shift to more inclusive terminology such as “frontline” and “treatment” centers, and less emphasis on Ebola-specific and “assessment hospital” designations. In cooperation with Indiana University (IU) Health Methodist Hospital’s Special Pathogens Unit (SPU), the State of Indiana has designated its first special pathogen treatment center.

RECORD OF CHANGES

Change #	Date	Section Affected	Date Posted	Who Posted

RECORD OF DISTRIBUTION

Plan #	Office/Department	Representative	Signature

PLANNING AGENCIES

Within each plan or annex, an agency or organization has been given the designation of primary, supporting, non-governmental or local agencies based on their authorities, resources and capabilities. The primary agency identifies the appropriate support agencies that fall under this plan and collaborates with each entity to determine whether they have the necessary resources, information and capabilities to perform the required tasks and activities within each phase of emergency management, including activations in the State Emergency Operations Center (SEOC) and impacted areas. Although an agency may be listed as a primary agency, it does do not control or manage those agencies identified as supporting agencies. The agencies listed below are part of the Whole Community Planning Committee for this plan/annex.

IDOH AGENCY DIVISIONS

IDOH Agency Divisions	
Division	**Planning Functions**
Infectious Disease Epidemiology and Prevention Division	The planning function of the Infectious Disease Epidemiology and Prevention Division is to provide subject matter expertise over disease surveillance, investigation, and monitoring.
Finance Division	The planning function of the Finance Division is to provide subject matter expertise on the provision of funds and tracking of resources before, during, and after an emergency response.
Office of Public Affairs	The planning function of the Office of Public Affairs is to provide subject matter expertise and to approve and provide guidance about public-facing communications.
Environmental Public Health Division	The planning function of the Environmental Public Health Division is to provide subject matter expertise on the prevention and control of environmental health and safety hazards.
Public Health Laboratories	The planning function of the Public Health Laboratories is to provide subject matter expertise of specific, high-quality laboratory tests, test data, and test interpretations.
Division of Emergency Preparedness	The planning function of the Division of Emergency Preparedness is to provide relevant public health plans and consult with relevant divisions in order to obtain subject matter expertise.
Local Health Department Outreach Division	The planning function of the Local Health Department Outreach Division is to provide subject matter expertise on outreach to local public health divisions.

Refer to **Assignment of Responsibilities** section of this plan for additional details on IDOH Agency Divisions.

SUPPORTING STATE AGENCIES

ESF 1: Transportation		
Primary Agency	**Support Agencies**	**Planning Functions**
Indiana Department of Transportation (INDOT)	IDHS, ISP, INNG, IDOE, IDOC, IDOA, BOAH, SPD, IDOL, IDOH	Subject matter expertise on state public road support; transportation safety; restoration/ recovery of transportation infrastructure; movement restrictions; damage and impact assessment
ESF 5: Emergency Management		
Primary Agency	**Support Agencies**	**Planning Functions**
Indiana Department of Homeland Security (IDHS)	All	Subject matter expertise on coordination of incident management and response efforts; issuance of mission assignments; resource and human capital; incident action planning; financial management for immediate response needs
ESF 8: Public Health and Medical Services		
Primary Agency	**Support Agencies**	**Planning Functions**
Indiana Department of Health (IDOH)	IDHS, EMS, INDOT, INNG, ISP, OFBCI, FSSA, BOAH, Dept. of Commerce, IDOA, State Budget Agency, IURC, Dept. of Insurance, Dept. of Labor, SPD, State Treasurer, IHA	Provide subject matter expertise on public health; medical support; mental health services; mortuary services
ESF 10: Oil and Hazardous Materials Response		
Primary Agency	**Support Agencies**	**Planning Functions**
Indiana Department of Environmental Management (IDEM)	IDNR, IDHS-HAZMAT, INDOT, IDOH, ISP, INNG, EMS, Dept. of Insurance, FSSA, IDOA, SPD	Subject matter expertise on oil and hazardous materials (chemical, biological, radiological, etc.) response; spill restoration, short-and long-term environmental cleanup
ESF 13: Public Safety and Security		
Primary Agency	**Support Agencies**	**Planning Functions**
Indiana State Police (ISP)	IDNR, State Excise Police, INNG, IDHS, Dept. of Correction, Dept. of Labor, IDOH, FSSA, INDOT, IDOA	Subject matter expertise on law enforcement and military assistance; security planning and technical resource assistance; public safety/security support/escort support; support to access, traffic, crowd control and evacuation

LOCAL ORGANIZATIONS

Local Organizations	
Organization	**Planning Functions**
Local Health Departments	Subject matter expertise on local health department functions/capabilities
Indiana Frontline Centers	Subject matter expertise on assessment of HCID PUIs
Indiana Emergency Medical Service Providers	Subject matter expertise on assessment of HCID PUIs
Indianapolis Emergency Medical Services (IEMS)	Subject matter expertise on assessment of HCID PUIs
Indiana District Healthcare Coalitions (HCCs)	Subject matter expertise on healthcare coalition (HCC) functions/capabilities

HHS DOMAINS AND PREPAREDNESS CAPABILITIES MATRIX

The information in this section was derived from the Centers for Disease Control and Prevention (CDC)'s Public Health Emergency Preparedness Capabilities, the Administration for Strategic Preparedness and Response (ASPR) Health Care Preparedness and Response Capabilities, as well as the Health and Human Services (HHS) Domains. The domains and capabilities relevant to the plan are highlighted in grey and **bolded** as necessary as shown in the table below. The aim of this section is to illustrate what phase of response the plan being presented is utilized in, as well as identify with, which capabilities this plan will fulfill.

ASPR Health Care Preparedness and Response Capabilities	
1	**Foundation for Healthcare and Medical**
2	**Healthcare and Medical Response Coordination**
3	Continuity of Healthcare Service Delivery
4	Medical Surge

CDC Public Health Emergency Preparedness and Response Capabilities			
1	**Community Preparedness**	9	**Medical Materiel Management and Distribution**
2	Community Recovery	10	Medical Surge
3	**Emergency Operations Coordination**	11	Nonpharmaceutical Interventions
4	**Emergency Public Information and Warning**	12	**Public Health Laboratory Testing**
5	Fatality Management	13	**Public Health Surveillance and Epidemiological Investigations**
6	**Information Sharing**	14	**Responder Safety and Health**
7	Mass Care	15	Volunteer Management
8	Medical Countermeasures Dispensing and Administration		

DOMAINS					
Community Resilience	Incident Management	Information Management	Surge Management	Countermeasures and Mitigation	Biosurveillance
Foundation for Healthcare and Medical Readiness Community Preparedness Community Recovery	**Foundation for Healthcare and Medical Readiness** **Healthcare and Medical Response Coordination** Continuity of Healthcare Service Delivery **Emergency Operations Coordination**	**Healthcare and Medical Response Coordination** **Public Information and Warning** **Information Sharing**	Continuity of Healthcare Service Delivery Medical Surge Fatality Management Mass Care Medical Surge Volunteer Management	**Foundation for Healthcare and Medical Readiness** Continuity of Healthcare Service Delivery Medical Countermeasure Dispensing **Medical Materiel Management and Distribution** Non-Pharmaceutical Interventions **Responder Safety and Health**	**Public Health Laboratory Testing** **Public Health Surveillance and Epidemiological Investigation**

COMMUNITY LIFELINES

A lifeline provides indispensable service that enable the continuous operation of critical business and government functions and is critical to human health and safety or economic security. In the table below, community lifelines are identified, and those relevant to the plan are highlighted.

Community Lifelines	
Lifelines	**Functions**
Safety and Security	Law Enforcement/Security, Search and Rescue, Fire Services, Government Services, Community Safety
Communications	Infrastructure, Alerts, Warnings and Messages, 911 and Dispatch, Responder Communications,
Food, Water, Sheltering	Food, Water, Shelter, Agriculture
Transportation	Highway/Roadway, Mass Transit, Railway, Aviation, Maritime
Health and Medical	Medical Care, Patient Movement, Public Health, Fatality Management, Medical Supply Chain Responder Communications, Financial Services
Hazardous Material	Facilities, Non-Fixed Sites
Energy (Power and Fuel)	Power, Fuel

I. Introduction

A. Purpose

The purpose of the Special Pathogens State Operation Plan is to describe the procedures for identification and response of a high-consequence infectious disease (HCID) emergency from the State at an operational level. It is to provide guidance for all response partners involved in the efforts to reduce the morbidity, mortality, social, and economic disruption caused by an infectious disease emergency.

B. Scope

The scope of this plan is limited to describing the operational intent when responding to persons under investigation for a suspected, as well as a confirmed, HCID/special pathogen in the State of Indiana. This plan includes considerations for public health agencies, Emergency Medical Services (EMS), and healthcare systems.

This document supplements policy and procedures contained in the National ESF-8 Public Health and Medical Services Annex and is consistent with the National Incident Management System (NIMS). This plan is an annex to the Infectious Disease State Operations Plan. It is to be utilized in conjunction with the Infectious Disease State Operations Plan, as well as with other Indiana Department of Health plans that include (but are not limited to):

- **IDOH Emergency Operation Plan / Framework**
- **ESF-8 Annex of State Emergency Operations Plan**
- **Medical Countermeasures (MCM) Operations and Distribution Plan**

Local health departments, including county and tribal health departments, are important local response entities for community-level planning and response activities. Frontline Centers, healthcare providers, emergency medical agencies, and other first responders play an essential role at the frontline of a special pathogen public health emergency response. All stakeholders involved in a special pathogen response within the State of Indiana are encouraged to provide ongoing input on the Special Pathogens State Operations Plan to ensure effective collaboration and coordination of future response efforts.

C. Jurisdictional Information

Indiana is a state located in the Midwest region of the United States. The population of Indiana is 6.697 million (as of the 2020 Census) and has a population density of approximately 181 people per square mile, ranking it as the 16th most densely populated state in the country. Its capital and largest city is Indianapolis, with a population of 892,656 (as of the 2020 Census) and a population density of approximately 2,469 people per square mile. The major airport within the state is the Indianapolis International Airport (IND), which served 7,175,979 passengers in 2021. There is no CDC Quarantine Station on-site at IND. Indiana may be covered by CDC Quarantine Stations at international airports in neighboring states in Illinois (Chicago – O'Hare (ORD)) and Michigan (Detroit (DTW)), which have been identified as sites for enhanced screening and surveillance activities during times of increased risk for a special pathogen-related outbreak. There are 92 counties and 94 local health departments within the state. Marion County is the largest county, with a population of 957,337 (as of the 2020 Census) and a population density of 2,466 people per square mile.

D. Special Pathogen Definitions

Special pathogens consist of highly infectious biological agents that include bacteria, viruses, or toxins; they are associated with high morbidity and high mortality within a population with little to no immunity. Special pathogens may have a high likelihood of person-to-person spread and may lack an effective vaccine, prophylaxis, or treatment. Depending on the severity, these pathogens may prompt the use of a specialized biocontainment unit (BCU) due to public health concerns. Special pathogens include (but are not limited to):

- **Viral Hemorrhagic Fevers (VHFs)**
    - Ebola virus
    - Marburg
    - Lassa
- **Special Respiratory Pathogens**
    - Middle Eastern Respiratory Syndrome Corona virus (MERS-CoV)
    - Severe Acute Respiratory Syndrome (SARS)
    - Novel influenza strains (e.g., H3N1, H5N1, H7N9)

For consistency purposes, special pathogens and high-consequence infectious diseases (HCID) will be used interchangeably throughout this document.

E. Planning Assumptions and Limitations

As it is impossible to address every variable impacting the effectiveness of a plan, every plan relies upon several assumptions coupled with limitations. The following is a list of possible assumptions and limitations, informing the audience of necessary conditions for a successful execution of the plan, in addition to caveats that may exist within planning content.

1. Planning Assumptions

- IDOH staff and supporting partnering agencies are aware of their roles and responsibilities as outlined in this plan.
- Agency subject matter experts will share the most up-to-date information, maintaining a common operating picture.
- The public will likely be worried over a special pathogens public health emergency and will require information and reassurance, which will involve crisis emergency risk communication (CERC).
- The State of Indiana Emergency Operations Center (SEOC) may be activated if widespread transmission occurs.
- All healthcare facilities in Indiana are referred to as "**Frontline Centers."**
- Necessary information will be disseminated to the public, as needed, ensuring appropriate action is taken by the public.
- During known outbreaks in which there is a greater risk of special pathogen-related cases presenting in the U.S., frontline and treatment centers maintain awareness of current disease-specific guidance.
- Healthcare workers are able to identify symptomatic people whose travel history suggests possible exposure to a special pathogen or other diseases endemic to a region and are equipped with appropriate PPE, patient isolation measures, and basic supportive care, and they will inform and consult with public health officials.
- Notification of hospitals by EMS will occur at the earliest possible opportunity when transporting a patient identified as potentially at risk for a special pathogen disease.
- The patient, also known as a "person under investigation" (PUI), will be assessed based on travel history and other screening protocols that frontline or treatment centers have in place (e.g., enhanced travel screenings).

2. Planning Limitations

- This plan is specific in nature to viral hemorrhagic fevers and special respiratory pathogens; however, with slight modification, it may describe operations for responding to other infectious disease/public health emergencies, including anthrax and smallpox.

- Indiana has one designated treatment center (IU Health Methodist); however, many of the frontline centers maintain advanced healthcare treatment capability meeting or, in some cases, surpassing the requirements of a special pathogen treatment center.
- This plan does not address the specific epidemiological and disease surveillance plans and protocols, nor does it address the medical treatment or protocols provided by healthcare services.
- This plan does not address many of the regulatory and work safety regulations and practices set forth through statutes or other organizations.
- Enhanced travel screening is currently not implemented for special pathogen diseases and may or may not be implemented in the future.

II. Concept of Operations

A. General

During an infectious disease emergency response, the Indiana Department of Health (IDOH) has the overall responsibility of activating the Special Pathogens Disease State Operations Plan. IDOH coordinates all items relating to public health and medical, with the ultimate goal of preserving life and safety in the State of Indiana. Although IDOH has overall coordinating responsibility, numerous organizations and agencies will prepare for and respond to a person under investigation (PUI) for a high-consequence infectious disease (HCID) or patients confirmed with an HCID. The following sections will provide response details, including all direction, control, and coordination activities.

B. Background and Overview

Although special pathogen-related diseases are rare, they are often deadly and have high case fatality rates if left untreated. Travel-associated and emerging/re-emerging diseases may present at any time, to any facility, at any stage of illness, and it may be difficult to recognize a special pathogen-related illnesses based on nonspecific symptoms. The following section provides a general description of two specific categories of special pathogens (VHFs and special respiratory), as well as general precaution and containment procedures.

1. Viral hemorrhagic fevers (VHFs)

Viral hemorrhagic fever (VHF) is a general term for an illness caused by members of several different viral families. This plan will focus on viruses that initially present with similar symptoms and may progress to more severe forms of illness, which include Ebola Virus Disease (EVD), Marburg, and Crimean-Congo hemorrhagic fever (CCHF). A majority of these viruses are restricted within their geographic range by limitations of natural host species, which usually include rodents, insects, and bats. As a result of these geographic limitations, a comprehensive travel history from the patient is essential for rapid diagnosis and case management.

Symptoms of VHFs can appear anywhere from 2 to 21 days after exposure and can include fever, headache, joint and muscle aches, weakness, diarrhea, vomiting, stomach pain, and abnormal bleeding. The most likely scenario of a person first identified as potentially having EVD will occur through patient screening when an individual seeks medical attention.

VHFs, such as EVD, are transmitted through direct contact with blood or bodily fluids of an infected, symptomatic person or through exposure to contaminated objects (e.g. needles, improperly decontaminated surfaces). VHF pathogens can remain in some body fluids (e.g.,

semen) of survivors longer than previously suspected, as seen in EVD cases. Therefore, transmission from asymptomatic survivors is possible. Other transmission considerations include:

- People are not contagious until they develop symptoms
- People at highest risk for VHF transmission include healthcare workers and other people with direct contact with infected/symptomatic people
- Effective isolation of patients and appropriate infection control measures can help contain potential spread

2. Special Respiratory Pathogens

A viral respiratory disease presents a significant risk to Indiana, as it has the potential to cause high levels of morbidity and mortality, challenge the ability of the state health system response, as well as disrupt communities both socially and economically. These diseases have the greatest potential to cause pandemics (as seen in the COVID-19 global pandemic), due to a strong link between the emergence of novel pandemic virus strains and human-animal (zoonotic) transmission. Examples include novel influenza strains transmitted by birds (H5N1) and pigs (H1N1 Swine flu); coronaviruses, which include Severe Acute Respiratory Syndrome (SARS) linked to bats and Middle East Respiratory Syndrome (MERS) linked to camels. Both influenza and coronaviruses are known to have high genetic mutation rates, leading to a high possibility for emerging novel viral strains to humans. These novel virus strains have the capability to cause significant morbidity and mortality due to a lack of immunity in human populations.

Special respiratory viruses such as influenza have non-specific symptoms characterized by fever, headache, muscle aches, fatigue, runny nose, sore throat and cough. Transmission occurs from person to person through respiratory droplets as a result from coughing or sneezing, or direct contact with respiratory secretions. Influenza is generally infectious a day prior to until 5-7 days after symptom onset (some individuals may be asymptomatic and potentially infectious for up to 3 weeks).

Coronaviruses (CoV) belong to a large family of viruses that cause illnesses ranging from the common cold to more severe respiratory diseases, with complications such as pneumonia. Transmission often occurs person to person through close contact with an infectious person, contact with respiratory droplets, or touching objects or surfaces (fomites) in contact with respiratory droplets from an infected person. Case definition for special respiratory diseases is highly variable; however, it is usually characterized by fever or acute respiratory infectious

(shortness of breath or cough) and can have an infectious period of up to two weeks (14 days).

C. Capabilities

Indiana has over 160 hospitals throughout the state. All Indiana hospitals, as well as ambulatory surgical centers, rural health clinics, and other healthcare facilities, are considered Frontline Centers within the state. Indiana continues to work with local healthcare and public health partners, such as the CDC and HHS. The IDOH continues to work with other states within HHS Region V on the continued development of the **HHS Region V: Ebola Virus Disease Coordination and Transportation Plan**.

The **Indiana University Health Methodist Special Pathogen Unit (IUH SPU)** was established in 2014 in response to the West Africa Ebola outbreak and currently serves as the only treatment hospital within the State of Indiana with special pathogen readiness capabilities. The IUH SPU suite consists of a single critical care patient room with one bed, and a separate doffing space. There is a holding room for waste, equipment used in patient care, and for decontamination of purified air powered respirators (PAPRs). The suite has 3-4 additional rooms that could be used for non-critical care, with an option of additional individual room HEPA filters. The unit is supported by nurses, respiratory therapists, infection preventionists, microbiologists, as well as Infectious Disease and Critical Care physicians who volunteer and are trained to care for SPU patients. Additionally, the unit is equipped with ancillary support from pharmacy, environmental services, employee health and facilities at IU Health Methodist Hospital.

D. Initial Actions

Situational awareness and monitoring of communicable disease outbreaks of international and public health concern is critical. A response is initiated though rapid detection and initial actions taken in the event of a potential HCID patient. If enhanced airport screening and traveler monitoring are not done, the mostly likely identification of an HCID individual is through patient screening. The IDOH follows the CDC-recommended guidance of: **Identify**, **Isolate**, and **Inform.**

1. Identify

It is essential that all healthcare facilities, EMS, Dispatch and call centers, as well as other organizations that interact with individuals reporting illness, continue the practice of screening individuals' travel and exposure history and are aware of symptoms associated with each disease.

- **For VHFs, does the individual:**

- have a fever greater than 100°F (38°C); **and/or**
- have symptoms of headache, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage?

- **For special respiratory infections, does the individual:**
  - have a fever greater than 100°F (38°C); **and/or**
  - have symptoms of coughing, shortness of breath, chills, body aches, sore throat, headache, vomiting, diarrhea?

Individuals with travel to regions where special respiratory or VHF outbreaks occur, or exposure to individuals with infections of high consequence, should be considered as potential persons under investigation.

- **For VHFs, has the individual:**
  - Lived in or traveled to a country with an active VHF outbreak within the past 21 days, or
  - Had contact with an individual with confirmed VHF within the past 21 days?
- **For special respiratory infections, has the individual:**
  - Lived in or traveled to a country with an active outbreak of special respiratory disease within the past 14 days, or
  - Had contact with an individual with confirmed special respiratory disease within the past 14 days?

In cases where Indiana has implemented a traveler monitoring program, the identification of these individuals with travel or exposure risk may already be known by the state and local health departments and monitored for HCID-like symptoms. Travelers with symptoms are instructed to notify the local health department and NOT present at a healthcare facility or call 911.

2. Isolate

If a person has been identified with a positive travel or exposure history and is symptomatic, the person becomes a person under investigation (PUI). A PUI who has presented at a healthcare facility should immediately be placed in a private room or space enclosed area with private bathroom as soon as possible. If a special respiratory patient has been

identified, the patient should be placed in an airborne infection isolation room (AIIR) if available.

Responding EMS should isolate themselves from the patient if identified as a PUI, including backing out of the residence. Only essential personnel with designated roles should evaluate the patient and provide care to minimize transmission risk. The use of personal protective equipment (PPE) appropriately determined based on the patient's clinical status and symptoms (i.e. bleeding, vomiting, diarrhea, or other bodily fluid release, or clinical need for potentially aerosolizing procedures).

3. Inform

After a person has been identified and isolated, the appropriate personnel within the healthcare facility or agency should be notified, as well as immediately notifying the IDOH. The patient should remain in isolation. The IDOH will work with the local health department, the CDC, and the appropriate Frontline Center personnel as needed to provide further direction. EMS or 911 should not be called unless the patient is experiencing life-threatening symptoms.

E. IDOH Notification

The initial notification to the IDOH begins the response phase of IDOH to a PUI or confirmed HCID patient. This initial notification should occur in one of three ways:

1. An individual with a positive travel or exposure history (21 days for VHF-like symptoms; up to 14 days for special respiratory pathogens) is experiencing signs and symptoms at a healthcare facility, to EMS, or local public health department. The IDOH has been notified after isolating the patient.

2. Enhanced traveler screening is being conducted and IDOH has implemented a level of monitoring. A monitored individual has become symptomatic, and the local health department has notified the IDOH Epidemiologist on Call or Traveler Monitoring Team, if active.

3. An individual with confirmed VHF or special respiratory pathogen is being transported through Indiana to a Treatment Center in an adjacent state or to a Regional Ebola and Other Special Pathogen Treatment Center (RESPTC). The IDOH has been notified as part of the **HHS Region V: Ebola Virus Disease Coordination and Transportation Plan** with plans to stop at an Indiana Frontline Center as a transfer point.

Upon receiving notification, the IDOH will notify the CDC Emergency Operations Center as appropriate.

The IU Health Methodist Special Pathogens Unit (SPU) is comprised of a multidisciplinary team of infectious disease experts. During the early notification of probably cases, the SPU may provide consultation to assist frontline facilities in patient care and management. This consultation may involve the assessment and treatment of HCIDs.

F. Coordination Call

Once IDOH has been notified, IDOH will prepare for a coordination call with all parties with an active role in the ongoing care and transportation of the PUI or patient. The purpose of the coordination call is to develop a plan of action for safe and timely movement of the PUI or patient to a Frontline Center for further diagnosis and confirmation of an infectious disease of high consequence, with considerations made based on the person's clinical condition and risk.

Epidemiological risk factors are evaluated for the person, based on the factors known at the time. These risk factors are utilized in the implementation of public health actions such as monitoring and movement restrictions, as well as healthcare and treatment actions. There are four primary levels of risk defined by the CDC:

- High Risk
- Some Risk
- Low (but not zero) Risk
- No Identifiable Risk

See **Appendix C – Epidemiological Risk Factors and Categories.**

When enhanced screening is implemented, the CDC makes risk-level determinations upon entry to the US. These risk factors are communicated to the IDOH, where they are reviewed and modified (higher risk category only) if appropriate.

The coordination call includes the following parties as applicable:

- IDOH Executive Staff
- IDOH Infectious Disease Epidemiology & Prevention Division (IDEP)
- IDOH Laboratory
- IDOH Division of Emergency Preparedness
- IDOH Office of Public Affairs
- Local Public Health Department(s) (current, home, or receiving jurisdiction if different)

- Other State Health Department(s) if applicable
- Healthcare Facility or EMS with PUI or Patient
- Nearest available Frontline Center if applicable
- IU Health Methodist Hospital Special Pathogens Unit (SPU)
- Other Treatment Center or Regional Ebola and Other Special Pathogen Treatment Center (RESPTC) if applicable
- Transporting EMS if applicable
- Centers for Disease Control and Prevention (CDC)

The call will discuss the following items:

- Review of travel or exposure history
- Review of current signs and symptoms
- Current location and clinical status
- In-home testing availability if applicable
- EMS availability and readiness for transport if applicable
- Frontline Center availability and readiness if applicable
- Transportation plan if transporting a patient through Indiana to other State
- Any additional needs or discussion

Additional coordination calls will occur as needed, throughout the care of the individual. These additional calls may vary in scope and purpose, and will be adjusted as needed.

G. PUI Transporation to Frontline Center

1. Transportation from PUI Home to Frontline or Treatment Center

Responding to a possible PUI residence requires an integrated approach based on information from the caller and dispatcher.

Depending on the initial patient assessment, the PUI may be transported to either a Frontline Center or a treatment center. This decision may also be dependent on the PUI's geographical location.

2. Transportation from Frontline to Treatment Center

If it is determined from the IDOH coordination call that the PUI will be transferred from the Frontline Center to the IU Health Methodist Treatment Center, EMS will transport the PUI. The EMS performing the transport may be based on the following circumstances:

1. The EMS already on scene, or from the jurisdiction the PUI is currently in or from, may serve as the transporting unit if properly trained, equipped, and authorized to transport to the determined Treatment or Frontline Center.

2. The Frontline Center may request an EMS service special response team in Special Pathogen Preparedness during the assessment process. This special response team will serve as the transporting unit if it has the current capabilities (e.g., trained personnel, necessary equipment) and authorized to transport the PUI from the current location.

3. The District Healthcare Coalition or District Planning Council may have identified a specific EMS service capable and authorized to perform a PUI transport that may provide transportation.

4. The IDOH maintains a contract with the Indianapolis Emergency Medical Services (IEMS) that will serve as a backup statewide for PUI transports.

The determination of the EMS service performing the transport should occur during the IDOH coordination call. However, if such determination cannot be made, the IDOH DEP will work with the local public health department(s) and the Frontline Center to make the determination and facilitate the request, up to and including IEMS if needed.

Transportation will occur in sync with the Frontline Center, ensuring that the PUI does not arrive at the hospital prior to full activation and staffing. The Frontline Center will confirm readiness with the EMS provider.

All Frontline Centers provide for EMS the means for disposal of contaminated waste arising from the delivery of PUIs to their facility for evaluation. An area for decontamination of ambulances is provided at Frontline Centers. EMS personnel providing the transport and contact with the PUI will be referred to the jurisdiction's local public health department for any monitoring or follow-up procedures.

H. Assessment and Confirmation

Once a PUI arrives at a Frontline Center, care will be provided consistent with the facility's special pathogen response plan. Testing of the patient's blood will occur in conjunction with the IDOH Laboratory to confirm a diagnosis. If it is determined that a PUI may remain home instead of transport to a Frontline Center, testing may occur remotely to confirm a result.

PUIs that have a negative confirmation for an HCID may be treated appropriately for the current illness and released per hospital protocols when appropriate.

I. Positive High-Consequence Infectious Disease Diagnosis

If a PUI confirms positive for a high-consequence infectious disease (HCID), the PUI becomes a HCID patient. Upon confirmation of an HCID patient, IDOH will convene a coordination call with the Frontline Center, local public health department, and CDC to discuss the diagnosis. IDOH executive staff will communicate appropriately with the Governor's office and the Indiana Department of Homeland Security.

J. Treatment

Several treatment options are available in Indiana and will be discussed in conjunction with the IDOH, Frontline Center, IU Health Methodist, CDC, and local public health departments. Treatment options include:

1. Remain at the Frontline Center for treatment

IU Health Methodist currently serves as the only special pathogen treatment center in the State of Indiana; however, all frontline centers have capabilities greater than baseline criteria, and in some cases also surpass the requirements of a treatment center. The Frontline Center may elect to treat the HCID patient.

2. Transfer the Patient to another Frontline Center for treatment

If the current Frontline Center elects to transfer the patient following diagnosis, another Indiana Frontline Center may elect to treat the HCID patient.

3. Transfer the Patient to IU Health Methodist (Treatment Center) for treatment

IU Health Methodist Hospital is currently the only state-designated special pathogens treatment center in the State of Indiana. The SPU has trained staff and resources capable of treating special pathogens.

4. Transfer the Patient to a Treatment Center out of state

Indiana is geographically surrounded by Treatment Centers from Michigan (6), Illinois (4), and Ohio (1). The IDOH may facilitate communications with neighboring states to determine treatment options and availability.

5. Transfer the Patient to a Regional Ebola and Other Special Pathogen Treatment Center (RESPTC)

The designated Regional Ebola and Other Special Pathogen Treatment Center (RESPTC) for HHS Region V is the University of Minnesota Medical Center - West Bank Campus,

Minneapolis, MN. The selection of this option will initiate the **HHS Region V: Ebola Virus Disease Coordination and Transportation Plan**.

K. HCID Patient Transport

Once the treatment course and location have been determined, IEMS is the primary EMS provider for HCID patient transportation. The transportation destination will be based on the preceding treatment options but will be one of the following:

- Frontline Center electing to treat an HCID patient
- IU Health Methodist Hospital (in-state Treatment Center)
- Out-of-state Treatment Center
- Designated airport for air transport to the Regional Ebola and Other Special Pathogen Treatment Center (RESPTC)
- Out-of-state transfer point for ground transport to the RESPTC

The IDOH, originating Frontline Center, local public health department, IEMS, CDC, and receiving hospital will have a coordination call to confirm specific times for pick up, travel time, and estimated time of arrival.

If the patient is being flown to the RESPTC as the preferred transport method, HHS provides air transportation in accordance with the **HHS Region V: Ebola Virus Disease Coordination and Transportation Plan**. The IDOH will work with the Indiana Department of Transportation (INDOT), the primary ESF-1 Transportation, to determine the availability and appropriate airport.

In addition, IDOH may request the Indiana State Police, the primary ESF-12 Public Safety, for escort or security purposes if appropriate. All Frontline Centers provide for EMS the means for disposal of contaminated waste arising from the delivery of PUIs to their facility for evaluation. EMS transporting to an airport shall return back to the originating Frontline Center for decontamination and waste disposal. An area for decontamination of ambulances is provided at Frontline Centers. EMS personnel providing the transport and contact with the PUI will be referred to the jurisdiction's local public health department for any monitoring or follow-up procedures.

L. Termination of Response

All individuals involved with the care or close proximity of an HCID patient will undergo the prescribed health monitoring following the last exposure (21 days for VHF; 14 days for special

respiratory pathogens). The response will conclude once there are no confirmed HCID patients in Indiana and the final monitoring has concluded.

M. Additional Planning Considerations

1. Access and Functional Needs

The State of Indiana works with public, private and non-profit organizations to build a culture of preparedness and readiness for emergencies and disasters that goes beyond meeting the legal requisites of people with disabilities as defined by the most current version of the Americans with Disabilities Act (ADA). IDHS integrates Federal Emergency Management Agency's Access and Functional Needs Framework, which is intended to ensure that individuals who have access and functional needs receive lawful and equal assistance before, during, and after a disaster or public health emergency

This framework also includes individuals with temporary needs or those who do not identify themselves as having a disability. This includes women who are pregnant, children, older individuals and individuals with limited English communication.

For the purposes of emergency preparedness and response, "needs" are organized into five categories:

Response Needs Categories (C-MIST)	
Categories	Definitions
C - Communications	Includes people who have limited or no ability to speak, see, hear or understand; may not be able to hear announcements, see signs, understand messages or verbalize their concerns during an incident or emergency
M - Medical	Includes individuals requiring assistance in managing activities of daily living, such as eating, dressing, grooming, transferring and going to the restroom
I - Independence	Includes people who are able to function independently if they have their assistive devices and/or equipment; items consist of mobility aids such as wheelchairs, walkers, canes, crutches; communication aids; medical equipment, such as catheters, oxygen, syringes, medications and service animals
S - Supervision	Includes people with supervision needs and may include those who have psychiatric conditions, such as dementia, Alzheimer's disease, schizophrenia, depression or severe

	mental illness; addiction problems; brain injury, or those who become anxious due to transfer trauma
T - Transportation	Emergency response requires mobility, and this category includes people who are unable to drive because of disability, age, temporary injury, poverty, addiction, legal restriction or lack of access to a vehicle; wheelchair accessible transportation may be necessary

"At-risk groups," also referred to as "populations with functional and access needs," require special attention in a disaster. During incidents, populations with specific functional and access needs are more likely to be adversely affected. These populations may include, but are not limited to, people with disabilities, older adults, and populations with limited English proficiency. Advanced planning is essential to ensuring that the specific needs of populations with access and functional needs are met. These needs may include assistance, accommodation or modification for mobility, communication, transportation, safety, or health maintenance.

2. Pediatrics

During an emergency or public health incident, young children are typically at a higher risk. They have yet to develop the resources, knowledge, or understanding to effectively cope with disasters, and they are more susceptible to injury and disease. Young children are also more vulnerable when they are separated from their parents or guardians, for example, at school or in daycare.

Pediatric-focused resources, experts, and facilities should be pre-identified for providing support to children. Pediatric planning includes ensuring there is sufficient access to age-appropriate medical supplies, mental health and age-appropriate support resources, coordination with dedicated children's healthcare facilities, and reunification with family members. Strategic partnerships should be formed when relevant and may include pediatric medical professionals and child-serving institutions such as schools and daycare centers.

3. Behavioral Health

Even in the suspected case of an individual with an infectious disease of high consequence, infectious disease outbreaks have unique characteristics that may increase fear and uncertainty due to misinformation about the causative agent, uncertainty about infection, and early stage symptoms that may be easily mistaken for a more well-known, benign illness (e.g., seasonal allergies). Additionally, patients and their families may find the appearance of

providers in PPE alarming, and patients in isolation may have higher mental health issues than those not isolated. Anger, anxiety, hostility, fear, and loneliness have higher prevalence in those who remain in medically ordered quarantine due to an HCID-related illness.

Healthcare workers (HCWs), public health professionals, and other responders can experience distress, anxiety, and fear for personal and family safety during an infectious disease response, and these conditions can linger long after the conclusion of the event. Counseling services through mental health providers at all levels of emergency response are essential to maintain community stability and cohesion.

Prompt and accurate public education is important at all levels of stakeholder engagement and should be disseminated through various mental health resources. Existing disaster public education campaigns, resources and initiatives can be found at the federal level and within Indiana through the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA).

4. Media and Mass Communication

If public knowledge exists about a potential PUI, there may be strong interest from the media and other special-interest groups. Local and state public health, EMS, and emergency management should work together through the Joint Information Center to carefully construct messages about the situation and its impact/risk to the public. Public relations for all stakeholders (state and local public health, Frontline Centers, etc.) should monitor traditional and social media for potentially inaccurate information and formulate a plan to proactively correct any misinformation (e.g., about contagion risk).

III. Direction, Organization, and Coordination

A. Direction

The overall authority for direction and control of the response is defined within this section. It typically includes reference that a medical emergency incident rests with the Governor, in conjunction with the State Health Commissioner (Title 10, IC 10-14-3, of the Indiana Code). The Governor Succession Act is contained in Article 5, Executive, of the Indiana State Constitution. The Governor is assisted in the exercise of direction and control activities by his/her staff in the coordination of activities by the Indiana Department of Health. The IDOH maintains a constant liaison with the federal government, state agencies, disaster relief organizations and other state disaster agencies.

In the event of an incident that requires activating the IDOH Special Pathogens State Operations Plan, the Indiana Department of Homeland Security (IDHS) will have a role as the state coordinating agency; IDHS will appropriately determine the Indiana State Emergency Operations Center (SEOC) activation level in support of the operations. The IDOH will be the lead response agency and the IDOH ESF-8 representative will provide a key coordination role for the incident, either directly at the SEOC or virtually. The IDOH may, though unlikely without multiple HCID patients, activate the IDOH Department Operations Center (DOC) to serve as a central command point between the CDC, the IDHS, District Healthcare Coalitions (HCC), local public health departments, Frontline Centers, and the IDOH if needed.

B. Organization

1. Principal of Incident Management

The National Incident Management System (NIMS) provides a unified approach to incident command, standard command and management structures and an emphasis on preparedness, mutual aid and resource management. NIMS is not an operational incident management or resource allocation plan, but a template to guide all levels of government, including private sector and nongovernmental organizations, to work together to prepare for, prevent, respond to, and recover from emergency incidents. NIMS implementation include process, operational and technical standards integrated into emergency response plans, procedures, and policies.

NIMS establishes the Incident Command System (ICS) as the organizational structure to be implemented to effectively and efficiently command and manage domestic incidents regardless of cause, size, or complexity. The ICS structure is a standardized, on-scene, all-hazard incident management concept that provides an integrated organizational structure

that is able to adapt to the complexities and needs of single or multiple incidents, regardless of jurisdictional boundaries.

Homeland Security Presidential Directive 5 (HSPD-5) requires all federal agencies and departments to adopt NIMS. The State of Indiana adopted NIMS as the state standard for incident management in Executive Order 05-09, or any subsequent Executive Order that replaces or supersedes it.

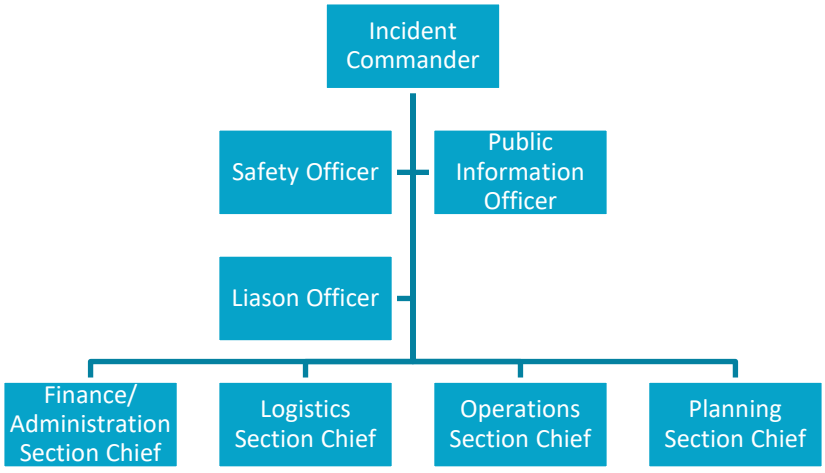
2. Incident Command System (ICS) / Public Health and Medical General Incident Command Structure

During large or small public health incidents, the Incident Command Structure (ICS) will be followed by all responders and responding agencies. The ICS is a standardized approach to incident management that:

- Is used for all varieties of incidents by all types of organizations and at all levels of government; ICS is applicable to incidents of all sizes
- Can be used for emergencies as well as planning events
- Enables a coordinated response among various jurisdictions and agencies
- Establishes a common process for incident-level planning and resource management
- Allows for the integration of resources with a common organizational structure

ICS is applicable to whether the IDOH Department Operations Center (DOC) is operational. Incident command, which could consist of a single Incident Commander or a Unified Command, will lead the effort and will assign command and general staff.

The following table is an example of a standard ICS command structure:



C. Internal Coordination

1. Department Operations Center (DOC)

The Indiana Department of Health (IDOH) Departmental Operations Center (DOC) is the location of centralized management for coordinating a public health and medical response to a disaster, in conjunction with the Indiana ESF-8 State EOC Representative. The purpose of the DOC is to bring together representatives from divisions of IDOH and its ESF-8 health and medical partners for more effective and efficient problem-solving and use of resources. The DOC operates only during, or in preparation for, disasters of a certain scale.

2. IDOH Policy Group / IDOH Strategic Advisory Committee

The committee serves as the overall IDOH Executive Policy, directing the activation of medical countermeasures, liaison to the Indiana Governor's Office, recommending public health emergency declarations, determining the allocation of limited resources, and providing overall command and authority to the IDOH response. See **IDOH Emergency Operations Plan / Framework** for more details. The committee may convene to review current employee absenteeism rates, review emerging contagious infectious diseases in the general public, and determine if action is needed. Actions can vary from minimalistic mitigation strategies to the full closure of an IDOH location. In the event of a closure, the extensive **IDOH Continuity of Operations Plan (COOP)** will be enacted.

3. Crisis and Emergency Risk Communications Plan

The IDOH utilizes Crisis and Emergency Risk Communication (CERC) during outbreaks and other disasters. CERC is a communication principle by the CDC built on six main principles:

1. **Be First:** Crises are time sensitive. Communicating information quickly is crucial. For members of the public, the first source of information often becomes the preferred source.

2. **Be Right:** Accuracy establishes credibility. Information can include what is known, what is not known, and what is being done to fill in the gaps.

3. **Be Credible:** Honesty and truthfulness should always be maintained.

4. **Express Empathy:** Crises create harm, and the suffering should be acknowledged in words. Addressing what people are feeling, and the challenges they face, builds trust and rapport.

5. **Promote Action:** Giving people meaningful things to do calms anxiety, helps restore order, and promotes some sense of control.

6. **Show Respect:** Respectful communication is particularly important when people feel vulnerable. Respectful communication promotes cooperation and rapport.

The IDOH Office of Public Affairs maintains an IDOH CERC Plan. This plan may be activated during the onset of an outbreak. As the situation expands and moves from a local emergency to a statewide emergency, public affairs will be coordinated more closely with other state agencies, up to and including the implementation of the State Joint Information Center (JIC).

D. Multi-Agency Coordination

The evolution of the size and complexity of hazards and threats has demonstrated the need for effective planning and coordinated emergency response. These events also show disasters have no geographical, economic, or social boundaries and involve multiple jurisdictions, agencies, and organizations. To effectively manage efforts of a multi-agency coordination system, the State of Indiana has adapted its planning and response capability based upon the following operational constructs:

1. State Emergency Operations Center

The Indiana State Emergency Operations Center (EOC) is the IDHS-managed physical location where multi-agency coordination occurs. The purpose of the State EOC is to provide a central coordination hub for the support of local, district, and state needs. The State EOC can be configured to expand or contract as necessary to respond to different levels of incidents requiring state assistance. The State EOC levels of activation are as follows:

Level	Name of Level	Description	Example
IV	Daily Ops	Normal daily operations; Watch Desk is monitoring activities within and around the state	Tornado Watch
An actual or potential for Incident of State Significance will drive the need for an increase in the activation/staffing levels			
III	Active Emergency Conditions	A situation has or may occur which requires an increase in activation of the state EOC, to include: section chiefs, JIC may be set up, limited ESF staffing, may have FED presence	Large Tornado >EF-3
II	Significant Emergency Conditions	A situation has or may occur which requires an increase in activation of the state EOC, to include: section chiefs, full ESF staffing, JIC will be set up, policy group will be activated, will have FED presence	Major Flooding
I	Full Emergency Conditions	A situation has or may occur which requires an increase in activation of the state EOC, to include: section chiefs, full ESF staffing, JIC will be setup, policy group is activated, Governor or designee present in policy group	Large Earthquake

The State EOC is staffed and organized with the Emergency Support Function (ESF) concept incorporated into an Incident Command System (ICS) structure. Agencies that represent ESF positions are activated in the State EOC during an incident to execute the response phase of emergency management. The designated primary and support agencies for the ESF positions in the State EOC can be arranged and tasked as needed by the IDHS Response Division Director of Operations. The ESF primary agencies remain responsible for the coordination of all phases of emergency management as outlined in their respective ESF annexes, regardless of their State EOC staffing assignments.

2. Executive Policy Group / IDHS Executive Policy Group

Emergencies and disasters can produce issues requiring prompt decisions to serve short- and long-term emergency management needs. The Executive Policy Group is a function of IDHS that may be established to address issues concerning the safety and welfare of Indiana residents, property, and the environment.

The Executive Policy Group may be activated to advise the Governor, local officials and the public and recommend protective actions to be taken during a radiological release. The Executive Policy Group may assemble in the SEOC to assist in coordination and decision-making.

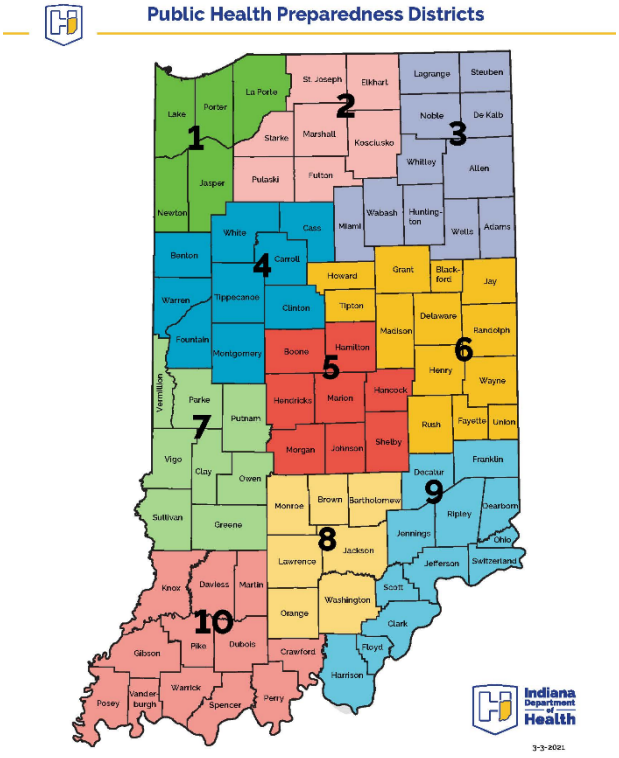
The composition of the Executive Policy Group consists of stakeholders with the authority to make policy-related decisions or make suggestions to support the state's response and technical evaluation during an incident, but it varies depending upon the type, size and complexity of the incident. The IDHS Executive Director or his/her designee will serve as chairperson of the Executive Policy Group. The Executive Policy group should consist of lead agency representatives from relevant ESFs, as well as subject matter experts as necessary.

3. Joint Information Center

During an incident or planned event, providing coordinated and timely public information is critical to helping the affected community. Effective and accurate communication to the public about an incident can save lives and property and help to ensure credibility and public trust. This vital public safety information is disseminated through various media outlets, including television, radio, print, websites, and social media. The JIC includes representatives from multiple agencies and organizations collaborating to provide a unified message regarding response and recovery efforts to the public. The IDOH Office of Public Affairs (OPA) is involved with these activities. Information regarding the provision of assistance is communicated in an accessible format from the JIC.

4. Indiana Districts

The district organization and planning concept is comprised of multiple jurisdictions, disciplines, and agencies. Together, they focus on common strategic goals and objectives to satisfy and meet national, state, and local homeland security and public safety needs. By coming together, many counties, local governments, and thestate benefit from sharing resources, eliminating redundancy in critical response activities, and



coordinating emergency planning, training, and exercise activities.

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While each district varies in infrastructure, organization, hazards, and other facets, several commonalities of Districts include: District Planning Councils, Healthcare Coalitions, Indiana District Response Task Forces, and other elements.

E. Information Management Systems

Information management for infectious disease will occur through various formats and access levels. The following is a list of some of the different information platforms utilized.

1. Essence

The Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) is a syndromic surveillance system developed by the Johns Hopkins University Applied Physics Laboratory. ESSENCE collects and analyzes data from participating hospital emergency departments and urgent care centers in Indiana. First started in Indiana in 2006, ESSENCE collects data that includes the patient's chief complaint or symptoms, age, sex, ZIP code, date and time of visit, and the hospital visited. Emergency departments are required to report syndromic data to the Indiana Department of Health in accordance with Indiana Administrative Code 410 IAC 1-2.4. Hospitals with emergency departments are to report all emergency department visits at the hospital within 24 hours from time of visit. Further guidance can be found in Indiana Administrative Code 410 IAC 1-2.4.

2. IHAN

The Indiana Health Alert Network (IHAN) is a mass notification system intended to distribute health alerts to healthcare providers and public health professionals across Indiana. The IDOH utilizes the IHAN system to alert local health entities and other partners, including volunteers, about public health emergencies, including pandemics. The IHAN communicates urgent information electronically to a wide audience of constituencies through a cascading network.

IHAN alert messages fall into one of the following categories:

Health Alert	Conveys the highest level of importance and warrants immediate action or attention
Health Advisory	Provides important information for a specific incident or situation and may not require immediate action of attention
Health Update	Provides updated information regarding incident or situation and is unlikely to require immediate action
Health Information	Provides general health information that is not considered to be of an emergent nature

3. NEDSS Base System (NBS)

The NEDSS Base System (NBS) is an electronic disease reporting and case management platform supported by the CDC. The Infectious Disease Epidemiology, Tuberculosis, Sexually Transmitted Diseases (STD), and Viral Hepatitis programs at the Indiana Department of Health (IDOH) conduct disease surveillance and monitoring through the centralized NBS system. Built and maintained by CDC, NBS integrates data from many sources on multiple public health conditions to help local, state, and territorial public health officials identify and track cases of disease over time.

4. WebEOC

WebEOC is a crisis information management system, used by the State of Indiana, as a communications platform for local, county and state emergency managers/homeland security partners. This tool is used to help capture emergency and disaster information. The system is a platform that will support real-time, simultaneous information sharing. During an emergency or disaster, the system allows emergency management partners to share information, document issues and track missions supporting local incident commanders. WebEOC is used on a daily basis in Indiana by emergency management personnel at the local, county and state level.

Only personnel who may serve in an operational capacity during an incident should have access to WebEOC. Additionally, sensitive information is contained in this Homeland Security System, and only vetted personnel will become authorized users. County emergency management directors provide access to county areas in the system. IDHS manages access for all state and federal partners.

5. EMResource

EMResource is a web-based resource management and communication tool developed by Juvare. EMResource is used by health care, public health, first responders, and other healthcare and government agencies. This system is utilized to monitor and notify changes in resources statuses, such as hospital diversions, EOC activations, resource availability, and other information.

F. Surge Support

1. Medical Surge

Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. Following the initial impact, medical surge supports the delivery of medical care and associated public health services, including disease surveillance, epidemiological inquiry, laboratory diagnostic services, and environmental health assessments.

Each Healthcare Coalition (HCC) within the state of Indiana maintains a pediatric surge annex. This pediatric-focused operational annex is an annex to a coalition's HCC Response Plan. It is intended to be a high-level response plan, identifying the experts and specialized resources that exist within the HCC, the mechanisms/ processes that will be used to determine which patients go to which facilities, and an understanding of how many children each facility will need to plan to receive.

2. Medical Reserve Corps (MRC)

The Medical Reserve Corps (MRC) is a national network of volunteers, organized locally to improve the health and safety of their communities. MRC volunteers include medical and public health professionals, as well as other community members without healthcare backgrounds. MRC units engage these volunteers to strengthen public health, improve emergency response capabilities, and build community resiliency. MRCs are maintained by the local health department (LHD) and are a function of the county.

3. State Emergency Registry of Volunteers for Indiana (SERV-IN)

The State Emergency Registry of Volunteers for Indiana (SERV-IN) is an electronic registration system and database of local, regional, and statewide programs who desire to assist public health and healthcare systems during an event or disaster. SERV-IN is comprised of local volunteer coordinators who mobilize medical and non-medical volunteers to respond to emergencies within the community, or if the volunteer is interested, within the

state. SERV-IN was created to assist in the process. The volunteers within the SERV-IN database are for local use.

During a surge situation, SERV-IN may be used to call relevant volunteers to support a variety of operations. This section should define the procedures used for activation, including defining who has the authority to trigger the activation.

G. Resource Support

In the event an incident requires local response entities to request state resource support, applicable existing or acquired state resources will be utilized first. Each of Indiana's 10 District Healthcare Coalitions maintains a cache or managed inventory of PPE that may be utilized in the treatment of a HCID patient. Additionally, the IDOH maintains a cache of medical and pharmaceutical supplies within the state warehouse that, when requested, could be distributed to resupply affected areas.

Additionally, the Indiana Department of Administration (IDOA) is the state agency responsible for providing support services to other state agencies via the use of capital or state Assets. There are a variety of assets at IDOA's disposal, including land, buildings, equipment, and infrastructure. Resource-sharing requests between state-level agencies and Emergency Support Functions will be made through the SEOC.

If the state inventory is not sufficient in supplying the need of the requesting entity, the State has the ability to request assets from alternate sources. Methods of doing so are as follows:

Quantity Purchase Agreement (QPA):

A QPA is a contract for repetitively purchased items and is established by the IDOA Procurement Division. This type of agreement requires a competitive solicitation process in which the vendor agrees to offer the quoted prices for the term of the contract based upon the State's estimated spending budget.

Special and Emergency Procurements

When unique circumstances arise, special purchasing methods may be used that allow standard practices to be circumvented. The need for this type of purchase must qualify under specific criteria, such as "Emergency Conditions," in which there is a threat to public health or safety, or where there is an opportunity to obtain supplies or services at a substantial savings. A full list of criteria can be found in IC 5-22-10.

Emergency Management Assistance Compact (EMAC)

The EMAC is the cornerstone of the United States' mutual aid system, offering assistance during governor-declared states of emergency by allowing states to send personnel, equipment, and commodities to help disaster relief efforts in other states. The EMAC comes into effect when the affected state routes a resource request to the EMAC A-Team, which then contacts the EMAC member atates to source the request beginning with the closest states by time and distance. The requesting and assisting State Emergency Management Agencies complete the EMAC Request for Assistance Form (REQ-A) for accepted offers of assistance. The completed REQ-A constitutes a legally binding agreement between the two states, and allows for credentials, licenses, and certifications to be honored across state lines.

Additionally, in instances where the state cannot meet the needs for emergency resources, the state has the ability to request Federal SNS resources from the ASPR. The Strategic National Stockpile (SNS) consists of medical material pre-positioned at caches around the nation, which includes PPE resources. These caches supply aid to state/local emergency response authorities in the event of a natural, man-made or terrorism-related biological event.

Additional information pertaining to resource support and procedures can be located in the **IDOH Administrative Preparedness Plan**.

IV. Special Pathogen Preparedness and Mitigation

During the 2014 West Africa EVD Outbreak, several public health and healthcare preparedness activities and mitigation strategies were implemented. While the majority of these actions are already completed, or no longer currently being conducted, these preparedness and mitigation strategies may be implemented or revisited during a future special pathogen outbreak.

A. Public Health Monitoring and Movement

During the 2014 West Africa EVD Outbreak, the CDC initiated enhanced returning traveler screening and designated five ports of entry for all travelers returning from a West African country experiencing widespread transmission. The CDC required all state health departments to implement an active monitoring program for all returning travelers and individuals with an exposure risk within the last 21 days. The IDOH implemented a direct active monitoring program for all travelers returning from West African countries experiencing widespread transmission or individuals with an exposure risk to EVD within the past 21 days.

The IDOH assisted with the monitoring of travelers, including the establishment of an IDOH Ebola Traveler Monitoring Team, and obtained lists of those requiring monitoring from the CDC Division of Global Migration and Quarantine (DGMQ) via secure email. The IDOH shared this list

with the local health department (LHD) public health nurses (PHN) and the IDOH Field Epidemiologist who coordinated a monitoring plan with the LHD.

Returning travelers underwent direct active monitoring twice a day for 21 days by the LHD where the traveler resided. Travelers were instructed to call the LHD if the traveler developed any of the specified symptoms. The local jurisdiction arranged for controlled movement, self-isolation, self-observation or quarantine of people at risk for EVD as the situation dictated and as the state law allows. Asymptomatic low-risk travelers were free to go about their usual routine during the 21 days of monitoring, including reporting to work. Each high-risk traveler was evaluated by local and state health authorities regarding any necessary restrictions of movement on a case-by-case basis. State law permits legal enforcement of quarantine laws if necessary.

If a monitored traveler became symptomatic, the LHD initiated normal public health contact investigations to identify and locate those with potential exposure to EVD and began monitoring procedures. Local health departments performed contact tracing for EVD patients in the same manner as any other infectious disease by talking with contacts to ascertain exposure and symptoms and, if needed, initiate the direct active monitoring program for 21 days. If a monitored traveler became non-compliant (i.e., did not answer phone or respond to e-mail and did not contact or respond to public health), response procedures were developed to contact the traveler, as well procedures to inform public safety and health partners in the community.

In the future, should widespread transmission of EVD or other special pathogen occur, it is possible that the CDC will again implement enhanced traveler screening and the IDOH will implement a direct active monitoring or active monitoring following the above procedures. IDOH currently has a new process in place for LHDs to enter monitoring information into the electronic database, Research Electronic Data Capture (REDCap).

More detailed information about REDCap and procedures for special pathogen disease monitoring are available in **Annex A: IDOH Local Health Department Special Pathogen Disease Monitoring Guidance**. The original LHD EVD monitoring guidance document is maintained by the IDOH Infectious Disease Epidemiology & Prevention Division (IDEP).

B. Isolation and Quarantine Procedures

Indiana's Isolation and Quarantine Statute is IC 16-41-9-1.5. It allows for the State Health Commissioner, the State Health Commissioner's designee, a Local Health Officer, or an authorized health or hospital corporation to order a person or persons into isolation or quarantine. Isolated patients will likely be hospitalized, so their needs will be addressed in the hospital.

People in quarantine will likely be housed at home or moved to a separate living facility. Large quarantine shelters will be unlikely. While in quarantine, the local jurisdiction should provide quarantined individuals with food and other daily living needs. The local health department should also provide daily health checks to see if anyone has developed symptoms from an active outbreak. Lastly, the LHD should work with local partners to help quarantined people meet other basic needs.

The local health officer has three options to initiate isolate or quarantine of individuals known or suspected of having an HCID, depending on urgency and exposure risk. Further details are provided in **Appendix B: Indiana Isolation and Quarantine Guidance for LHDs**, which also contains additional procedures and recommendations. A person who knowingly and intentionally violates a condition of isolation or quarantine commits a Class A misdemeanor. State and local law enforcement agencies will cooperate with the local health officer to enforce an order of isolation and quarantine.

C. EMS Preparation and Support

Extensive education and preparation have been provided to local EMS agencies throughout the state regarding the assessment and transportation of PUIs and confirmed HCID patients. Topics covered include Preparedness, Responder Roles, Responder Safety, Dispatch, Assessments, Precautions and PPE, and Decontamination/Waste Removal. IDOH, in conjunction with Indiana Department of Homeland Security (IDHS) EMS, will continue to provide coordination and updated guidance to local EMS providers. See **Appendix D: Special Pathogen Response Guidance and Recommendations for First Responders**, **Appendix E: Personal Protective Equipment Recommendations for First Responders**, and **Appendix F: Special Pathogen Guide for 911 Dispatch and Call Centers** for additional information.

In addition, the CDC has released guidance on safe practices for healthcare professionals caring for HCID patients to prevent HCID transmission during pre-hospital care, inpatient settings, and inter-facility transport. Those EMS agencies identified to transport patients with EVD or other HCID should have standard operating procedures (SOPs) specifically for transport of EVD and HCID suspected or confirmed cases. The SOPs should address the following:

- Adjusted list of required ambulance equipment
- Ambulance preparation
- PPE requirements, donning and doffing procedures
- Waste management protocols and agreements
- On scene and transport assessment and treatment guidelines, including if a patient becomes unresponsive
- Communication with health departments, law enforcement, and hospitals

- Monitoring of personnel
- Contingencies, i.e. transferring between two ambulances

The guidance below reflects lessons learned from the EVD outbreak of 2014-2016 and emphasizes the importance of training, practice, competence, and observation of personnel in correct donning and doffing procedures of PPE. As of August 27, 2015, the CDC recommends the following PPE to be used while caring for a patient with suspected or confirmed EVD:

- Single-use (disposable) impermeable gowns extending at least to mid-calf OR single-use (disposable) coverall
- Powered Air Purifying Respirators (PAPRs), or disposable, National Institute for Occupational Safety and Health (NIOSH) certified, N95 respirators with full face shield
- Single-use (disposable) examination gloves with extended cuffs
- Single-use (disposable) boot covers
- Single-use (disposable) apron
- Single-use (disposable) hood that extends to the shoulders and fully covers the neck

In addition to appropriate PPE, the CDC highlights training as a vital part of protecting health care personnel, including EMS, from contracting HCIDs like EVD. The CDC stresses repeated training with demonstrated PPE competency as essential in preventing transmission. Ambulance services willing to transport highly infectious disease patients should have regularly scheduled training specifically for PPE.

D. Healthcare Preparation and Support

During the 2014 EVD outbreak, IDOH developed a process to assist with planning and help assess the preparedness of the healthcare facilities throughout the state. For those healthcare facilities, several hospitals volunteered to become EVD Assessment Hospitals, while none elected to become EVD Treatment Centers.

The IDOH implemented the CDC-guided Hospital Ebola Preparedness Evaluation for Assessment Hospitals. The evaluation was not designed to be a pass/fail system, but rather an ongoing relationship with IDOH to maximize the safety and efficiency of patient assessment for EVD virus disease. The process flow included the following steps:

The IDOH provided a Pre-Visit Assessment Checklist for self-review of hospital facility and assessment plans.

1. The IDOH and the facility conducted a brief conference call to review the checklist, answer questions, and provide clarification as to how to properly document the checklist elements.

2. Each candidate hospital submitted documentation to support the assessment checklist criteria, i.e. plans, policies, procedures, checklists, etc.

3. The IDOH scheduled a conference call with the hospital team once it determined the facility met the requirements outlined in the Assessment Tool and submitted documentation for review.

4. Additional documentation or information was requested by the IDOH on the call as needed. Once the hospital sent those items to the IDOH, a site visit was scheduled.

5. The on-site visit at the facility included a final document review, walk-through of the facility, and review of the patient assessment protocols.

6. The IDOH issued a post-site-visit report, which included any suggested corrective actions or requests for additional documentation.

7. Each facility was notified once designated as an Ebola Assessment Hospital.

The Indiana Hospital Ebola Preparedness Evaluation Self-Assessment Tool included the following areas:

- Pre-Hospital Transport Plans and Emergency Medical Services
- Emergency Department Triage and Reception Preparedness
- Patient Transport from Point(s) of Entry to Designated Ebola Treatment Area
- Patient Placement
- Personal Protective Equipment and Procedures for Donning and Doffing
- Staffing of Ebola Patient Care Team
- Pediatrics
- Monitoring Healthcare Personnel and Managing Exposures
- Laboratory Safety
- Environmental Infection Control
- Waste Management
- Communications
- Hospital Incident Command System
- Disposition of Human Remains
- Exercise
- Additional Information

E. Infection Control Preparedness

The Healthcare Associated Infections (HAI) Advisory Group at IDOH consists of representatives from the University of Indianapolis, IDOH (Regulatory Division, Infectious Disease Epidemiology & Prevention Division (IDEP), Laboratory Services, and Division of Emergency Preparedness), Hoosier Owners and Providers for the Elderly, Indiana Assisted Living Association, Indiana Health Care Association, Indiana University Methodist Hospital, Indiana Hospital Association, State Long Term Care Ombudsman, Qsource, Indiana Patient Safety Center, Association of Professionals in Infection Control and Epidemiology, Union Hospital, Indiana University School of Public Health, Indiana University School of Medicine, Indiana Association for Home and Hospice Care, Indiana State Medical Association, Renal Network, and Marion County Public Health Department.

F. Laboratory Service Support and Preparedness

Diagnostic testing is available for detection of select infectious diseases. The IDOH Laboratory is one of 52 Laboratory Response Network (LRN) laboratories located within the U.S. and has the capability to perform presumptive testing for a variety of special pathogens. The IDOH Laboratory utilizes polymerase chain reaction (PCR) testing for presumptive testing. Confirmation of a positive or intermediate results is performed by CDC; however, Biofire assays could be used to identify negative causative special pathogens. While several clinical laboratories have capabilities to run special pathogen assays on Biofire, the IDOH Laboratory must still perform PCR for presumptive testing.

Frontline Centers are able to obtain whole blood samples from PUIs for further testing. All samples are packaged and couriered to the IDOH Laboratory in accordance with the DOT Category A packaging and transportation regulations. The IDOH Laboratory provides Category A and B sample packaging and shipping training to hospital laboratories. All Indiana Frontline Centers received Category A and B packaging and shipping training. The IDOH provides the courier for special pathogens (such as Ebola) specimens directly through IDOH Field Epidemiologists or IDOH DEP Field Coordinators, due primarily to the urgency and time constraints.

The IDOH Laboratory works closely with each Frontline Center laboratory, as well as other Clinical Laboratory Improvement Amendments (CLIA)-certified clinical laboratories, to ensure laboratory testing and methods follow current guidance and best practices.

G. Waste Management Considerations

Waste generated during the transport of a confirmed case of VHF (e.g., EVD) is federally considered Division 6.2 Materials, Category A Infectious Substances. Items deemed Category A waste include: medical equipment, sharps, linens, disposable PPE, all used healthcare products

ranging from gauze to emesis basins, in addition to the transport vehicle. Category A waste is regulated by the U.S. Department of Transportation (USDOT) Hazardous Materials Regulations (HMR) 49 Code of Federal Regulations (CFR), 42 CFR Parts 72-73, and 29 CFR, Section 1910.1030. Note that special respiratory pathogens, such as MERS-CoV, are considered Category B Infectious substances and have different waste handling instructions. This waste does not typically pose the same level of risk as Category A infectious substances.

After a transport is completed and prior to doffing PPE, EMS personnel should, at minimum, perform a gross decontamination of the ambulance and appropriately contain their waste. All Category A waste should be left at the patient transfer point (PTP). PTPs without autoclaving capabilities should package the waste following USDOT requirements or in accordance with the special authorization permit issued to the waste management contractor or hauler by the USDOT. The packaged waste should be properly labeled and placed into a secure storage area until picked up by their waste management contractor.

The Occupational Safety and Health Administration (OSHA) recommends that an Environmental Protection Agency (EPA)-registered disinfectant with label claims for use against non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) be used to treat contamination/spills and to disinfect non-porous surfaces after bulk spill material has been removed. Chemical treatment alone will not remove the Category A designation of the waste.

Special pathogen 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 Category A or B waste and is not subject to the HMR; 49 CFR, Parts 171-180.28. See **Appendix G: Special Pathogens Waste Management Guide** for additional information.

H. Mortuary Affairs

The burial of deceased persons in Indiana is handled at the local level. Local funeral homes have been engaged and educated about the handling and burial of human remains. Except for the concept of no autopsy, no embalming, no open casket, and immediate burial, the families' wishes are followed as far as type of burial and memorial service. Hospitals, funeral directors, and coroners have all received education about processes to follow with deceased HCID victims. Note that if the individual is deceased due to VHF (e.g., EVD, Lassa, Marburg), the body is subject to local, state, and/or federal regulations as described in Category A infectious substance category for safe removal, transport, and disposal.

V. Assignment of Responsibilities

A. General

Most departments/agencies of government have emergency functions operate in addition to their normal, day-to-day duties. These emergency functions in parallel to or complement normal functions. Each department/agency is responsible for developing and maintaining its own emergency management procedures.

B. Non-Governmental Organizations

1. American Red Cross

The American Red Cross works with a network of volunteers, donors and partners to help people affected by disaster across the country and around the world receive shelter and care. Additionally, it assists vulnerable communities in preparedness efforts and helps ensure access to safe blood and blood products when necessary.

2. Indiana Hospital Association

The Indiana Hospital Association's (IHA) mission is to provide Indiana hospitals with leadership, representation, and support to improve the health of Indiana citizens. The IHA serves to collect, analyze, and distribute required data, as well as act as a connection and coordination agency between hospitals and policymakers when necessary.

C. Local Organizations

1. Frontline Centers

Indiana Frontline Centers are responsible for maintaining a state of readiness for Special Pathogen assessment, in accordance with the most recent guidance from the CDC and the IDOH. These facilities participate in grants with the IDOH DEP and are responsible for delivering the prescribed Special Pathogen preparedness performance metrics. Additionally, they are responsible for providing patient care to a PUI during the first 72-hour period until a Special Pathogen/HCID diagnosis can be confirmed.

Frontline Centers are responsible for implementing the CDC's three Is (3I) of **Identify**, **Isolate**, and **Inform** for individuals with a travel or exposure history to a special pathogen within 14-21 days and experiencing HCID signs and symptoms. Frontline Centers are responsible for knowing who to contact at IDOH should the event arise – **Infectious Disease Epidemiology & Prevention Division (IDEP)** – **(317) 233-7125** (8:15 AM – 4:45 PM) and **(317) 233-1325** (After Hours Emergency Calls).

2. Indiana Emergency Medical Service Providers

EMS providers and personnel are responsible for the same awareness level as Frontline Centers, with the ability to implement the **Identify**, **Isolate**, and **Inform** protocols. EMS providers that are willing to transport PUIs to a Frontline Center should be well trained in Special Pathogen protocols and PPE procedures. Additionally, EMS providers should prepare with the Frontline Centers to maintain familiarity of the plans and procedures for patient admission, as well as the decontamination process.

a. Indianapolis Emergency Medical Services (IEMS)

Indianapolis Emergency Medical Services (IEMS) is available through a subaward contract with the Indiana Department of Health (IDOH) to provide statewide transport of persons under investigation (PUI) of special pathogens/HCID. Transport is available from anywhere within the state to Frontline Centers or a Regional Ebola and Special Pathogen Treatment Center.

3. Indiana Local Health Departments (LHDs)

Indiana has 94 local public health jurisdictions throughout the state, responsible for the public health welfare of Indiana residents. During a Special Pathogen response, the local public health department is responsible for implementing a monitoring program for individuals with identified risk. During the 2014 West Africa EVD Outbreak, the local public health department performed direct active traveler monitoring for all individuals returning from a Western Africa country experiencing widespread transmission. This was accomplished via face-to-face interviews, followed by bi-daily temperature checks via video conferencing or in-person. The results were reported daily to the IDOH EVD Traveler Monitoring Team. Additionally, the local public health department is responsible for reporting all potential PUI's to the IDOH as identified, from any report from a healthcare facility or walk-in to the health department. The local health department is responsible for working with Frontline and Treatment Centers and EMS providers that are involved with a PUI, transportation, or treatment of an HCID patient to implement a monitoring program for the appropriate period following last exposure (21 days for VHFs; 14 days for special respiratory pathogens).

4. Indiana District Healthcare Coalitions (HCC)

Indiana has 10 district health coalitions. Each HCC is responsible for emergency healthcare coordination and facilitates resource and information sharing. Each healthcare coalition maintains a level of PPE or medical supplies and may include some resources that could be utilized for HCID patient treatment.

D. State Organizations

1. Indiana Department of Health (IDOH)

The IDOH is the lead ESF-8 agency for Indiana. The IDOH is charged with the coordination, support, and overall responsibility for the public health and health care in Indiana. At the IDOH, the following divisions have specific roles and responsibility in the response to an HCID patient.

b. **IDOH Executive Staff**

The IDOH executive staff, led by the State Health Commissioner, leads the policies and directives of the IDOH. The IDOH executive staff additionally includes the IDOH Chief of Staff, Deputy State Health Commissioner, Chief Medical Officer, State Epidemiologist, Assistant Commissioners, and several executive offices. During a Special Pathogen Response, the executive staff will participate and provide direction on the IDOH coordination calls. If needed, the State Health Commissioner may implement isolation and quarantine procedures.

a. **IDOH Infectious Disease Epidemiology & Prevention Division (IDEP)**

The IDEP is responsible for overseeing the epidemiological surveillance and investigation of all communicable diseases in the State of Indiana. The IDEP additionally provides a Travel Monitoring Team during enhanced screening and direct active monitoring implementation, such as during 2014 West Africa EVD Outbreak. The IDEP maintains an Epidemiologist on Call, available 24/7 for epidemiological related emergencies.

During a Special Pathogen Response, the IDEP will provide support and guidance for disease surveillance and monitoring as needed by the local health department. The IDEP will establish all coordination calls with partners as needed.

b. **IDOH Laboratory**

The IDOH Laboratory is a Level II Laboratory Response Network (LRN) lab capable of performing a variety of testing (including polymerase chain reaction (PCR). The IDOH Laboratory additionally provides guidance and CLIA best practices to hospital and clinic labs throughout the state. The IDOH Laboratory provides Category A and B specimen packaging and shipment training to hospitals.

During a Special Pathogen Response, the IDOH Laboratory will provide presumptive testing and provide guidance and support to Frontline Center laboratories as needed.

c. **IDOH Division of Emergency Preparedness (DEP)**

The IDOH DEP is responsible for administering the CDC and ASPR cooperative agreements, to include Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) grants with local public health departments and Healthcare Coalitions. The IDOH DEP is responsible for staffing the ESF-8 position in the State Emergency Operations Center (SEOC) when needed and serves as an emergency management liaison to the Indiana Department of Homeland Security and other response agencies. The IDOH DEP communicates regularly with the ASPR HPP Project Officer, CDC PHEP Project Officer, ASPR Strategic National Stockpile (SNS), and the HHS Region V Regional Emergency Coordinators. The IDOH DEP is responsible for maintaining the Indiana Special Pathogens State Operations Plan, as well as the appropriate portion of the **HHS Region V: Ebola Virus Disease Coordination and Transportation Plan**, and coordinating Special Pathogen exercises and supporting exercise documentation.

During a Special Pathogen Response, the IDOH DEP will provide coordination and resource support to hospitals, local public health, and throughout the agency. The IDOH DEP will provide ESF-8 staffing to the SEOC if appropriate. The IDOH DEP will work directly with IDOH Finance on the deployment of any Special Pathogen Personal Protective Equipment caches, or with the procurement of any emergency resources. The IDOH DEP may additionally open and manage a public call center if needed. The IDOH DEP may work with the ASPR Office of Emergency Management to request any other emergency resources not available in state.

d. **IDOH Office of Public Affairs (OPA)**

The IDOH OPA maintains all media relations for the IDOH, as well as the Crisis and Emergency Risk Communication (CERC) Plan. During a Special Pathogen Response, the IDOH OPA will lead the state media relations as appropriate. If a Joint Information Center (JIC) is established, the IDOH OPA will have the lead role in operations.

2. Indiana Department of Homeland Security (IDHS)

The Indiana Department of Homeland Security (IDHS) is responsible for the oversight and daily operations of both the Indiana State Emergency Operations Center and the Indiana Joint Information Center, including the determination of current activation and staffing levels. The IDHS additionally is responsible for the overall guidance and support to local emergency management, firefighters, EMS, and hazardous material responders. During a

response, the IDHS may provide additional support to local jurisdictions if needed and provide overall state coordination efforts through the SEOC.

3. Indiana Department of Environmental Management (IDEM)

The Indiana Department of Environmental Management (IDEM) is the lead ESF-10 agency for the Indiana. The IDEM is responsible for the overall environmental regulations within the state. The IDEM is responsible for the regulation and permitting of waste facilities in Indiana, include those that potentially could accept special pathogen waste.

4. Indiana Department of Transportation (INDOT)

The Indiana Department of Transportation (INDOT) is the lead ESF-1 agency for Indiana. The INDOT is responsible for the overall transportation infrastructure within the state, including road, air, water, and rail. The INDOT is responsible for maintaining data on airports, to include technical information such as runway length. During a response, the INDOT will be coordinated with in selecting and contacting an appropriate airport for air transportation of an HCID patient through the HHS provided air service.

5. Indiana State Police (ISP)

The Indiana State Police (ISP) is the lead ESF-12 agency for Indiana. The ISP is responsible for the overall security and enforcement of laws within the state. During a Special Pathogen Response, the IDOH will coordinate with the ISP any issues regarding law enforcement assistance with isolation and quarantine. Additionally, the IDOH may request security and escort during any HCID patient or PUI transportation if needed, including an interstate transport through Indiana from an out-of-state patient transport to the Regional Ebola and Other Special Pathogen Treatment Center (RESPTC).

E. Regional And Federal Organizations

1. HHS Region V States

The HHS Region V includes Illinois (and City of Chicago), Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Each state is tasked with developing a Special Pathogen CONOPS for response to an HCID patient, as this document serves for Indiana. In addition, states are responsible for participating in regional-based exercise. Other Region V states maintain their own frontline and treatment centers. States are responsible for communicating with the region and HHS regarding HCID patients and status.

2. Regional Ebola and Other Special Pathogen Treatment Center (RESPTC)

The RESPTC is an Ebola Treatment Center that has been designated by HHS and the Region and has recently expanded to include "special pathogen" response. RESPTCs are designated as having enhanced preparedness capabilities to ensure that they are the leading provider of care and treatment for patients with an HCID in the U.S. and have capabilities needed to manage other high-consequence infectious diseases in the future. The University of Minnesota Medical Center - West Bank Campus, Minneapolis, MN serves as the RESPTC for Region V. There are a total of 10 RESPTCs, one per each of the 10 HHS regions. RESPTCs are responsible for the following:

- Accept patients within eight hours of notification
- Be able to treat at least two HCID patients simultaneously
- Have respiratory infectious disease isolation capacity or negative pressure rooms for at least 10 patients
- Conduct trainings and exercises each quarter
- Be able to treat pediatric patients with an HCID or partner with a nearby facility to do so
- Be able to handle waste from such patients
- Receive annual readiness assessment from the National Emerging Special Pathogens Training and Education Center (NETEC, formerly National Ebola Training and Education Center).

3. Great Lakes Healthcare Partnership (GLHP)

The GLHP is a 501(c)(3) non-profit organization made up by the Region V states. The GLHP is the sponsoring organization for the development and maintenance of the Regional Ebola CONOPS and regional exercise. The Regional EVD CONOPS describes the response and actions for an Ebola patient transported by air or grant to the Regional Ebola Treatment Center in Minnesota. See - **HHS Region V: Ebola Virus Disease Coordination and Transportation Plan**.

4. U.S. Health and Human Services (HHS)

HHS is the lead ESF-8 agency for the federal government. HHS consists of several divisions and organizations that have instrumental roles in the response to special pathogens. The following are several specific organizations and divisions:

e. Administration for Strategic Preparedness and Response (ASPR)

ASPR is responsible for the implementation of the Healthcare Preparedness Program (HPP), aimed at the preparedness of health care and healthcare coalitions. ASPR represents one of two partnerships in the ASPR-CDC cooperative agreements that IDOH participates with. With ASPR, the HPP Project Officer is responsible for regional

communication regarding HCID patients. The Regional Emergency Coordinator (REC) is responsible for tasking the Secretary of State for the need of air transport for a regional transport, arranged through Phoenix Air Group. In the event of a confirmed HCID Patient, the ASPR will provide direct support to the state, through a combination of resources from medical and public health personnel to resources such as medical supplies and equipment from the Division of Strategic National Stockpile.

f. **Centers for Disease Control and Prevention (CDC)**

The CDC is responsible for the public health welfare of the U.S. The CDC is responsible for providing guidance and assistance to state and local health departments during outbreaks and other times of need. The CDC led the implementation of enhanced screening during the 2014 West Africa EVD Outbreak, working closely with other federal agencies such as the Transportation Security Authority, Customs and Border Protection, Coast Guard, and others. The CDC maintains an Emergency Operations Center which would be notified in the event of a PUI or confirmed HCID Patient and would participate in the IDOH coordination calls.

F. Other Agencies and Organizations

Several other agencies play a role in the overall response to an HCID patient, from local emergency management, the American Red Cross, Indiana Hospital Association (IHA), Indiana Family Social Services Administration (FSSA), and others that have a role in information management, resource provision and coordination, or other aspects of public health and healthcare.

VI. Plan Development and Maintenance

A. Development

The planning and preparedness section of the Division of Emergency Preparedness (DEP) has the responsibility of creating, maintaining, training, exercising, and updating IDOH emergency plans. The section also has the responsibility of supporting plan development by providing relevant trainings to foster plan development.

B. Maintenance

1. Requirements

The DEP will maintain, distribute, and update the Special Pathogens State Operations Plan. Responsible officials in state or local agencies should recommend changes and provide updated information periodically (e.g., changes of personnel and available resources). Revisions will be forwarded to people on the distribution list.

2. Review and Update

a. Review

The Special Pathogens State Operations Plan and its appendices should be reviewed periodically to ensure that the information contained is accurate and current. IDOH DEP must establish a process for the annual review of planning documents by those tasked in those documents, and for preparation and distribution of revisions or changes.

b. Update

i. Changes

Changes should be made to plans and appendices when the documents are no longer current. Changes in planning documents may be needed:

- When hazard consequences or risk areas change
- When the concept of operations for emergencies changes
- When departments, agencies, or groups that perform emergency functions are reorganized and can no longer perform the emergency tasks laid out in planning documents
- When warning and communications systems change
- When additional emergency resources are obtained through acquisition or agreement, the disposition of existing resources changes, or anticipated emergency resources are no longer available

- When a training exercise or an actual emergency reveals significant deficiencies in existing planning documents

ii. Methods of updating planning documents

1) Plan Revision
A revision is a complete rewrite of an existing EOP or appendix that essentially results in a new document. Revision is advisable when numerous pages of the document have to be updated, when major portions of the existing document must be deleted or substantial text added, or when the existing document was prepared using a word processing program that is obsolete or no longer available. Revised documents should be given a new date and require new signatures by officials.

2) Formal Plan Change
A formal change to a planning document involves updating portions of the document by making specific changes to a limited number of pages. Changes are identified by numbers and are issued to holders of the document with a cover memorandum that has replacement pages attached. The cover memorandum indicates which pages are to be removed and which replacement pages are to be inserted in the document to update it. The person receiving the change is expected to make the required page changes to the document and then annotate the record of changes at the front of the document to indicate that the change has been incorporated into the document.

C. Training and Exercise

1. Training

In order to best fulfill the requirements laid out by this plan, a number of trainings should be completed. Through coordination with the Indiana Department of Homeland Security (IDHS), FEMA training consortiums, and local partners (LHDs, HCCs, hospitals, etc.), IDOH supports continuing education of the public health, healthcare, and emergency preparedness community.

2. Exercises

In order to ensure this plan is feasible and accurate, an exercise or exercises must be completed testing applicable parts or all of this plan. When creating a new plan or updating an existing plan, planners should coordinate with exercise staff in order to ensure that plans are exercised in a timely manner.

VII. Authorities and References

The following provides Indiana code citations related to special pathogen emergency preparedness and response activities. The following should not be construed to be an exhaustive list. For additional public health preparedness citations, please reference the **IDOH Administrative Preparedness Plan**. These citations may be used as a reference, however the full text of the law should be consulted before utilizing or enforcing any law during or in preparation for an emergency. Additionally, the IDOH Office of Legal Affairs and local government counsel should be consulted, whenever necessary.

Special Pathogens Emergency Legal Authorities and References		
General		
Code	Usage	Description
IC 10-14-3-11	*Governor's Emergency Powers*	If emergency is beyond local control, the governor can: ○ Assume operational control of all or part of emergency management functions ○ Make, amend, or restrict orders, rules, and regulations ○ Coordinate with other states or federal government ○ Employ any measures regarding recommendations from IDOH or local health departments ○ Use resources from state and local governments ○ Establish agencies, offices, and appoint personnel
IC 10-16-7-7	*Activation of National Guard*	Governor can activate the Indiana National Guard in cases including public disasters and any time the Governor considers necessary
IC 5-10-13	*Death and Disability Benefits for Emergency and Public Safety Employees*	▪ "Exposure Risk Disease," including anthrax and smallpox ▪ Applies to state and local employees including individuals at high risk for occupational exposure to an exposure risk disease in the line of duty ▪ Applies to employees diagnosed with health condition caused by exposure risk disease that employee was exposed to while in the line of duty
Disaster Declarations/Proclamations		
Code	Usage	Description

IC 10-14-3-12	*Disaster Declaration; Governor's Powers under a Disaster Declaration*	▪ Disaster declaration procedure ▪ Under a disaster declaration the governor can: o Suspend provisions of regulatory statutes o Use state and local resources o Use state agencies and personnel for emergency services o Commandeer or use private property o Assist in evacuations o Suspend or limit the sale of alcohol o Make provisions for temporary emergency housing o Allow out-of-state health practitioners to practice in Indiana o Give authority to allocate drugs, food, other resources and services
IC 16-19-4-10 **IC 16-41-7.5**	*Public Health Emergency Declaration*	State Health Commissioner has the authority to declare a public health emergency
IC 15-17-10-11	*Animal Health Emergency Declaration*	Board of Animal Health has authority to request emergency funding to address animals that are deemed hazardous to citizens or animals of Indiana
IC 10-14-3-29	*Local Disaster Emergency*	Local disaster declarations can be made by the principal executive of the local government. Local governments cannot use a disaster declaration to prohibit individuals employed in emergency public service from traveling on highways within the local jurisdiction.
Emergency Rulemaking and Suspension of Laws		
Code	**Usage**	**Description**
IC 10-14-3-11 **IC 10-14-3-12**	*Governor suspending laws*	▪ The governor may make, amend, or restrict orders, rules, and regulations during an emergency ▪ The governor may suspend provisions of regulatory statutes during a disaster declaration
IC 10-14-3-22	*State agencies suspending laws*	Indiana state agencies may make, amend, and rescind orders, rules, and regulations when necessary for emergency management purposes
IC 10-14-3-22	*Local governments suspending laws*	Local governments may make, amend, and rescind orders, rules, and regulations when necessary for emergency management purposes

Limiting Transmission		
Code	**Usage**	**Description**
IC 16-18-2-91	*Dangerous Communicable Disease*	Definition of dangerous communicable disease
IC 16-41-6-2	*Compulsory Testing for Communicable Diseases*	Upon court order, the State Health Commissioner or local health officer can compel examination of an individual who may have a communicable disease or other disease that is a serious and present danger to health
IC 16-18-2-302.6 **IC 16-19-3-9** **IC 16-41-9**	*Quarantine*	▪ Definition of quarantine ▪ SHC and local health officers have the authority to quarantine and take measures to prevent and suppress disease ▪ Quarantine procedure
IC 16-18-2-194.5 **IC 16-41-9**	*Isolation*	▪ Definition of isolation ▪ Isolation procedure
IC 16-41-9-5	*Mentally Ill, Dangerous, or Gravely Disabled Disease Carrier*	State or local health officers may detain an individual carrying a dangerous communicable disease if he/she is deemed mentally ill, dangerous, or gravely disabled
IC 16-19-3-10 **IC 16-20-1-24**	*Closing Schools and Churches and Banning Public Gatherings*	▪ IDOH has the authority to order schools and churches to close and forbid public gatherings to prevent or stop epidemics ▪ Local health officers have the authority to order schools and churches to close and forbid public gatherings to prevent or stop epidemics
IC 16-41-9-3	*Excluding Infected Students from Attending School*	▪ Local health officers may exclude a student from school if he/she has a dangerous communicable disease that is transmitted through normal school related contacts and the disease poses a substantial threat to the school community ▪ Students deemed to no longer have the dangerous communicable disease shall be given a certificate of health and readmitted to school
IC 16-20-1-21 **IC 16-20-4-18**	*Local Health Department Communicable Disease Control*	Local health departments have the duty and authority to take any action authorized by law or IDOH to control communicable diseases

IC 15-17-10	*Diseased Animals*	State and federal government can examine, quarantine, and condemn diseased or dangerous animals
IC 16-41-5	*IDOH Inspection of Private Property*	IDOH has situational authority to enter private property to conduct an inspection of communicable disease.
IC 16-20-1-23	*Local Health Department Inspection of Private Property*	Local health departments have situational authority to enter any premise to inspect, investigate, evaluate, conduct tests, or take samples to determine compliance with public health laws/rules and for prevention and suppression of disease.
IC 10-46-2	*Use of State Funds to Prevent Disease*	Governor may draw state funds at any time to prevent the introduction or spread of contagious and infectious diseases in Indiana
Treatment		
Code	**Code**	**Code**
IC 16-41-9-1.7	*Immunizations*	▪ Immunization programs must include information on benefits and risks of immunization ▪ No adult can be immunized without his/her consent ▪ No child can be immunized without his/her parent/guardian's consent ▪ Individuals who refuse immunization can be subjected to isolation or quarantine
IC 16-19-4-11 **IC 25-0.5-11**	*Administration of Immunizations by Healthcare Providers*	The State Health Commissioner has the authority to issue a standing order, prescription, or protocol allowing pharmacists and providers regulated by any of the licensure boards listed in IC 25-0.5-11 to administer immunizations
IC 16-38-5-2	*Documentation of Immunizations*	▪ Providers administering immunizations or their designee must provide immunization data to immunization data registry ▪ No emergency exception
IC 10-14-3-23 **IC 16-31-1-3** **IC 16-41-1-1**	*Exception to compulsory medical treatment*	The government cannot compel an individual to submit to physical examination, medical treatment, or immunization if the individual or his/her guardian decides to rely on spiritual means or prayer to prevent or cure disease or suffering

IC 16-41-16	*Infectious Waste*	Instructions for handling infectious waste
Points of Disbursement (POD)		
Code	**Usage**	**Description**
IC 16-19-11-1 **IC 16-19-11-2** **IC 16-19-11-3**	*Security of IDOH Property*	▪ The State Health Commissioner can appoint security officers to protect properties owned or occupied by IDOH, including the streets passing through or adjacent to those properties. ▪ Appointed security officers have general police powers, including authority to arrest ▪ IDOH can control traffic and parking around IDOH properties
IC 10-14-3-33.5	*Regulation of Firearms during Emergencies*	State and local governments cannot prohibit or restrict the lawful possession, transfer, sale, transportation, storage, display, or use of firearms or ammunition during a disaster emergency, energy emergency, or local disaster emergency. Some exceptions: school property, postsecondary education institutions, emergency shelter care child caring institution, private secure facilities, emergency shelter care group homes, domestic violence shelters, etc.
Surveillance		
Code	**Usage**	**Description**
IC 16-19-10-8	*Counterterrorism Surveillance*	IDOH must report and monitor data on symptoms and health syndromes for outbreaks of dangerous disease and health conditions
IC 16-41-2 **IC 16-41-3** **410 IAC 1-2.5**	*Communicable Disease Surveillance*	IDOH has the authority to make rules establishing reporting, monitoring, and preventing communicable disease
512 IAC 1-2-1 **512 IAC 1-2-2**	*School Attendance Reporting System for Outbreaks*	▪ School corporations and accredited nonpublic schools must develop an attendance system for reporting symptoms and health syndromes from outbreaks or suspected outbreaks of disease or other health conditions that are a danger to public health ▪ When the percentage of students absent equals or is greater than 20%, schools must report the

		percentage of students absent to the local health department
Licensure		
Code	**Usage**	**Description**
IC 10-14-3-15	*Exceptions to Licensure Requirements for Emergency Management Workers*	Professional, mechanical, or other skill-related licensure requirements do not apply to emergency management workers
IC 16-31-3-3	*Exceptions to EMS Certification or Licensure Requirements*	Certification or licensure is not required for an emergency ambulance service, EMT, ambulance, EMS non-transport vehicle, or ALS when providing EMS services during a major catastrophe or disaster when EMS resources are insufficient
IC 16-31-3.5-2	*Exceptions to Emergency Medical Dispatch Requirements*	Training requirements for emergency medical dispatchers do not apply during a major catastrophe or disaster when emergency medical dispatch resources are insufficient
IC 10-14-5-5	*Exceptions to Licensure Requirements related to EMAC resources*	▪ Individuals with professional, mechanical, and other skills who are requested through EMAC will be considered licensed in the receiving state if they are licensed in any EMAC member state. ▪ The governor of the receiving state can put limitations and conditions on the scope of practice of these individuals.
IC 10-14-6.5-5	*Exceptions to Licensure Requirements related to interstate mutual aid resources*	▪ Emergency responders licensed in another state are considered to be licensed in Indiana when providing aid related to an interstate mutual aid agreement ▪ The emergency responders' scope of practice is limited to the responders' license and the equivalent license in Indiana
Legal Immunities		
Code	**Usage**	**Description**
PREP Act	*Immunity for Administration or Use of Countermeasures*	▪ Federal law that provides immunity from liability for claims of loss related to administration or use of countermeasures

		▪ Secretary of Health and Human Services can issue a PREP Act declaration at any time, not just during emergencies ▪ Excludes acts of willful misconduct ▪ Current declarations include pandemic influenza countermeasures
IC 34-30-13.5	*Immunity for Healthcare Providers and Facilities*	▪ Only applies when the governor has declared a disaster ▪ Applies to healthcare services, provided before, after, or during the disaster declaration, in response to an event that resulted in a disaster declaration ▪ Healthcare provider must be licensed in Indiana
IC 34-30-12.5	*Immunity for Health Care Provider Providing Smallpox Immunization*	▪ Healthcare provider includes physicians, healthcare facilities, nurses, paramedics, and EMTs and their medical staff ▪ Healthcare provider administering medical countermeasure against an actual or potential bioterrorist incident or public health emergency is immune from civil liability for any injury or damage resulting from the administration of the medical countermeasure ▪ Applies only when federal government authorizes IDOH to administer medical countermeasures
IC 16-31-6-4	*Immunity for Paramedics and EMTs*	EMS, government, and healthcare individuals/entities are not liable for acts or omissions by paramedics or EMTs while treating a patient in good faith in connection with a disaster declaration for an act of terrorism
IC 16-39-7-1	*Immunity for Destruction of Health Records*	A provider is not liable for destroying or failing to maintain a health record, in good faith, in connection with an emergency declaration or other disaster
IC 25-38.1-4-7	*Immunity for Veterinarians*	Veterinarians and veterinary technicians are immune from damages to the owner of an animal the veterinarian or veterinary technician provides emergency treatment to, including euthanasia
Emergency Mutual Aid		
Code	**Usage**	**Description**

IC 10-14-3-10.8 **IC 10-14-3-16** **IC 10-14-3-17** **844 IAC 5-9-8**	*Indiana Intrastate Mutual Aid Compact*	Creates a mutual aid compact between participating local governments, fire departments, and private individuals in Indiana
IC 10-14-5	*Emergency Management Assistance Compact (EMAC)*	▪ Indiana may request emergency resources from and provide emergency resources to other states participating in EMAC ▪ The requesting state will reimburse the providing state for any loss, damage, or expense related to provided resources, unless the providing state determines reimbursement is unnecessary
IC 10-14-6.5	*Interstate Mutual Aid Agreement*	▪ State or local governments may enter into mutual aid agreements with state or local governments of other states for emergencies that do not require a state or local emergency declaration
IC 10-14-3.5	*Uniform Emergency Volunteer Health Practitioners Act*	Registered volunteer health and veterinary health practitioners licensed in Indiana or another state can provide services in Indiana while an emergency declaration is in effect

Resources for Frontline Healthcare Facilities

ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE)

ASPR TRACIE. EMS Infectious Disease Playbook

National Emerging Special Pathogens Training and Educational Center (NETEC)

New York City Health + Hospitals. (2019). Frontline Hospital Planning Guide: Special Pathogens

ANNEX A: LOCAL HEALTH DEPARTMENT

SPECIAL PATHOGEN DISEASE MONITORING GUIDANCE

Below is an adaptation of the Local Health Department Ebola Virus Disease Monitoring Guidance document maintained by the IDOH Infectious Disease Epidemiology & Prevention Division (IDEP). It has been expanded to include other special pathogen considerations (e.g., respiratory) for monitoring guidance.

Special Pathogens Quick Facts	
Special Respiratory Diseases	**Viral Hemorrhagic fevers (VHFs)**
• Special respiratory viruses include SARS, MERS-CoV, and novel influenza strains (e.g., H3N1, H5N1, H7N9) and are spread by droplets that come from coughing and sneezing. • Signs and symptoms vary by disease and may be nonspecific, but may include fever, chills, cough, sore throat, shortness of breath, etc. • Those infected may start showing symptoms within 14 days from initial contact. • Individuals who have a history of travel to a country experiencing widespread transmission within the past 14 days or have a history of direct contact with a patient who has a special respiratory HCID and have symptoms to warrant further investigation.	• Viral hemorrhagic fevers (VHFs), such as EVD, are transmitted by direct contact with blood and body fluids from a symptomatic individual having a fever, headache, body aches, abdominal pain, vomiting, and diarrhea. • The infection can be spread only by someone who has symptoms. • Those infected may start showing symptoms ranging from 2 to 21 days from initial contact • VHFs are not transmitted by food, water, or airborne routes. • Individuals must have a history of travel to a country experiencing widespread transmission within the past 21 days or have a history of direct contact with a VHF patient and have symptoms to warrant further investigation.

I. Introduction

This document provides definitions, guidance, and forms for 14- to 21-day (as indicated by disease in question) temperature and symptom monitoring by the local health department (LHD) for persons who have recently traveled to countries experiencing widespread transmission of a high-consequence infectious disease (HCID). This plan aligns with the IDOH Infectious Disease State Operations Plan, in addition to: IDOH Emergency Operation Plan/Framework, ESF-8 Annex of State Emergency Operations Plan, and the Medical Countermeasures (MCM) Operations and Distribution Plan.

A. Background

Special pathogens (or HCID) cause infectious diseases that have the ability to spread rapidly through a population within a short time. Increased global travel and frequent exposure to infectious sources (such as food, infected animals, and vectors), in conjunction with frequent person-to-person spread, facilitates the transmission of these diseases. A HCID has the potential to spread rapidly through a population if a system is not in place to identify, treat, and mitigate infectious threats to public health.

II. Notification

The Centers for Disease Control and Prevention (CDC) and the Department of Homeland Security Customs & Border Protection (CBP) performs entry screening at U.S. airports that receive travelers from countries experiencing widespread transmission of special pathogens. Trained CBP staff will observe the traveler for signs of illness, ask a series of health and exposure questions, and provide health information for HCIDs and reminders to self-monitor for symptoms. Trained medical staff will take the traveler's temperature with a non-contact thermometer.

If the person has fever, symptoms, or the health questionnaire reveals a possible HCID exposure, the individual will be evaluated by a CDC quarantine station public health officer. The public health officer will again take a temperature reading and make a public health assessment. Persons who, after this assessment, are determined to require further evaluation or monitoring will be referred to the appropriate state public health authority. Persons from these countries who lack symptoms/fever or do not have a known history of exposure will receive health information for self-monitoring.

IDOH Special Pathogens Monitoring Plan

The CDC will distribute contact information for persons to the state in which they reside or intend to stay via Epi-X. Upon receiving the notification, the IDOH Infectious Disease Epidemiology &

Prevention Division (IDEP) will distribute a list of affected persons to the LHDs of residence for monitoring.

III. Roles and Responsibilities

A. IDOH Infectious Disease Epidemiology & Prevention Division (IDEP)

The IDEP is responsible for overseeing the epidemiological surveillance and investigation of all communicable diseases in the State of Indiana. The IDEP maintains information webpages containing CDC guidance, IDOH guidance, and other best practices concerning special pathogen diseases. The IDEP maintains an Epidemiologist on Call, available 24/7 for epidemiologic-related emergencies. Additionally, the IDEP provides disease-specific Travel Monitoring Teams during enhanced screening and direct active monitoring implementation. The IDEP Travel Monitoring Team will provide support and guidance for disease surveillance and monitoring as needed by the LHDs. If needed, the IDEP Field Epidemiologists will serve as specimen couriers to the IDOH Laboratory. The IDEP will coordinate with the IDOH Division of Emergency Preparedness for response activities, to include activation of the Indiana Special Pathogen Response Plan, should an individual become symptomatic.

B. Indiana Local Health Departments (LHD)

The LHDs in Indiana are responsible for the public health and welfare of its residents. LHDs in Indiana are expected to collaborate with other LHDs, IDOH, and external partners to accomplish the monitoring for each person. LHDs are to implement a sustainable, long-term system to track persons receiving monitoring, as this surveillance program is expected to last at least several months. Surge capacity may be needed for counties with multiple persons or those that have staffing limitations. LHDs will notify the IDEP about any persons from impacted countries that are received from sources other than CDC Epi-X. LHDs are expected to contact all identified persons within 24 hours of notification and supply all collected information to the IDEP daily. If additional persons are identified from other sources other than Epi-X, LHDs are responsible for notifying the IDEP immediately. LHDs will report all potential persons under investigation (PUIs) to the IDOH Monitoring Team as identified, from any report from a healthcare facility or walk-in to the LHD.

IV. Determination of Risk Category

An accurate risk assessment is necessary to ensure appropriate public health monitoring and activity restrictions are put in place. Information received from CDC Epi-X and provided to IDOH determines the individual's initial risk category. The LHD will use this information to re-assess and confirm the individual's level of risk using the IDOH EVD assessment algorithm.

High Risk

• <u>In any country</u>
  ○ Direct contact with body fluids, from a person showing symptoms, through a needle stick, splashes to eyes, nose or mouth, OR getting body fluids directly on skin
  ○ Direct contact with a person who has symptoms, or the person's body fluids, **while not wearing appropriate personal protective equipment (PPE)**
  ○ Laboratory processing of blood or body fluids from a person who has symptoms **while not wearing appropriate PPE or without using standard precautions**
  ○ Providing direct care to a person showing symptoms in a household setting
• <u>In countries experiencing widespread transmission</u>
  ○ Actively participated in a funeral or had any other contact with the remains of a known/suspect HCID patient

Some Risk

• <u>In any country</u>
  ○ Close contact with a symptomatic person within a household, healthcare facility, or the community **while not wearing appropriate PPE**
  ▪ *Close contact means being within 3 feet of a symptomatic individual for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes).*
• <u>In countries experiencing widespread transmission</u>
  ○ Direct contact with a symptomatic individual, or the person's body fluids**, while wearing appropriate PPE**
  ○ Being in the patient-care area of a Special Pathogen treatment unit
  ○ Providing any direct patient care in non-Special Pathogen healthcare settings

Low (but not zero) Risk

• <u>In any country</u>
  ○ Brief direct contact (such as shaking hands) with a person with early symptoms, **while not wearing appropriate PPE**. Early signs can include fever, fatigue, cough, or headache.
  ○ Brief proximity with a person who has symptoms (such as being in the same room, but not in close contact) **while not wearing appropriate PPE**
  ○ Laboratory processing of blood or body fluids from a person who has symptoms while wearing appropriate PPE and using standard precautions
  ○ Traveling on an airplane with a person who has symptoms and having had no identified *some* or *high-risk* exposures
• <u>In countries experiencing widespread transmission</u>
  ○ Having been in a country with a large outbreak within the past 21 days, with no known exposure (such as NO direct contact with body fluids from a symptomatic individual)

No Identifiable Risk
• Laboratory processing of HCID-containing specimens in a Biosafety Level 4 facility (e.g., VHFs such as Ebola) • Any contact with a person who is no longer symptomatic, even if the person had potential exposure • Contact with a person before the person developed symptoms • Any potential exposure that occurred more than 21 days previously • Having been in a country with HCID-related cases, but without widespread transmission and not having any other exposures • Having had laboratory-confirmed specimen and determined by public health officials to no longer be infectious (i.e., survivors)

V. Public Health Monitoring and Movement

A. Initial Health Risk Assessment by LHD to Determine Monitoring

- IDOH will receive notification from the CDC Division of Global Migration and Quarantine (DGMQ) via Epi-X.
- IDOH will notify LHD of all exposed persons and send the **IDOH Special Pathogen Assessment Algorithm**.
- The LHD must make contact with the person(s) within 24 hours and conduct an in-person assessment to confirm the exposure and risk.
- Persons should be asked about illness prior to in-person visit. If symptoms are identified, contact the IDOH IDEP immediately.
- While in-person, the person should be assessed using the **IDOH Special Pathogen assessment algorithm** to determine the level of risk for the individual. Once risk is determined, the following steps should be taken, regardless of risk level:
    - The person should be provided a number to contact appropriate LHD staff 24/7.
    - Advise persons on the components of monitoring (see Monitoring Following Initial Assessment), including 21-day symptom window and twice-daily fever monitoring.
    - Advise them on the process for calling them to check on their health status prior to any potential visit.
    - Obtain alternate contact information from the person in case of loss of primary communication method.
    - Review the process for notifying LHDs prior to seeking healthcare if they develop signs or symptoms.
    - Educate the individual on how to properly take their temperature with the same thermometer each time.
    - Establish a procedure for twice-daily (every 10-14 hours) reporting of symptoms.
- Complete the **Monitoring Information Form** and enter the information into the person's profile.
- LHD will confirm the level of risk and return the risk assessment to IDOH via secure email/fax.
- If a higher level of risk is identified than the predetermined risk by the CDC, the LHD will consult the IDOH IDEP.

B. Monitoring Following Initial Assessment

1. Persons Deemed High Risk

- Monitoring will take place for 21 days following the last exposure using Research Electronic Data Capture (REDCap).
- Individuals will be asked to voluntarily quarantine for the duration of the monitoring period. Non-compliance with voluntary quarantine will result in involuntary quarantine by the Local Health Officer.
- Monitoring consists of in-person twice daily temperature and symptom checks by a LHD official.
    - The LHD official or designee will call the individual to determine whether there has been any symptom onset, and if none, will travel to the self-quarantine location.
    - The LHD official or designee will observe the individual taking their temperature and the LHD official will record the time, temperature, and presence or absence of all symptoms.
        - If the individual is determined to be ill during the in-person visit, staff should not have any direct contact with the person or objects contaminated with blood or body fluid. The LHD will immediately notify the IDOH IDEP.
    - If a person has not been in contact for four hours or more after a designated meeting time, additional efforts will be made to find and observe the person and the IDEP will be notified.
    - At the conclusion of each visit, the LHD staff should perform normal hand hygiene; this includes washing hands with soap and water or an alcohol-based hand sanitizer regardless of presence of symptoms.
- Once the 21-day period is concluded, the individual no longer needs to be monitored.

2. Persons Deemed Some or Low Risk

- Monitoring will take place for 21 days following last exposure using Research Electronic Data Capture (REDCap).
- Monitoring consists of twice-daily self-temperature checks reported to the LHD by phone or other method determined by the LHD.
- The persons should immediately report any fever or other symptoms to the LHD.
    - If symptoms are identified, the LHD will instruct the individual to voluntarily quarantine and will immediately contact the IDOH IDEP. Non-compliance with voluntary quarantine will result in involuntary quarantine by the Local Health Officer.

- If the individual is determined to be ill during the in-person visit, staff should not have any direct contact with the person or objects contaminated with blood or body fluid. The LHD will immediately notify the IDOH IDEP.

- Once the 21-day period is concluded, the individual no longer needs to be monitored.

3. Persons Deemed No Identifiable Risk

No monitoring is recommended, but individuals should be advised to call the LHD if symptoms are observed. Other diseases associated with travel should be considered.

C. Identification of Symptoms

In the event that any individual is identified as having symptoms consistent with EVD, the LHD will contact the IDOH IDEP. If a monitored person becomes symptomatic, the LHD will initiate a normal public health contact tracing investigation to identify and locate those with potential exposure to a HCID and would begin monitoring procedures.

D. Considerations for Temperature Checks

Temperature should be taken twice a day around the same time in the morning and evening about 12 hours (10-14 hours) apart. Temperature should be taken orally using the same thermometer each time. Ask the person if they are taking aspirin, Tylenol® (acetaminophen), ibuprofen, or any medicine that can lower a fever. The temperature should be taken before taking the above-mentioned medications and prior to eating or drinking within 30 minutes.

VI. Difficulty in Monitoring

This plan annex is intended to be used in a vector-borne infectious disease emergency that requires a response that exceeds normal disease control capacity, or that requires an increased level of coordination and communication between agencies. Outbreak investigations and public health events begin and end at the local level. In the event an emergency situation exceeds the capabilities of a local jurisdiction, additional support is available at the district, state, and federal levels.

A. Failure to Make Initial Contact

LHDs will attempt to make contact with the persons within the first 24 hours after notification by the IDOH IDEP. LHDs will make attempts to locate the individual by making visits to the home address that was provided and by communication with the emergency contact that was provided. LHDs will alert local healthcare facilities and EMS in the event that the individual(s) calls 9-1-1 or presents at a healthcare facility in their jurisdiction. IDOH will assist the LHD if the LHD is unable to establish initial contact within 24 hours (for a person considered to be high

risk) or 48 hours (for a person considered to be some or low risk). IDOH will use their resources to assist in locating the individual.

B. Failure to Make Follow-up Monitoring Contact

If an LHD makes a successful initial contact, but difficulty is encountered in making follow-up monitoring attempts, one or more of the following steps to reach the individual will be taken by the LHD:

- Home visits
- Contacting the emergency contact IDOH Special Pathogen Monitoring Plan
- Contacting local hospitals to ensure the person has not been admitted

If unsuccessful, the following additional tactics may be used:

- Applying local public health authority, possibly by consulting with the county attorney for guidance
- Involving local law enforcement
- Providing the individuals' name to the health department staff members who are likely to field calls from healthcare providers requesting a consultation when there is a concern about a special pathogen-related disease.

IDOH will be informed if an LHD is unable to make follow-up monitoring contact with the individual within 48 hours (for a person considered high risk) or 72 hours (for a person considered some or low risk). If a LHD is unable to make follow-up monitoring contact within the designated timeframes, IDOH will use its resources to assist in locating the individual.

C. Unwilling Person

In the event that a person being monitored fails to cooperate with the LHD, IDOH will work with the local health officer who has the authority to begin the process of involuntary isolation and quarantine.

Indiana's Isolation and Quarantine statute is IC 16-41-9-1.5. This statute allows the State Health Commissioner, the State Health Commissioner's designee, a Local Health Officer, or an authorized health or hospital corporation to order a person or persons into isolation or quarantine. The local health officer has three options to initiate isolate or quarantine of individuals known or suspected of having a HCID, depending on urgency and exposure risk. Each option is detailed in the **Indiana Isolation and Quarantine Guidance for LHDs** document, which also contains additional procedures and recommendations. This process will be initiated based on a case-by-case evaluation with collaboration between the local health officer, their county attorney, IDOH and CDC, if needed.

LHDs will encourage the individual to agree to voluntary compliance before proceeding with involuntary action, including a written notification of the requested actions and subsequent consequences if these actions are not followed. Any isolation and quarantine orders will be by the least restrictive means necessary to prevent the spread of contagious or possible contagious disease. The health status of an individual will be monitored regularly, as an individual must be immediately released when there is no longer a risk of transmitting a contagious or potentially contagious disease to others.

VII. Public Activity and Travel Restrictions

A. Public Activity Restrictions

All persons being monitored will be treated on a case-by-case basis for activity restrictions. Under IC 16-41-9-1.5, local health officers have the authority to restrict the movement of people under monitoring if the public is at risk. Potential public activity restrictions may include, but are not limited to, movies/concerts, school, work, sporting events, shopping, and church/worship services. Per local public health authority, individuals may participate in non-congregate public activities if they can ensure 3-foot distance to others (e.g., jogging in the park).

All high-risk persons will be advised to voluntarily quarantine themselves for the duration of the monitoring period. Each high-risk person will be evaluated by local and state health authorities regarding any necessary restrictions of movement on a case-by-case basis. State law permits enforcement of an involuntary quarantine under IC 16-41-9-1.5.

All some- or low-risk persons are free to go about their usual routine during the 21 days of monitoring, including reporting to work.

B. Travel between Jurisdictions in Indiana

If traveling from one jurisdiction to another does occur, the LHDs will notify the IDEP. The LHD will coordinate to ensure the monitoring and follow-up continue uninterrupted. The local health officer may limit or restrict travel by bus, airplane, boat, ship, ferry, subway/metro, train, or shuttle. Travel by nonpublic conveyance, such as a private chartered flight or a private vehicle, may be allowed as long as it is coordinated with public health authorities at both the origin and destination of travel, and monitoring can occur uninterrupted. IDEP will ensure that the person's information is shared between LHDs.

C. Short-Term Interstate Travel

If an individual is traveling overnight (or longer) outside their original jurisdiction, the LHD will inform the IDEP about the planned travel. LHD staff will initiate discussions with the other affected local health department(s) to determine who will take over monitoring. If necessary, the

originating LHD will ensure appropriate routing of the individual's information to the other LHD. Unless other arrangements are made, the originating LHD will maintain responsibility for monitoring and documentation.

D. Long-Term Out-of-state and International Travel

If an individual will be traveling outside of Indiana during their monitoring period, the LHD will notify the IDEP as soon as possible. IDEP will alert the receiving state via Epi-X and a phone call (or CDC for international travel) of the individual's travel plans immediately. The LHD will collect all travel information (including flight times, cities/states, itinerary, etc.) and relay information to the IDEP. Any travel will be coordinated with local and state public health authorities to ensure uninterrupted monitoring.

APPENDIX A: ACRONYM LIST

Acronym	Term
ACS	American Community Survey
ADA	Americans with Disabilities Act
ASPR	Administration for Strategic Preparedness and Response
CBRNE	Chemical, Biological, Radiological, Nuclear, and Explosives
CDC	Centers for Disease Control and Prevention
CEMP	Comprehensive Emergency Management Plan
CERC	Crisis and Emergency Risk Communication
C-MIST	Communications, Medical, Independence, Supervision, Transportation
CONOPS	Concept of Operations
COOP	Continuity of Operations
DEP	IDOH Division of Emergency Preparedness
DGMQ	Division of Global Migration and Quarantine
DOC	Department Operations Center
ELC	Epidemiology and Laboratory Capacity for Infectious Diseases
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOF	Emergency Operations Framework
EPA	US Environmental Protection Agency
Epi-X	Epidemic Information Exchange
ESF	Emergency Support Function
ESSENCE	Electronic Surveillance System for the Early Notification of Community-Based Epidemics
EVD	Ebola Virus Disease
FOA	Funding Opportunity Announcements
FSSA	Indiana Family Social Services Administration
GLHP	Great Lakes Healthcare Partnership
HAI	Healthcare-Associated Infections
HCC	Healthcare Coalition

HCID	High Consequence Infectious Disease
HHS	Health and Human Services
HPP	Hospital Preparedness Program
ICS	Incident Command System
IDEM	Indiana Department of Environmental Management
IDEP	IDOH Infectious Disease Epidemiology and Prevention Division
IDHS	Indiana Department of Homeland Security
IDOA	Indiana Department of Administration
IDOH	Indiana Department of Health
IEMS	Indianapolis Emergency Medical Services
IHA	Indiana Hospital Association
IHAN	Indiana Health Alert Network
INDOT	Indiana Department of Transportation
ISP	Indiana State Police
JIC	Joint Information Center
LHD	Local Health Department
LRN	Laboratory Response Network
MRC	Medical Reserve Corps
NBS	NEDSS Base System
NETEC	National Ebola Training and Education Center
NIMS	National incident Management System
NIOSH	National Institute for Occupational Safety and Health
OPA	IDOH Office of Public Affairs
OSHA	US Occupational Safety and Health Administration
PAPR	Powered Air Purifying Respirators
PCR	Polymerase Chain Reaction
PHEP	Public Health Emergency Preparedness
PHN	Public Health Nurse
PPE	Personal Protective Equipment
PUI	Persons Under Investigation
QPA	Quantity Purchase Agreement

REDCap	Research Electronic Data Capture
SEOC	State Emergency Operations Center
SERV-IN	State Emergency Registry of Volunteers for Indiana
SNS	Strategic National Stockpile
SOP	Standard Operating Procedure
USDOT	US Department of Transportation
WHO	World Health Organization

APPENDIX B: GUIDANCE FOR LOCAL HEALTH DEPARTMENTS ON ISOLATION AND QUARANTINE PROCEDURES

Isolation is the separation of an infected individual (or group of individuals) from non-infected individuals, whereas **quarantine** is defined as the separation of an individual (or group of individuals) exposed to a communicable disease from non-infected and non-exposed individuals.

IMPLEMENTING ISOLATION AND QUARANTINE DURING HCID OUTBREAKS

The **Indiana Isolation and Quarantine Statute IC 16-41-9-1.5** allows the State Health Commissioner, the State Health Commissioner's designee, a local health officer, or an authorized health or hospital corporation to order a person or persons into isolation or quarantine. Isolated patients will likely be hospitalized in order to receive necessary medical attention as a result of the disease.

People in quarantine will likely be housed at home or moved to a separate living facility. Large quarantine shelters will be unlikely. While in quarantine, the local jurisdiction provides quarantined individuals with food and other daily living needs. The local health department also should also provide daily health checks to see if anyone has developed symptoms of the active disease outbreak. Lastly, the local health department works with local partners to help quarantined people meet other basic needs.

Recommendations for local health departments include the distribution of information to the public concerning the risks of communicable diseases, how the disease is transmitted, precautions to reduce transmission, as well as all known symptoms and treatments.

The local health officer has three options to isolate or quarantine individuals known or suspected of having a communicable disease:

- First, the local health officer may seek an isolation or quarantine order granted by a circuit or superior court in the respective county. The isolation or quarantine order is only granted after the court holds a hearing in which the potentially isolated or quarantined individual has had an opportunity to be heard.
- Second, the local health officer may seek an emergency order of isolation or quarantine. An emergency order of isolation is granted by a circuit or superior court without a hearing. However, the local health officer must prove to the court that the potentially isolated or quarantined individual will expose an uninfected individual to a high consequence infectious disease (HCID) before a timely notice for an opportunity to be heard.
- Third, the local health officer may issue an immediate order of isolation or quarantine. An immediate order of isolation or quarantine may only be issued if exigent circumstances exist that make it impracticable for the local health officer to seek an order from a court and

obtaining the individual's voluntary compliance is or has proven impracticable or ineffective. An immediate order of isolation or quarantine expires after 72 hours. After the 72-hour period ends, the local health officer must petition a circuit or superior court in their county to renew the order of isolation or quarantine.

A person who knowingly and intentionally violates a condition of isolation or quarantine commits a Class A misdemeanor. State and local law enforcement agencies will cooperate with the local health officer to enforce an order of isolation or quarantine.

Please read the statute for more detailed information. Additionally, please refer to the **IDOH "Implementing Isolation and Quarantine" manual** for further guidance. Local jurisdictions should make certain all appropriate individuals are familiar with the Isolation and Quarantine Statute, including the Local Health Department staff, the local health officer, the EMA, the county attorney, and any judge who may be involved.

The local health officer should make every attempt to talk the person into voluntary isolation or quarantine. If the local health officer is unsuccessful in garnering voluntary compliance, one of the following orders of isolation or quarantine should be obtained:

a. Order of Isolation or Quarantine (granted after hearing w/ individual)
b. Emergency Order of Isolation or Quarantine (granted w/o individual)
c. Immediate Order of Isolation or Quarantine (issued by local health officer)

State and local law enforcement agencies will cooperate with the local health officer to enforce an order of isolation or quarantine

The Local Health Departments should:

a. Distribute information to the public concerning:
    i. The risks of the disease
    ii. How the disease is transmitted
    iii. Available precautions to reduce the risk of contracting the disease
    iv. Symptoms of the disease
    v. Available medical or nonmedical treatments for the disease
b. Instruct the public concerning social distancing

c. Request the public inform the local health officer or a law enforcement agency if a family member contracts the disease
d. Instruct the public on self-quarantine and provide a distinctive means of identifying a home that is self-quarantined
e. Instruct the public on the appropriate means of reducing exposure to the disease
f. Close schools, athletic events, and other nonessential situations in which people gather. If quarantine is imposed, the public health authority shall ensure to the extent possible, quarantined individuals have sufficient supplies to remain in their own home.

APPENDIX C: Epidemiological Risk Factors and Categories

DETERMINATION OF RISK CATEGORY

An accurate risk assessment is necessary to ensure appropriate public health monitoring and activity restrictions are put in place for high-consequence infectious disease (HCID). During the initial EVD outbreak in West Africa in 2014-2016, a multi-agency protocol was developed for evaluating risk in returning travelers (including healthcare workers) from EVD-affected countries. The risk categories used include:

- High risk
- Some risk
- Low (but not zero) risk
- No identifiable risk

Based on the EVD Risk Assessment Model, each risk category depended on travel to affected countries and activities performed within the country during an individual stay. Public health action was based upon specific risk categories and includes daily check-in over the phone or via email, public health officials visiting travelers each day, travel restrictions, and isolation or quarantine.

CDC Public Health Recommendations for returning travelers from Ebola affected countries without EVD symptoms during EVD epidemic in West Africa 2014-2016

Exposure Category	Monitoring	Isolation/Quarantine	Restrict travel?
No identifiable risk	No	No	No
Low (but not zero) risk	Active monitoring	No	No
Some risk	Direct Active Monitoring	Case-by-case assessment	Case-by-case assessment
High risk	Direct Active Monitoring	Yes	Yes

Depending on the characteristics of a newly emerging special pathogen, this existing model can be used for evaluation of risk in a person under investigation (PUI). Modifications should be made based on CDC recommendations.

Information received from CDC Epi-X and provided to IDOH determines the individual's initial risk category. The LHD will use this information to re-assess and confirm the individual's level of risk using the **IDOH Special Pathogen Disease assessment algorithm.** Further information is located in **Annex A: LHD Special Pathogen Disease Monitoring Guidance**.

High Risk

• In any country
  ○ Direct contact with body fluids, from a sick individual who is showing symptoms of an HCID, through a needle stick, splashes to eyes, nose or mouth, OR getting body fluids directly on skin
  ○ Direct contact with a person with Ebola who has symptoms of an HCID, or the person's body fluids, **while not wearing appropriate personal protective equipment (PPE)**
  ○ Laboratory processing of blood or body fluids from a sick individual who has HCID-like symptoms **while not wearing appropriate PPE or without using standard biosafety practices**
  ○ Providing direct care to a person showing symptoms of an HCID in a household setting
• In countries experiencing widespread transmission
  ○ Actively participated in a funeral or had any other contact with the remains of a known/suspect HCID patient

Some Risk

• In any country
  ○ Close contact with a sick individual who is showing symptoms of an HCID, such as in a household, healthcare facility, or the community **while not wearing appropriate PPE**
  ▪ *Close contact means being within 3 feet of the person sick with an HCID for a long time.*
• In countries experiencing widespread transmission
  ○ Direct contact with a person sick with an HCID, or the person's body fluids**, while wearing appropriate PPE**
  ○ Being in the patient-care area of a special pathogen treatment unit
  ○ Providing any direct patient care in non-special pathogen healthcare settings

Low (but not zero) Risk

• In any country
  ○ Brief direct contact (such as shaking hands) with a person in the early stages of HCID-related illness, **while not wearing appropriate PPE**. Early signs may be non-specific, but can include fever, fatigue, or headache. Special respiratory HCID may include a cough, in addition to non-specific symptoms.
  ○ Brief proximity with a person with an HCID-like illness who has symptoms (such as being in the same room, but not in close contact) **while not wearing appropriate PPE**
  ○ Laboratory processing of blood or body fluids from a person with an HCID who has symptoms while wearing appropriate PPE and using standard biosafety practices
  ○ Traveling on an airplane with a person with an HCID illness who has symptoms and having had no identified *some* or *high-risk* exposures
• In countries experiencing widespread transmission
  ○ Having been in a country with a large HCID outbreak within the past 21 days for VHFs (up to 14 days for special respiratory), with no known exposure (such as NO direct contact with body fluids from a sick individual)

No Identifiable Risk

- Laboratory processing of special pathogens (e.g., Ebola) virus-containing specimens in a Biosafety Level 3 or 4 facility
- Any contact with a person who is no longer symptomatic for an HCID, even if the person had potential exposure to an HCID
- Contact with a person with an HCID-like illness before the person developed symptoms
- Any potential exposure to an HCID-like illness that occurred more than 21 days previously for VHFs (up to 14 days for special respiratory pathogens)
- Having been in a country with special pathogen cases, but without widespread transmission and not having any other exposures
- Having had laboratory-confirmed special pathogens and determined by public health officials to no longer be infectious (i.e., EVD survivors)

APPENDIX D: Special Pathogens Response Guidance and Recommendations for First Responders

Special Pathogens Quick Facts	
Special Respiratory Diseases	**Viral Hemorrhagic fevers (VHFs)**
• Special respiratory viruses include SARS, MERS-CoV, and novel influenza strains (e.g., H3N1, H5N1, H7N9) and are spread by droplets that come from coughing and sneezing. • Signs and symptoms vary by disease and may be nonspecific, but may include fever, chills, cough, sore throat, shortness of breath, etc. • Those infected may start showing symptoms within 14 days from initial contact. • Individuals who have a history of travel to a country experiencing widespread transmission within the past 14 days or have a history of direct contact with a patient who has a special respiratory HCID and have symptoms to warrant further investigation.	• Viral hemorrhagic fevers (VHFs) such as Ebola, are transmitted by direct contact with blood and body fluids from a symptomatic individual having a fever, headache, body aches, abdominal pain, vomiting, and diarrhea. • The infection can be spread only by someone who has symptoms. • Those infected may start showing symptoms ranging from 2 to 21 days from initial contact • VHFs are not transmitted by food, water, or airborne routes. • Individuals must have a history of travel to a country experiencing widespread transmission within the past 21 days or have a history of direct contact with a VHF patient and have symptoms to warrant further investigation.

PREPAREDNESS

Prior to receiving a dispatch or call, first responders should already discuss and plan response to a suspected or confirmed HCID patient within the jurisdiction. Discussion with all partners should occur in each Indiana district as a unified collaboration, as well as in each local jurisdiction. Regardless of dispatch information, first responders should be vigilant for travel history and signs and symptoms of communicable disease (e.g., fever, cough, gastrointestinal issues).

In each local jurisdiction, all partners must meet and discuss the preparedness and planning to include at minimum EMS, fire, police, EMA, Hazmat, public health, dispatch, medical directors and hospitals. Each jurisdiction should identify, when possible, the appropriate EMS unit(s) and support units capable of responding to a suspected or confirmed special pathogen call.

Determining the transportation destination is done through coordination of the local health department and partners, Frontline Centers, IDOH, and the CDC. While pre-planning is important, several factors go into the actual decision during an incident:

- Appropriate information from the caller and dispatcher
- Appropriate protocols for response, clinical care, application of hierarchy of controls by responding EMS personnel; and
- Transport to a facility that can provide appropriate evaluation and treatment of the PUI.

Pre-identification of partners is essential in ensuring safe and proper response. Additionally, jurisdictions should preplan possible transport destinations for suspected or confirmed HCID patients to an appropriate Frontline Center for the initial 72 hours of isolation until a negative test. Later, should the test result be positive, IDOH and CDC will initiate a transfer of the patient to a treatment center. If information about communicable diseases is disclosed during the initial PUI call, ensure that this information is relayed to responders in accordance with established protocols on handling patient-related/HIPAA-protected information.

RESPONDER ROLES

Emergency medical services (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, EMS patient care is provided in an uncontrolled environment before getting to a hospital.

This setting is often confined to a very small space and frequently requires rapid medical decision-making and interventions with limited information. EMS personnel are frequently unable to determine the patient history before having to administer emergency care. It is essential that strict standard and transmission-based precautions based on dispatch information are implemented to avoid exposure to potentially infectious bodily fluids, droplets, and airborne particles

Coordination among 911 Public Safety Answering Points (PSAPs), EMS providers, healthcare facilities, local public health, and other public safety agencies is important when responding to patients with a suspected HCID.

RESPONDER SAFETY

Prior to responding to or transporting a suspected or confirmed HCID patient, all first responders involved in the care of the patient must have received proper training and have demonstrated

competency in performing all special pathogen-related infection control practices and procedures, and specifically in donning/doffing proper PPE.

While working in PPE, first responders caring for an HCID patient should have no skin exposed at any time. Every step of each PPE donning/doffing procedure must be supervised by a trained observer (safety officer) to ensure proper completion of established PPE protocols and utilize a buddy system.

Responders must limit the number of personnel who come into contact with the HCID patient to only the essential personnel required. It is recommended that no more than two responders come into contact with the patient. No responder should enter a residence or patient area that is suspected or confirmed for a special pathogen without proper PPE.

Powered Air-Purifying Respirators (PAPR) are the recommended choice of protection. However, responders choosing to utilize Full Face Air-Purifying Respirators (APR) must ensure compliance with all elements of the OSHA Respiratory Protection Standard, 29 CFR 1910.134, including fit testing, medical evaluation, and training of the responder.

All responders involved in any response should complete annual OSHA blood borne pathogen training and *always* utilize universal precautions. All responders should be familiar with the department or agency exposure control plans in the event of an unintentional break in procedure.

Refer to **Appendix E: Personal Protective Equipment Recommendations for First Responders for a detailed overview of PPE.**

DISPATCH OR CALL TO SUSPECTED OR CONFIRMED HCID PATIENT

Upon receiving a dispatch or call to a suspected or confirmed HCID patient, review screening criteria with dispatch.

- **For VHFs**
  - Patient has a fever (>100 degrees F) or other symptoms like headache, body aches, abdominal pain, vomiting, or diarrhea**; and**
  - Patient has traveled to a country experiencing widespread transmission in the past 21 days or has had contact with anyone being treated for a VHF
- **For Special Respiratory**
  - Patient has compatible symptoms: coughing, shortness of breath, chills, body aches, sore throat, etc.; and
  - Patient has traveled to a country experiencing widespread transmission in the past 14 days or has had contact with anyone being treated for a special respiratory disease.

If the above symptoms are confirmed with dispatch, EMS shall request appropriate support personnel and proceed non-emergent to scene. If both screening criteria above are not met, STOP and proceed as normal.

SUSPECTED OR CONFIRMED HCID PATIENT PRECAUTIONS

All personnel on scene should fully plan the response. All calls meeting the above screening criteria should implement the Incident Command System and have a designated Incident Commander by another EMS or fire unit. A safety officer should be designated to oversee all donning of personal protective equipment. Additional law enforcement or fire should be requested for assistance as needed in restricting access to the scene and security but should at no time enter the scene without appropriate personal protective equipment.

EMS should confirm with the local health department to which Frontline Center they are transporting. The local health department will have already spoken with IDOH, the CDC, and the Frontline Center to make the determination. EMS should make phone contact with that hospital to relay all information and receive all special instructions for the transport (i.e. staging location, etc).

Additionally, EMS should contact medical direction for any special instructions and verify with medical director their destination. Medical direction may be difficult while wearing full PPE during transport. EMS should confirm all information with the EMS medical director prior to donning when possible.

PATIENT ASSESSMENT

After properly donning personal protective equipment under supervision, EMS should approach the residence. Before entering, EMS should make verbal contact with the patient from outside or at the door. EMS should again confirm the preceding screening criteria. **If the patient does not meet screening criteria, proceed as normal.**

- Upon arrival, first responders should issue patient instructions, which may include:
    - Keep porch light on
    - Control animals
    - Gather medications
    - Request family member to meet personnel at door
- First responders should prepare to confirm the screening criteria from at least 3 feet from the individual/outside the residence. For suspected respiratory illnesses, interviews should be conducted at least 6 feet apart from the patient in order to avoid contact with respiratory droplets.
    - For geographically associated HCIDs such as EVD or MERS, public health or EMS authority may request responders ask additional screening questions, including:

        - Travel history and/or direct exposure to potential case within incubation period of the suspected HCID (e.g., MERS-14 days; EVD – 21 days)
        - Specific signs and symptoms of illness
- If the screening criterion is met, EMS should assure the patient that additional medical personnel will be arriving shortly. EMS should back away from the residence and request an appropriate EMS unit that has been identified to manage and transport a suspected or confirmed HCID patient. At no time, should any first responders enter the residence or make contact with patient without donning full PPE as specified below.
- EMS should don standard isolation personal protective equipment: gloves, gown, mask, and eye protection (or higher level of protection as appropriate and trained).
- EMS should reassure the patient. EMS should give patient the following PPE:
    - Patient gown
    - Mask
    - Foot coverings
- Keep non-essential equipment away from the patient to minimize contamination on scene and in the ambulance.

EMS should keep the patient separated from other persons who may be in the residence as much as possible. Caution should be used when approaching a patient with HCID. Certain illnesses (e.g., EVD) may cause delirium, with erratic behavior that can place EMS personnel at risk of infection, e.g. flailing or staggering.

If possible, EMS will instruct the patient to walk to the ambulance. If the patient is unable to walk, the patient may need assistance onto a stretcher. EMS should be extremely careful in any strenuous activities. If the primary two EMS are unable to manage the patient safely, an additional two EMS should be requested to assist after fully donning PPE.

PATIENT TRANSPORT

The EMS driver should remain isolated in the front of the cab, separated from the patient compartment by a closed door. The driver should contact the receiving hospital when en-route. Unless otherwise warranted by patient symptoms or medical protocols, transport should be considered non-emergency and extremely cautious. Transports should avoid any unnecessary abrupt movements that could compromise EMS PPE. EMS should request a law enforcement escort to further ensure safety and security of the crew and patient.

During transport, it is recommended that no procedures are performed on the patient unless life saving measures or as directed by medical direction. Both EMTs should remain seated with appropriate restraint devices. All PPE must be worn for the entire duration of transport.
Upon arrival, EMS should stage at pre-identified location, i.e., outside ER bay. Hospital staff will meet EMS and transfer patient care.

DECONTAMINATION

First responders should consider requesting decontamination support from local Hazardous Materials Teams. Decontamination should be taken with the same high level of care and precaution as with patient contact. The following are general guidelines for cleaning or maintaining EMS transport vehicles and equipment after transporting a patient with suspected or confirmed HCID:

- An EPA-registered hospital disinfectant with label claims for viruses that share some technical similarities to special pathogens (such as norovirus, rotavirus, adenovirus, poliovirus)[4] and instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids should be used according to those instructions. After the bulk waste is wiped up, the surface should be disinfected as described below.
    - If EPA-registered hospital disinfectants become unavailable or are in short supply during a pandemic, consider dilute bleach solution as per CDC and WHO guidance (see Additional Information)
- EMS personnel performing cleaning and disinfection should follow the "Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)". Follow the same careful attention to the safety of the EMS personnel during the cleaning and disinfection of the transport vehicle as there is during the care of the patient.
- Patient-care surfaces (including stretchers, railings, medical equipment control panels, and adjacent flooring, walls and work surfaces), as well as stretcher wheels, brackets, and other areas, are likely to become contaminated and should be cleaned and disinfected after each transport.
- A blood spill or spill of other body fluid or substance (e.g., feces or vomit) should be managed by trained personnel wearing correct PPE, through removal of bulk spill matter, cleaning the site, and then disinfecting the site.
    - For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient.
- Contaminated reusable patient care equipment (e.g., glucometer, blood pressure cuff) should be placed in biohazard bags and labeled for cleaning and disinfection according to agency policies.

- Reusable equipment should be cleaned and disinfected according to manufacturer's instructions by trained personnel wearing correct PPE. Avoid contamination of reusable porous surfaces that cannot be made single use.

- Use only a mattress and pillow with plastic or other covering that fluids cannot get through. To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, non-fluid-impermeable pillows or mattresses as appropriate.

WASTE MANAGEMENT

VHFs such as EVD and Marburg are classified as Category A infectious substance regulated by the U.S. Department of Transportation's (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Most Special Respiratory HCIDs are classified as Category B infectious substances (with the exception of Nipah and Hanta). Any item transported for disposal that is contaminated or suspected of being contaminated with a Category A and B infectious substances must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, and used healthcare products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used PPE, [e.g., gowns, masks, gloves, goggles, face shields, respirators, booties] or byproducts of cleaning) contaminated or suspected of being contaminated with a Category A infectious substance.

Any waste generated should be bagged at the receiving hospital for proper disposal.

For more information, refer to **Appendix G – Waste Management Guide**

ADDITONAL INFORMATION

The recommendations for Special Pathogens Response Guidance for First Responders has been developed based upon the guidance and best practiced identified by the CDC. The following links contain further information:

NYC Health + Hospitals. (2019). Frontline Hospital Planning Guide: Special Pathogens
https://hhinternet.blob.core.windows.net/uploads/2019/07/NYCHH-Frontline-Hospital-Planning-Guide.pdf

Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)
http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html

Emergency Medical Services (EMS) Systems and 9-1-1 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

CDC. Guideline for Disinfection and Sterilization in Healthcare Facilities (2008).

https://www.cdc.gov/infectioncontrol/guidelines/disinfection/disinfection-methods/index.html

APPENDIX E: PERSONAL PROTECTIVE EQUIPMENT RECOMMENDATIONS FOR FIRST RESPONDERS AND FRONTLINE CENTERS

The following information intends to provide personal protective equipment (PPE) recommendations for first responders and frontline centers. Responders and frontline centers vary greatly in terms of access to resources and transportation capabilities. Both entities may choose to adopt other PPE procedures due to preference, training, supply, consistency, or other related factors. First responders and frontline facilities should develop checklists and standard operating procedures for both the donning and doffing of PPE processes.

Precautions are initiated and PPE is donned as soon as a suspected case is recognized and sufficient for special respiratory diseases (influenza, MERS, SARS). For EVD/VHF, precautions are initiated and PPE is donned when suspicion for EVD or another VHF is likely based on current outbreak epidemiology and patient status (e.g., unstable, vomiting, diarrhea, bleeding).

Basic Special Pathogens PPE	Additional EVD/VHF PPE

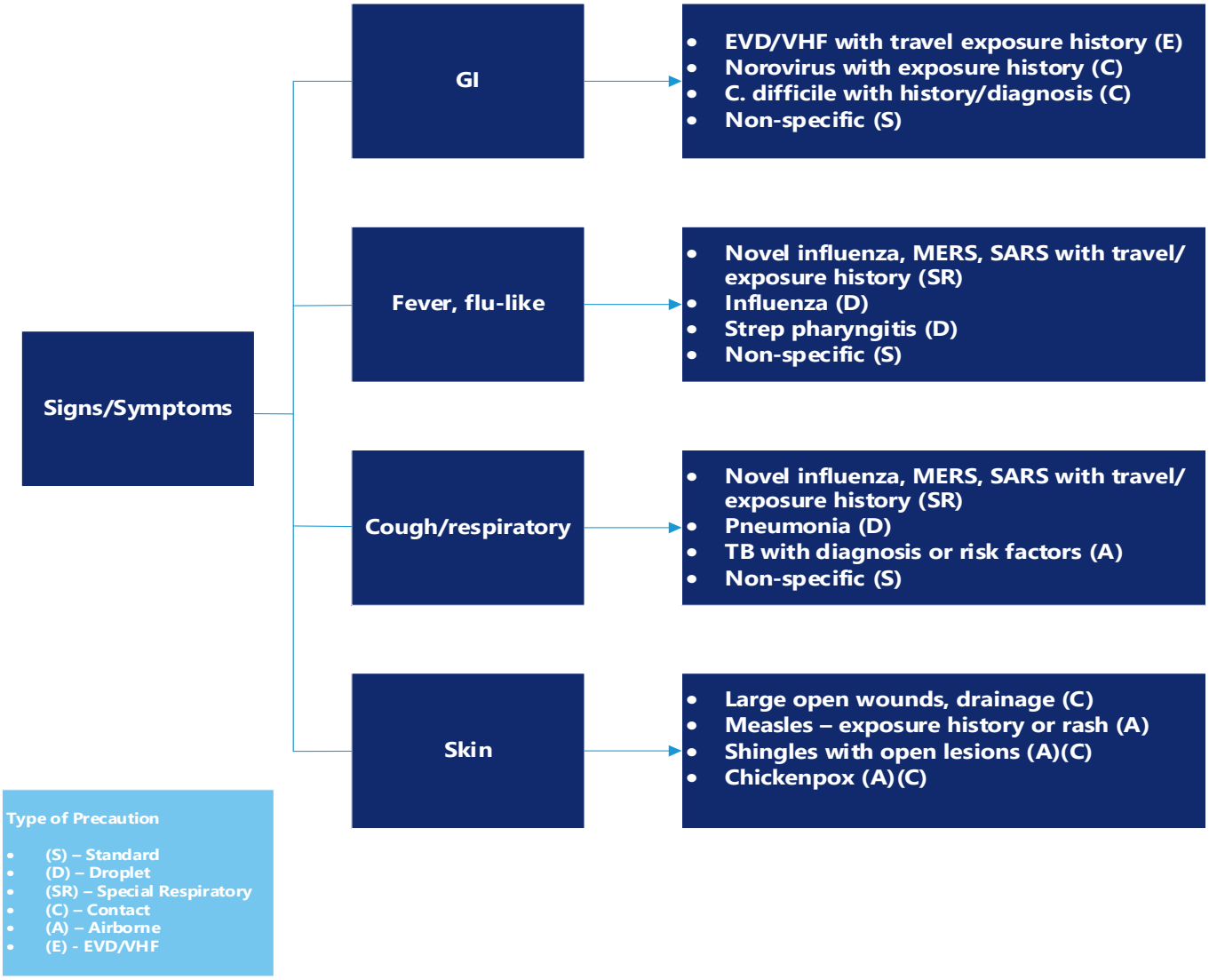
• Disposable exam gloves (standard gloves for standard precautions; elongated cuffs for use with barrier gowns/suits)
• Cleanable goggles or face shield
• Surgical masks for patients and providers
• Disposable fluid-resistant gown or disposable fluid-resistant coverall
• Disposable National Institute for Occupational Safety and Health (NIOSH)-approved, fit-tested N95 or equivalent/higher level respirator (e.g., reusable half-face elastomeric respirator N95 or higher rating mask, or PAPR with full hood and HEPA filter)
• Disposable boot/shoe covers
  ○ Note: Disposable boot/shoe and head covers are not required by CDC but recommended by OSHA
	• Full face shield (plus head cover)
	• Respiratory protection options:
	  ○ NIOSH-approved, fit-tested N95 respirator worn with impermeable hood covering head and shoulder, along with full face shield)
	  ○ PAPR with HEPA filtration and integrated impermeable drape-style hood
	  ○ Boots (disposable or reusable)
	  ○ Fluid-resistant coverall (if gowns are used for other contact exposures)
	  ▪ OPTIONAL: Disposable, impermeable apron in addition to fluid-resistant coverall for unstable patients

TRANSMISSION BASED PRECAUTIONS

Type of Precautions	PPE
Standard (S)	Gloves, gown, simple mask, goggles or face shield. Ensemble is determined by the type of interaction (if any) with the patient and patient signs and symptoms
Contact (C)	fluid-resistant gown, gloves
Droplet (D)	Simple mask, eye protection, gloves
Airborne (A)	fit-tested N95 or equivalent/higher respirator or powered air-purifying respirator (PAPR)

The following PPE assessment algorithm depicts the recommended PPE based on reported patient symptoms and correspond to the transmission based precautions as described in the table above. Note that transmission-based precautions are always accompanied by standard precautions.

Transmission-based PPE Algorithm



ADDITIONAL RESOURCES

CDC. Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)
http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html

CDC. Transmission-Based Precautions
https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html

HHS/ASPR TRACIE. EMS Infectious Disease Playbook
https://files.asprtracie.hhs.gov/documents/aspr-tracie-transport-playbook-508.pdf

NETEC Resource Library. Personal Protective Equipment (PPE).
https://repository.netecweb.org/exhibits/show/ppe101/ppe

NYC Health + Hospitals. (2019). Frontline Hospital Planning Guide: Special Pathogens
https://hhinternet.blob.core.windows.net/uploads/2019/07/NYCHH-Frontline-Hospital-Planning-Guide.pdf

APPENDIX F: Special Pathogen Guide for 911 Dispatch and Call Centers

Special Pathogens Quick Facts	
Special Respiratory Diseases	**Viral Hemorrhagic fevers (VHFs)**
• Special respiratory viruses include SARS, MERS-CoV, and novel influenza strains (e.g., H3N1, H5N1, H7N9) and are spread by droplets that come from coughing and sneezing. • Signs and symptoms vary by disease and may be nonspecific, but may include fever, chills, cough, sore throat, shortness of breath, etc. • Those infected may start showing symptoms within 14 days from initial contact. • Individuals who have a history of travel to a country experiencing widespread transmission within the past 14 days or have a history of direct contact with a patient who has a special respiratory HCID and have symptoms to warrant further investigation.	• Viral hemorrhagic fevers (VHFs), such as EVD, are transmitted by direct contact with blood and body fluids from a symptomatic individual having a fever, headache, body aches, abdominal pain, vomiting, and diarrhea. • The infection can be spread only by someone who has symptoms. • Those infected may start showing symptoms ranging from 2 to 21 days from initial contact • VHFs are not transmitted by food, water, or airborne routes. • Individuals must have a history of travel to a country experiencing widespread transmission within the past 21 days or have a history of direct contact with a VHF patient and have symptoms to warrant further investigation.

MEDIA-BASED INQUIRIES

If you do not have a standing protocol for handling special pathogen-related media inquiries within your jurisdiction, then direct them to:

Jennifer O'Malley
Chief Communications Officer, Indiana Department of Health
317.233.7315
JOMalley@health.in.gov
ISDH Media: Media@isdh.IN.gov

RESPONDING TO GENERAL NON-EMERGENCY CALLER INQUIRIES

If a caller has general, non-emergency questions related to a special pathogen that you cannot answer using the information provided here, you may direct them to the Indiana Department of Health at: **317-233-1325**. Additional information is available at www.CDC.gov and http://ww.in.gov/health

MAINTAINING PATIENT PRIVACY

Infectious diseases of high-consequence (HCID) are highly sensitive and emotionally charged topics. Even a simple mention of a potential patient with an HCID or outbreak via an open source, public safety communications system could potentially create widespread concern among the public and the media. **If it becomes necessary to communicate information related to a potential or suspect case, non-specific terminology or private modes of communication should be utilized.**

The Health Insurance Portability and Accountability Act (HIPAA) and other patient confidentiality rules and regulations apply to infectious disease public health emergencies. Exercise the same precautions to protect confidential information as needed in any other situation with managing sensitive patient information. It is highly recommended any local responders dispatched to the scene are done so in a confidential manner not disclosing a potential special pathogen/HCID situation.

WHEN A CALLER IS SPECIFICALLY CONCERNED ABOUT A SPECIAL PATHOGEN OR HCID:

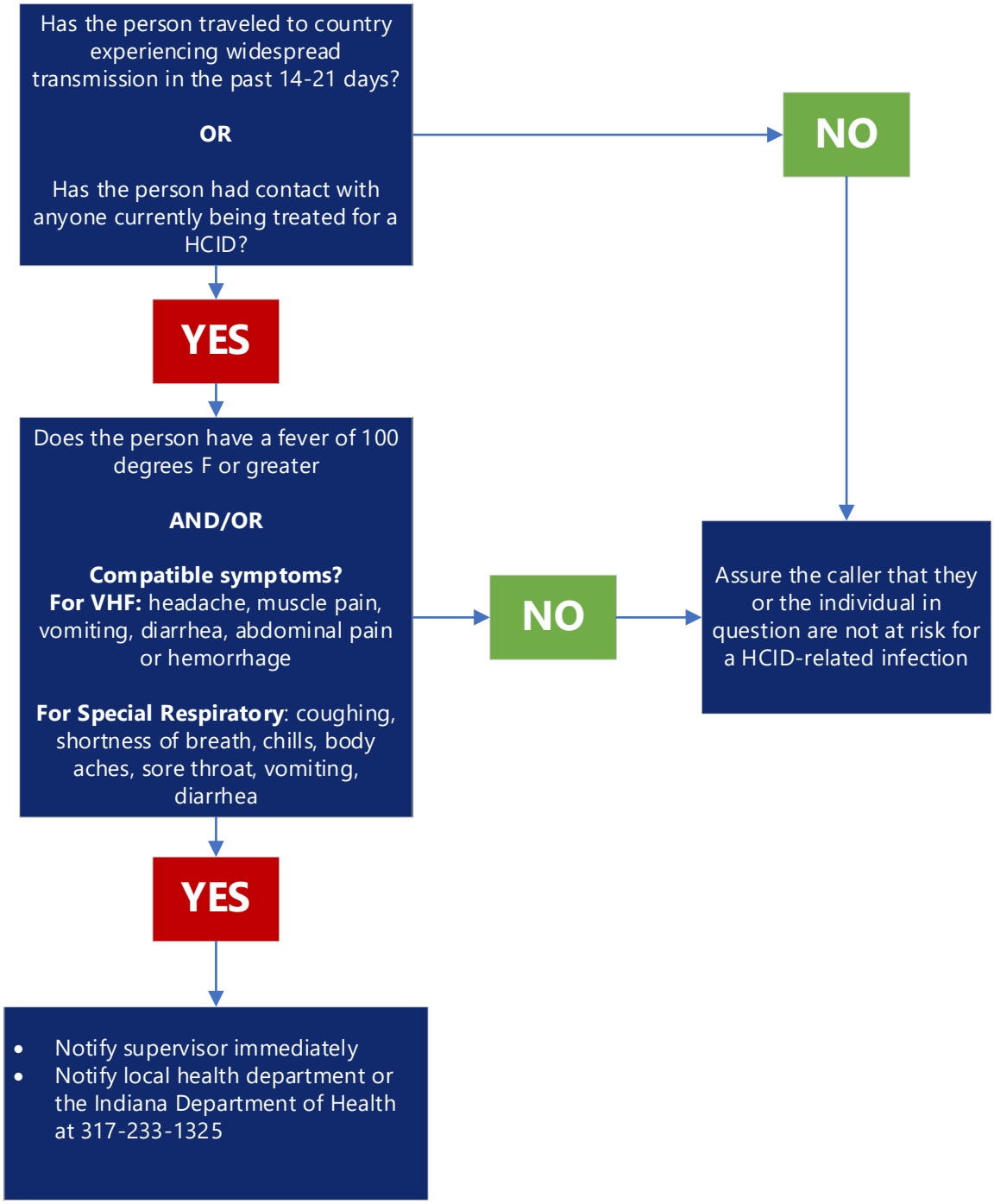
It is likely, especially during flu season or from the recent COVID-19 pandemic, that 911 dispatch and call centers may experience a high volume of calls related to citizens experiencing symptoms comparable to an HCID. While it is extremely unlikely the caller has been exposed to a special pathogen (e.g., EVD), the 911 operator may still inquire about the caller's condition to eliminate any possibility; however, it is important not to create concern for the caller that a special pathogen is a likely cause of the symptoms if they have not already expressed it.

If after providing a caller the facts about a special pathogen and the caller remains concerned about becoming infected or knows someone at risk of being infected, refer to the following flowchart to determine if the caller's concerns require additional investigation.

If the caller is determined to not be at risk for an HCID, yet remains concerned about a potential disease, the individual can be directed to the IDOH Infectious Disease Epidemiology and Prevention Division (317-233-7125 / 317-233-1325 (after hours)).

The local health department and local partners, along with the Indiana Department of Health, Frontline Centers, EMS identified for transport, and the CDC will determine the appropriate transport destination.

SPECIAL PATHOGEN CALLER ALGORITHM



APPENDIX G: SPECIAL PATHOGENS WASTE MANAGEMENT GUIDE

Special pathogens or high-consequence infectious diseases (HCIDs) have the potential to cause high mortality among otherwise healthy people. All forms of medical waste originating from an affected patient (including patient excreta, blood, tissue, tissue swabs, specimens) are classified as "Category A" infectious substances. Objects such as needles, syringes, personal protective equipment, or textiles that have been exposed to special pathogens may transmit it to another person if decontamination and disposal are not properly handled.

Handling suspected or confirmed special pathogen-associated waste should be done with strict adherence to proper handling, transport, and disposal procedures; however, if a treated patient is no longer considered an HCID-risk patient, then any waste generated for the remainder of the patient's care should be treated as regulated medical waste as set forth by the healthcare facility guidelines for waste disposal.

Isolation and Management of Special Pathogen-contaminated Solid Medical Waste

Medical waste contaminated with special pathogens such as Ebola Virus Disease and any waste comingled with special pathogen/EVD-contaminated waste must be kept isolated from and disposed of separately from other regulated medical waste.

- Waste generated during the treatment of a suspected or confirmed HCID patient should be collected in the patient's room or designated area, and identified as HCID (e.g., EVD) waste.
- All contaminated waste should be disposed of in a leak-proof bag that is initially placed in a rigid container to provide support and decrease contamination to the exterior of the waste bag.
- This bag should be considered full when the waste receptacle has reached 75% capacity. Overfilling the bag could cause exposure through spillage, or may cause the bag to tear.
- Prior to closure, treat the bagged waste with a non-aerosol liquid solution of U.S. EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) recommended by the CDC for use as a disinfectant for special pathogenic waste. Use a small amount sufficient to coat the surface of the materials contained within the bag without creating free liquids at the bottom. Do not attempt to stir or mix contents.
- Tie off the top of the bag with a knot or equally effective means such as heat sealing, tape, or adhesive to ensure any liquid cannot leak from the packaging.
- Disinfect the exterior of the bag using bleach wipes or other non-aerosol liquid solution of U.S. EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) that is recommended by the CDC for use as a disinfectant for special pathogens.

- Place this bag in a secondary packaging and tie off the top of the bag with a knot or equally effective means, such as heat sealing, tape, or adhesive to ensure any liquid cannot leak from the packaging.
- Disinfect the exterior of the secondary packaging using bleach wipes or other non-aerosol liquid solution U.S. EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) recommended by the CDC for use as a disinfectant for special pathogens

Onsite Treatment of Special Pathogen-contaminated Solid Medical Waste

Waste generated during the care of a suspected or confirmed special pathogen/HCID patient can be treated onsite through inactivation or incineration.

- Onsite inactivation: Special pathogen-associated waste may be inactivated through the appropriate use of autoclaves.
- Onsite incineration: Special pathogen-associated waste may be inactivated through the use of appropriate incineration; however no hospitals in Indiana currently utilize incinerators.
- Link to CDC guidance on disinfection and sterilization in healthcare facilities: http://www.cdc.gov/hicpac/disinfection_sterilization/13_0sterilization.html
- **Special pathogen waste that has been appropriately incinerated, autoclaved, or otherwise inactivated is no longer infectious, does not pose a health risk, and is not considered to be regulated medical waste or a hazardous material under Federal law. Products of incineration of special pathogen-associated waste can be transported and disposed of in accordance with state/local regulations and standard protocols for hospital waste disposal.**

Onsite Transportation of Special Pathogen-contaminated Solid Medical Waste

Special pathogens such as VHFs (e.g., Ebola, Lassa, Marburg) is regulated as a Category A infectious substance and is considered a hazardous material under the U.S. Department of Transportation's Hazardous Materials Regulation (HMR; 49 C.F.R. Parts 171-180). Therefore, certain disposal protocols set forth by this regulation must be met prior to transporting special pathogen-associated waste offsite that has not been inactivated onsite.

Prior to transport offsite, a Category A infectious substance must be tripled packed in a primary watertight receptacle, a watertight secondary packaging, and a rigid outer packaging.

Individual plastic film packaging

- Must weigh no more than 10kg (22lbs) when full
- Must be 175 liters (46 gallons) or smaller
- Must be marked and certified by its manufacturer as having an impact resistance of 165 grams and a tearing resistance of 480 grams in both parallel and perpendicular planes with respect to the length of the bag when tested in accordance with ASTM D 1709 and ASTM D 1922
- Must be compatible with the non-aerosol liquid solution EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) recommended by the CDC for use as a disinfectant for a special pathogen

Rigid outer packaging

- Must be either a United Nations (UN) Standard or DOT approved non-bulk packaging
  - Drums made of plastic, or triple wall corrugated fiberboard (authorized under approval)
  - Boxes made of plastic or triple wall fiberboard
- Must be certified and tested to the PG II Level for medium danger
- Must have a minimum of a 6-millimeter polyethylene plastic liner if the outer packaging is fiberboard
- Must be marked and labeled in accordance to U.S. DOT Hazardous Materials Regulation.

After outer packaging has been closed as specified by the manufacture of the packaging, disinfect the exterior surface of the outer packaging with a non-aerosol liquid solution EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) that is recommended by the CDC for use as a disinfectant.

NOTE: It is important that healthcare facilities coordinate with their current waste management vendor to discuss their protocol on disposal of waste contaminated with infectious viral hemorrhagic fever or other Category A Infectious Waste designated substances. Be sure to include questions such as:

1. Whether the vendor has an arrangement with a waste disposal or processing facility that holds the required permits to receive waste contaminated with special pathogens, such as infectious viral hemorrhagic fever.

2. Indiana waste disposal and processing facilities must have a permit from the Indiana Department of Environmental Management to accept and process infectious wastes - including an explicit provision authorizing the facility to dispose or treat waste contaminated with viral hemorrhagic fevers or other Category A infectious substances.

3. If the waste disposal or processing facility is located outside Indiana, the vendor must ensure the facility has their state's approval to receive and treat Category A infectious waste.

4. Whether the vendor can properly package a U.S. DOT regulated Category A infectious substance according to Hazardous Waste Regulations for transportation offsite.

5. Whether the vendor knows the proper protocol for requesting the Special Permit from U.S. DOT in the event that they may need to transport a Category A infectious substance from the healthcare facility.

IMPORTANT: There are four requirements in order to be approved for the Special Permit as regulated by U.S. DOT:

- Waste must be triple packaged as instructed in the previous section
- Transport containers must be labeled as: UN number 2814 infectious substances affecting humans
- Transport must have a security plan and en route security detail
- Facilities must develop an emergency response plan in the event of a spill or other emergency

U.S. DOT has confirmed that it will not issue the Special Permit in advance. This permit can only be issued once the regulated medical waste is suspected or confirmed to be a Category A infectious substance.

Recommendations for Liquid Waste Disposal

Wastewater treatment facilities are appropriately able to administer sewage handling processes that are designed to inactivate infectious agents. The CDC does not recommend any special pretreatment for liquid waste disposal.

- Any liquid generated by the patient or during treatment (i.e., blood transfusion, dialysis, used saline, irrigation procedures) should be delivered to a sanitary sewage receptacle with no additional processing necessary.
- The CDC recognizes that the wastewater treatment community and other stakeholders have concerns allowing waste to enter the sanitary sewer system. Wastewater treatment plant processes are designed to inactivate or remove pathogens; however, some wastewater treatment systems may require hospitals caring for HCID patients to treat the waste before discharge into sanitary sewers.
- Various sources have used different approaches to treat special pathogen waste before discharge in the U.S. based on their experience treating EVD patients, including:
    - Use portable toilets and add solidifying agents to the patient's waste before disposal as VHF-associated solid waste.

- Add a hospital grade disinfectant at the manufacturer's recommended concentration to the toilet containing the patient's waste, then hold the waste in the toilet for 2.5 times the recommended contact time before flushing.
- Add bleach or quaternary ammonium compounds to the toilet containing the patient's waste for 5 minutes before flushing (type and concentration of disinfectants used in this protocol were not provided to CDC) with approval from local municipality.

- When using bleach as a wastewater treatment method, the CDC has highlighted the following concerns:
  - There are currently no U.S. EPA registered disinfectants approved for use against enveloped or non-enveloped viruses in feces, urine, or vomit in the toilet before their disposal in the sanitary sewer system. If the product is not used according to these instructions, there is no guaranteed effectiveness.
  - Viruses (including Ebola) will associate with particles and organic material in patient waste and be protected from disinfectant, thereby decreasing the effectiveness of the disinfectant.
  - Bleach is a strongly corrosive agent and may react chemically with organic compounds to produce harmful vapors, requiring additional ventilation of the patient's room.
- Human waste, blood, and other potentially infectious materials are routinely released into sanitary sewers. Wastewater treatment plant processes are designed to inactivate or remove human disease-causing organisms, including bacteria and viruses.
- Enveloped viruses (such as Ebola) are more susceptible to environmental stresses and to chemical germicides than non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus).
- Although there is a very low risk of exposure, the WHO has established guidelines for hygiene and PPE to prevent exposure to pathogens when working with untreated sewage.
  - Develop and fully implement routine protocols that ensure workers are protected against potential exposures (i.e., contact with broken skin, eyes, nose or mouth).
  - Ensure all workers always practice good personal hygiene, including frequent hand washing, to reduce potential exposures to any of the pathogens in sewage.

NOTE: Although the CDC does not have any special recommendations, please be sure to contact your local wastewater treatment facility to discuss liquid waste disposal.

ADDITIONAL RESOURCES

CDC (2019). Ebola-Associated Waste Management.
https://www.cdc.gov/vhf/ebola/clinicians/cleaning/waste-management.html

HHS/ASPR TRACIE. EMS Infectious Disease Playbook
https://files.asprtracie.hhs.gov/documents/aspr-tracie-transport-playbook-508.pdf

NYC Health + Hospitals. (2019). Frontline Hospital Planning Guide: Special Pathogens
https://hhinternet.blob.core.windows.net/uploads/2019/07/NYCHH-Frontline-Hospital-Planning-Guide.pdf

APPENDIX H: SPECIAL PATHOGENS RESPONSE MATRIX

	Disease	Initial Signs/Symptoms	Incubation Period	Transmission-based Precautions	PPE	Division 6.2 Infectious Substances Category: A or B
Viral hemorrhagic fevers (VHFs)	Crimean-Congo Hemorrhagic Fever	Fever, headache, back pain, joint pain, stomach pain, vomiting, red eyes, flushed face, red throat, petechiae (red spots) on the palate	3-10 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Nitrile gloves with extended cuff - 2 pairs Impermeable gown extending to at least mid-calf Knee high pull-on impermeable shoe covers Surgical hood Face shield Impermeable apron added for patients with significant body fluid losses/exposure risk	Category A
	Ebola Virus Disease	Fever, abdominal pain, vomiting, diarrhea, general malaise and weakness, and headache, fatigue, unexplained hemorrhage	2-21 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Nitrile gloves with extended cuff - 2 pairs Impermeable gown extending to at least mid-calf Knee high pull-on impermeable shoe covers Surgical hood Face shield Impermeable apron added for patients with significant body fluid losses/exposure risk	Category A
	Lassa; Lujo; Machupo; Junin Hemorrhagic Fevers	Fever, myalgia, abdominal pain, vomiting, diarrhea, malaise, headache, unexplained hemorrhage. Lujo- morbilliform rash on face/trunk	Lassa: 6-21 days Lujo: 7-13 days Machupo: 3-16 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Nitrile gloves with extended cuff - 2 pairs Impermeable gown extending to at least mid-calf Knee high pull-on impermeable shoe covers Surgical hood Face shield Impermeable apron added for patients with significant body fluid losses/exposure risk	Category A
	Marburg Hemorrhagic Fever	Fever, chills, headache, and myalgia	5-10 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Nitrile gloves with extended cuff - 2 pairs Impermeable gown extending to at least mid-calf Knee high pull-on impermeable shoe covers Surgical hood Face shield Impermeable apron added for patients with significant body fluid losses/exposure risk	Category A
Special Respiratory	Severe Acute Respiratry Syndrome (SARS)	Fever, headache, fatigue, myalgia	2-7days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Fluid-resistant gown extending at least mid-calf Nitrile gloves with extended cuff - 2 pairs Face shield Shoe and head covers optional	Category B

	Disease	Initial Signs/Symptoms	Incubation Period	Transmission-based Precautions	PPE	Division 6.2 Infectious Substances Category: A or B
	Middle East Respiratory Syndrome (MERS)	Fever, cough, shortness of breath	2-14 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Fluid-resistant gown extending at least mid-calf Nitrile gloves with extended cuff - 2 pairs Face shield Shoe and head covers optional	Category B
	Nipah Virus	Fever, headache, drowsiness, respiratory illness, disoriention, confusion, encephalitis	5-14 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Fluid-resistant gown extending at least mid-calf Nitrile gloves with extended cuff - 2 pairs Face shield Shoe and head covers optional	Category A
	Plague (pneumonic)	Fever, headache, weakness, rapidly developing pneumonia, chest pain, shortness of breath	2-6 days	Standard, Contact and Droplet	Gown Gloves Facemask Eye protection	Category B (Microbiology lab cultures only are Category A)
	Novel influenza with pandemic potential (e.g., H3N1, H7N9, H5N1)	Fever, chills, myalgia, cough, shortness of breath, fatigue	1-4 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Fluid-resistant gown extending at least mid-calf Nitrile gloves with extended cuff - 2 pairs Face shield Shoe and head covers optional	Category B
	Hantavirus HFRS (hemorragic fever with renal syndrome)	Headache, back and abdominal pain, fever, chills, nausea, blurred vision	7-14 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Fluid-resistant gown extending at least mid-calf Nitrile gloves with extended cuff - 2 pairs Face shield Shoe and head covers optional	Category A
Other Diseases of Public Health Concern	Smallpox	fever, head and body aches, vomiting, rash	7-19 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Fluid-resistant gown extending at least mid-calf Nitrile gloves with extended cuff - 2 pairs Face shield Shoe and head covers optional	Category A
	Monkeypox	Fever, Headache, Muscle aches, Backache, Swollen lymph nodes, Chills, Exhaustion, rash	5-21 days	Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Fluid-resistant gown extending at least mid-calf Nitrile gloves with extended cuff - 2 pairs Face shield Shoe and head covers optional	Category A

	Disease	Initial Signs/Symptoms	Incubation Period	Transmission-based Precautions	PPE	Division 6.2 Infectious Substances Category: A or B
	Anthrax	*Cutaneous:* Painless, reddish papule that progresses from central vesicle, then a pustular, necrotic eschar with edema. *Pulmonary:* fever, fatigue, malaise and a cough or chest pain. *Gastrointestinal:* fever, nausea, vomiting with progression to hematemesis, bloody diarrhea, and intestinal necrotic ulcerated lesions.	Cutaneous: 1-7 days Pulmonary: 1-7 days GI: 1-7 days	Standard Note: If environmental anthrax is suspected (e.g. in powder form) use SP Level 2 VHF PAPR/CAPR ensemble	Fit-tested N95 or equivalent/higher respirator Fluid-resistant gown extending at least mid-calf Nitrile gloves with extended cuff - 2 pairs Face shield Shoe and head covers optional For powder, VHF PPE recommended: Fit-tested N95 or equivalent/higher respirator Nitrile gloves with extended cuff - 2 pairs Impermeable gown extending to at least mid-calf Knee high pull-on impermeable shoe covers Surgical hood Face shield Impermeable apron added for patients with significant body fluid losses/exposure risk	Category B (Microbiology lab cultures only are Category A)
	Unknown Illness of Public Health Concern	—		Standard, Contact, Airborne	Fit-tested N95 or equivalent/higher respirator Nitrile gloves with extended cuff - 2 pairs Impermeable gown extending to at least mid-calf Knee high pull-on impermeable shoe covers Surgical hood Face shield Impermeable apron added for patients with significant body fluid losses/exposure risk	— —