SCOPE: All Adirondack Health staff and facilities.

POLICY: Use this guide as a reference to help direct activities in response to a high impact biological incident. In addition to this, use related guidelines from Surge Capacity and Infection Control Guidelines which include Centers for Disease Control and Prevention (CDC) recommendations on isolation precautions.

PROCEDURE: To mitigate, prepare for, respond to, and recover from a high-impact communicable disease. This protocol is for biological incidents with high morbidity and mortality (e.g. SARS), high mortality pandemics, and those suspected of being a Weapon of Mass Destruction (WMD). Infections include: Anthrax, Brucellosis, Plague, Q Fever, Small Pox, Tularemia, Viral Hemorrhagic Fever). For issues related to routine infection prevention, please refer to policies and protocols developed or adopted by the Infection Control and Environment of Care Committees. Currently the high impact diseases this plan is established for includes:

**BIOLOGICALS OF CONCERN - WEAPONS OF MASS DESTRUCTION (WMD)**

Most biologicals of concern are not anticipated to be identified until after onset of disease. Because of this, decontamination would not be indicated. Decontamination would be indicated if the victim was recently exposed to a dispersal of contaminant. Immediately notify the County Health Department and the NYS Department of Health if any contaminants are identified.
<table>
<thead>
<tr>
<th>BIOLOGICALS</th>
<th>PRECAUTIONS INDICATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthrax – a bacteria</td>
<td>Decon not indicated unless victim has recently been directly contaminated (WMD). Follow Infection Control - Standard Precautions. Decon of contaminated living environment.</td>
</tr>
<tr>
<td>Botulism – a toxin</td>
<td>If patient shows signs of paralysis, use Droplet Precautions otherwise follow Infection Control - Standard Precautions. Eliminate access to contaminated food source</td>
</tr>
<tr>
<td>Brucellosis – a bacteria</td>
<td>Follow Infection Control - Standard Precautions</td>
</tr>
<tr>
<td>Plague – (Yersinia Pestis) – a</td>
<td><strong>Bubonic</strong> - Follow Infection Control - Standard Precautions</td>
</tr>
<tr>
<td>bacteria</td>
<td><strong>Pneumonic</strong> Follow Infection Control - Droplet Precautions</td>
</tr>
<tr>
<td></td>
<td>Until 48 hrs after treatment begins. Antimicrobial prophylaxis for exposed HCW.</td>
</tr>
<tr>
<td>Q Fever - Coxiella burneti – a</td>
<td>Follow Infection Control - Standard Precautions</td>
</tr>
<tr>
<td>bacteria</td>
<td></td>
</tr>
<tr>
<td>Ricin – a toxin</td>
<td>Follow Infection Control - Standard Precautions</td>
</tr>
<tr>
<td></td>
<td>This is a poison not spread by casual contact</td>
</tr>
<tr>
<td>SARS – Severe Acute Respiratory</td>
<td>Airborne Precautions preferred; Droplet if negative pressure isolation room unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol-generating procedures and “supershedders” highest risk for transmission via small droplet nuclei and large droplets. Vigilant environmental disinfection</td>
</tr>
<tr>
<td>Syndrome – a virus</td>
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<tr>
<td>Small Pox – a virus</td>
<td>Place in negative pressure isolation room. Airborne and contact isolation until all scabs have crusted and separated (3-4 weeks). Non-vaccinated. HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and others entering the patient’s room.</td>
</tr>
<tr>
<td>Tularemia – Francisella tularensis</td>
<td>Follow Infection Control - Standard Precautions</td>
</tr>
<tr>
<td>Viral Hemorrhagic Fever Including:</td>
<td></td>
</tr>
<tr>
<td>Crimean-Congo hemorrhagic fever</td>
<td>Single-patient room preferred. Emphasize: 1) use of sharps safety devices and safe work practices, 2) hand hygiene; 3) barrier protection against blood and body fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4) appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected 212, 314, 740, 772</td>
</tr>
<tr>
<td>(CCHF)</td>
<td></td>
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<tr>
<td>Ebola hemorrhagic fever</td>
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<tr>
<td>Hantavirus Pulmonary Syndrome</td>
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<tr>
<td>Hemorrhagic fever with renal</td>
<td></td>
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<tr>
<td>syndrome (HFRS)</td>
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<tr>
<td>Lassa Fever</td>
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<tr>
<td>Marburg hemorrhagic fever</td>
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</table>
ACTIVATION OF THE COMPREHENSIVE EMERGENCY MANAGEMENT PLAN

The individual who receives notification of a disease outbreak shall immediately confer with the Administrator on Call (AOC) and/or the PCC regarding the situation. The AOC or PCC will become the Incident Commander (IC) and will activate the Comprehensive Emergency Management Plan (CEMP). The IC will use all information provided as well as recommendations from the Infection Control Coordinator in selecting a course of action.

The CEMP will be activated at a level appropriate to the incident and its impact on the hospital. Note that initial activation (Level 1) for an anticipated event may be limited to planning and preparation activities, including risk communication. It may not warrant the activation of the Hospital Command Center (HCC) or be disruptive to the hospital routine.

The HCC will be activated at a point when organizational concern, mobilization, or impact is sufficient enough that establishing visible centralized leadership and control is beneficial.

MITIGATION AND PREPAREDNESS

As part of its ongoing programs for infection control, employee health, occupational safety, and emergency management, Adirondack Health conducts a series of mitigation and preparedness activities in readiness for a biological incident. These include:

1. Doing routine syndromic surveillance activities with ongoing participation in the NYSDOH Electronic Syndromic Surveillance Program. This includes surveillance for influenza-like-illnesses that are reported to the NYSDOH and testing for influenza as recommended by NYSDOH.

2. Maintaining ongoing communications with, and procedures for collaborating with, local and state public health departments in developing a case definition during a disease outbreak.

3. Ensuring staff have access to personal protection equipment and communicating infection precaution instructions in a timely manner.

4. Providing Personal Protective Equipment (PPE) in designated work locations including Lab.

5. Maintaining an inventory of medications, including antibiotics.

6. Identifying, when indicated, essential personnel (e.g., medical, nursing, environmental services, facilities, nutrition and food services, administrative, respiratory therapy, radiology technicians, medical records, information technology, laboratory, etc.) that would be prioritized for receiving prophylaxis and PPE. This would protect those staff most at risk and to ensure the continuation of essential services.

7. CEMP I - 20 HPOD (Hospital Point of Dispensing) for mass prophylaxis/immunizations for employees, their family members, and others.

8. Maintain availability of two people to be on duty when needed who have Health Commerce System (HCS) (formerly known as the Health Provider Network - HPN) access.

9. Ensure timely updates of HERDS data as required.

10. Have a designated means of notifying external partners (e.g., DOH, police, Office of Emergency Services) when a biological incident is suspected.

11. Have a process for safely packaging, identifying, and transferring lab specimens to external testing sites, including state and federal labs.
12. Have the capability of handling the documentation associated with a surge in specific diagnostic testing.

13. Have a process for relaying laboratory results to internal clinical sites and external partners.

**BIOLOGIC INCIDENT TRAINING**

The Infection Control Coordinator (ICC), with assistance from the Emergency Preparedness Coordinator, is the Biological Incident Training Coordinator for the hospital. When indicated, they will:

1. Review and/or update biological incident training competencies and curricula.

2. Ensure that education is consistent with best practice recommendations, current threat assessments, and hospital needs.

3. Coordinate training activities and opportunities with the staff educators and Department Directors who provide in-service education for line staff.

4. Provide guidance for Just-In-Time or as-needed training when there is a need to expand competency and general awareness during a sudden onset event.

5. Training exercises will be conducted when indicated and designed to provide staff with an opportunity to demonstrate competency on protocols related to biological incidents.

**SURVEILLANCE AND REPORTING:**

When indicated or requested by an authorized agency, Adirondack Health (AH) will implement the following surveillance measures:

1. Surveillance at any and all sites as requested by our Infection Prevention Specialist or other authority.

2. As directed by NYSDOH, AH will participate in regional Emergency Department (ED) chief-complaint-based syndromic surveillance system as part of the community-wide effort at public health preparedness.

3. Surveillance of potentially exposed staff will be conducted when indicated.

4. Surveillance of potentially exposed patients and visitors may be conducted before they are granted access to hospital facilities.

5. The ICC, in consultation with the local county DOH, shall implement the necessary tracking processes for monitoring patients admitted or discharged with a possible communicable disease.

**REQUIRED COMMUNICABLE DISEASE REPORTING**

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10 NYCRR 2.10, 2.14). Reports should be made to the local health department in the county in which the patient resides and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately to local health departments by phone. A list of diseases and information on properly reporting them can be found under [Communicable Disease Reporting Requirements](#).
For more information on communicable disease reporting, call the Franklin County DOH or the New York State Department of Health's Bureau of Communicable Disease Control.

**Uploading Digital Photographs for Consultation with Public Health**

The Health Commerce System provides a mechanism to electronically upload digital photographs to the NYSDOH. This is helpful for patients suspected to have smallpox, cutaneous anthrax, or an adverse event to smallpox vaccination. There is a hospital-issued digital camera in the ED for this purpose.

Prior to submitting digital photographs, alert the appropriate local health department. In order to evaluate a suspect lesion or rash, the photo must be a sharp and clear close-up with sufficient detail to be used in a clinical assessment. A ruler or other measuring device in the photo is helpful in assessing the size of the area being evaluated.

Upload photos by signing on to the NYSDOH Health Commerce System using your secure access. Go to “Upload Digital Photo” application, and follow directions.

**RESPONSE TO SUSPECTED BIOLOGICAL INCIDENT**

Most of the potential pathogens that could be used as a biologic weapon (e.g., anthrax, plague, and smallpox) would present initially as a non-specific influenza-like illness. The most common features of an outbreak caused by a bioterrorist agent or emerging infectious disease may include:

1. An unusual clinical presentation
2. A single case of an uncommon disease, or any suspected or confirmed communicable disease that is not endemic in New York (e.g., anthrax, plague, smallpox, or viral hemorrhagic fever)
3. Any person without a history of recent (within the past two to four weeks) travel to a foreign country who presents with symptoms of high fever, cough, respiratory distress, rigors, delirium, rash (not characteristic of measles or chick pox), extreme myalgias, prostration, shock, diffuse hemorrhagic lesions or petechiae; and/or extreme dehydration due to vomiting or diarrhea with or without blood loss
4. A confirmed or suspected lab result of a biological agent
5. An increase in reports of dead animals or simultaneous disease outbreaks in human and animal populations
6. A symptom or cluster of symptoms associated with a particular disease of bioagent concern appears in a normally healthy population or an increased number of patients who expire within 72 hours after admission to the hospital
7. A rapid increase (hours, days, or weeks) in the number of previously healthy persons with similar symptoms seeking medical treatment
8. A cluster of previously healthy persons with similar symptoms who live, work, or recreate in a common geographical area

9. Any sudden increase in non-specific syndromes, especially if illness is occurring in previously healthy individuals and if there is an obvious common site of exposure. This could include respiratory illness with fever, gastrointestinal illness, encephalitis or meningitis, neuromuscular illness (e.g., botulism), fever with rash, bleeding disorders

10. Any unusual chronological and/or geographic clustering of illness (e.g., persons who attended the same public event or religious gathering)

11. Any unusual age distributions or clustering for a rare or common disease (e.g., chickenpox or measles in adults)

12. An epidemic curve that rises and falls during a short period of time

13. Lower rates of illness in those persons who are protected (e.g., confined to home, vaccinated, not exposed to large crowds)

RESPONSE TO PATIENTS or OTHERS WITH HIGH IMPACT ILLNESS

1. Initiate isolation precautions – see Infection Control Policies including CDC Isolation Protocols

2. Notify the PCC who will assess the situation and determine our level of response

3. If recommended by Infection Control policy, place patient in a negative pressure isolation room (mask patient prior to moving patient to minimize exposure)

4. Initiate appropriate clinical care and discuss actions with the county health department and/or NYSDOH and collaborate on next steps

5. When seeing the patient, use infection control precautions based on guidelines for suspected agent

6. Obtain demographic and epidemiological information on patient. Assist state or local agencies in obtaining biological agent exposure epidemiology information

7. If there is concern for communicability, implement the following measures for incident management:
   - Isolate affected ED or unit area and deny entry to other patients and staff not already in the area
   - Consider Facility Lockdown
   - Consider ED ambulance diversion or not allowing other patients or employees on unit
   - Determine areas where subject patient had spent time
   - Determine if patient constitutes an at-risk or routine exposure
   - Consider relocating all Unit or ED activities to an alternate site until cleaning/decontamination is completed
   - If indicated, relocate Unit or ED activities to an unaffected area
   - Identify all persons present on unit or in ED who may have been exposed to the subject patient (including staff, other patients, and visitors), and document their location, time(s) of exposure, and activities
8. Using our call down list (DEOP-2), notify the Executive Group and our Infection Control Coordinator as well as other community, state and federal agencies.

MAINTAINING BIOLOGICAL INCIDENT SITUATIONAL AWARENESS

The Infection Control Coordinator plays a key role in maintaining biological incident situational awareness for the facility. Being in routine contact with both the epidemiological source points inside the facility and the inputs from the public health and infectious disease community outside the facility (including internet-based resources), the ICC shall take the lead in ensuring the Infection Control Committee is informed of the latest information.

In addition, the ICC will monitor or receive reports from pertinent sites which may include the CDC (www.cdc.gov), the HPN, online news and/or TV such as CNN and other online resources. These sources may summarize current surveillance or provide outbreak information. This will assist in gauging the potential local impact of the incident.

BIOLOGICAL INCIDENT MANAGEMENT TEAM:

When the CEMP is activated, a Code Triage Active is announced. HICS protocols as noted in the CEMP will be followed. The team that will manage this event will generally include: (one person may be assigned more than one role)

Command and General Staff
  Incident Commander
  Safety Officer
  Public Information Officer
  Liaison Officer
  Biological/Infectious Disease Medical/Technical Specialist

Planning Staff
  Operations Section Chief
  Planning/Intelligence Section Chief
  Logistics Section Chief

Operations Staff
  Medical Care Branch Director

Finance Staff

Other leaders may be brought into the Incident Management Team as needed.

INFECTION CONTROL

Infection Control will provide support to the Incident Commander. They will arrange for adequate coverage sufficient to meet 24-hour, seven-day capability. The Infection Control Coordinator will:

1. Monitor the Health Commerce System (HCS)
2. Maintain situational awareness
3. Coordinate with county and state health departments
4. Monitor internal surveillance systems and healthcare-associated transmission of disease
5. Maintain oversight of pre-triage and pre-entry screening points, as established
6. Arrange for or provide for just-in-time training on infection control procedures, including monitoring and directing use of personal protective equipment and isolation precautions
7. Provide technical guidance and support
Use Healthcare Infection Control Practices Advisory Committee (HICPAC)/CDC Isolation guidelines appropriate to the nature of the illness/exposure

1. Cohort as necessary (same exposure/same symptoms)
2. It is not practical to place masks on infants or young children to contain respiratory droplets/droplet nuclei: substitute hand hygiene/face washing/nose wiping
3. It is not practical to place infants or young children in portable isolation units alone to contain respiratory droplets/droplet nuclei
4. Promptly evaluate and separate as soon as possible from symptomatic children and symptomatic adults
5. Traumatized children may regress under duress and may require additional help with sanitary needs
6. Smaller group size is associated with a lower risk of infection in child care settings
7. For infants/young children: establish diapering protocols
8. Have cleaning/disinfection procedures and schedules for toilets, bathrooms, changing stations, sleeping mats, toys, etc. Any reusable equipment should be appropriately cleaned following AH Infection Control procedures, or as recommended for the agent of concern.

ISOLATION AND QUARANTINE

In the event of a biological incident, Franklin or Essex County Local Health Departments may decide to implement hospital quarantine. This decision is legally within the authority of their County Commissioner of Health, and may occur under such circumstances where significant communicable disease exposure has occurred.

In the event of hospital-wide isolation or quarantine procedures, the provision of necessary supplies, equipment, and necessities to maintain the quarantine may not be possible through conventional deliveries directly to the hospital campus. In such cases, all deliveries, including food and perishables, shall be made to the location designated by our Materials Management Department and/or Nutritional Services Department. The location of this site will be determined at the time this action is needed. Deliveries could be received at the Saranac Lake Site, Lake Placid Site, Mercy Living Center or other local storage facility if they are not also impacted in the event and it is determined these will be the best alternate destinations. Materials Management will coordinate movement of delivered materials between the designated site and the hospital campus to best maintain the isolation protocols.

If on-site isolation or quarantine is ordered, the Security Branch Director, in coordination with the ICC, will determine the need for law enforcement or security support to enforce the isolation and/or quarantine. Anticipated compliance with isolation and/or quarantine during a biological incident is not known, although 100 percent compliance is not assured based on historic experience in other communities. As conditions warrant, procedures including a campus-wide lockdown supported by Essex and/or Franklin County Sheriff or NY State Police may be necessary.

INFECTION CONTROL TRANSMISSION BASED PRECAUTIONS
See HICPAC/CDC Isolation Guideline and/or other nationally recognized guidelines and rules and regulations for each biological agent for recommended practices. Ensure that rooms are appropriately prioritized for cleaning, removal of trash and disinfection with a focus on cleaning frequently-touched surfaces. Susceptible staff shall be restricted from entering the rooms of patients known or suspected to have a particular disease when other immune healthcare personnel are available. Discontinue precautions after signs and symptoms of the infection have resolved or according to pathogen-specific recommendations in Appendix A of the HICPAC/CDC Isolation Guideline.

DECONTAMINATION OF PATIENTS

In most cases, patient decontamination will not be necessary during a biological incident. The incubation period of biological agents makes it unlikely that victims of a bioterrorist attack will present immediately following the exposure event. The exceptions may be following an overt release of a biological agent, with gross surface contamination of victims by the agent.

People who were actually exposed to a release (e.g., in the cloud of a disseminated agent, or passing through the area where an agent was released after the fact, or those bearing signs of physical contamination [such as dust or powder evident on exposed surfaces]) should be initially managed with both infectious disease and hazardous materials precautions.

In the rare cases where patient decontamination may be warranted, simple washing with bactericidal soap and water is sufficient. Refer to CEMP I - 21-00 Code Orange- Decontamination Guide for additional information on patient decontamination procedures.

DECONTAMINATION OF ENVIRONMENTAL SURFACES

If necessary, environmental surfaces can be decontaminated with an U.S. Environmental Protection Agency (EPA) registered sporidical disinfectant or with a 0.5% hypochlorite solution (1 part household bleach added to 9 parts water). Bleach solution should NOT be used to decontaminate patients or service animals.

CLEANING OF CHILDREN’S TOYS

The optimum strategy is to ensure toy isolation and not allow the sharing to the greatest extent possible. Families should be cautioned against bringing irreplaceable children’s comfort items to the hospital, as conditions may require that such items be disposed of. Cleaning of specific toy items may be carried out as recommended by the ICC’s based on the material of the item (e.g., launderable fabric; washable plastic) and the risk of transmission.

DISPOSAL OF REGULAR TRASH AND REGULATED MEDICAL WASTE

Standard procedures for handling regular trash and regulated medical waste during a biological event shall remain in effect, unless modified by the ICC based on pathogen-specific concerns. In the event that a need arises for prolonged storage or on-site management of such materials, such as when routine pick-up of waste cannot occur due to the incident, the Director of Environmental Services shall, in consultation with the ICC, designate a suitable location for secure storage of necessary items. Considerations may include obtaining and safely securing a temporary storage container.
PRE-ENTRY SCREENING FOR PATIENTS STAFF, VENDORS, AND VISITORS

Under certain highly infectious communicable disease scenarios (e.g., SARS, plague), pre-entry screening will be done for all people entering the hospital, in an effort to prevent disease transmission. Patients arriving shall be screened using a pre-atriage screening process. At the discretion of the Incident Commander, a similar process shall be instituted for staff, vendors, and visitors. Under these circumstances, no person shall be permitted access to the hospital building without evidence of pre-entry screening clearance.

A pre-entry screening point shall be established at appropriate entrances as designated by the Incident Commander. The screening process will be pathogen-specific. The following general guidelines will apply.

All persons whose arrival at the facility is anticipated shall be notified in advance when possible, informed of the situation and the case definition, instructed as to where to report, and given direction regarding what to do if they meet the case definition prior to arrival. Notification could be by telephone, blast email/fax or other method of communication that pre-entry screening protocols are in effect, the appropriate reporting location for arriving and entering the hospital, and the potential for delay. This includes:

1. Employees (on and off duty) shall be notified by their departments

2. Medical staff shall be notified by the Medical Staff Office or designee.

3. EMS, public safety, and commercial ambulance agencies shall be notified by Emergency Department Staff.

4. Vendors shall be notified by Materials Management

5. Patients shall be notified by their unit staff, and asked to inform their potential visitors

6. All persons arriving for pre-entry screening will be queued for screening. When needed, separate queues will be set up for staff (including physicians), vendors, and visitors.

7. Screening will be conducted by nursing or other trained staff.

8. Security personnel will be assigned to be ready to respond to the screening point when needed.

9. If conditions warrant the careful application of personal protective equipment, one or more individuals will be assigned to brief, assist, and monitor employees as they don their PPE.

10. All persons who are ill/symptomatic will be referred to a pre-established location/entrance for pre-atriage screening

11. All visitors, vendors and others who are medically cleared for access will be identified by a tag or similar label, which shall be in effect for approximately 24 hours. The tag could be a “color of the day tag” with the color determined each day by the Security Officer.

12. If needed, employees and medical staff will have color-of-the-day tags or similar label placed on or near their ID cards affording them institutional access. If there is a need for limited access to areas in the facility, the color of the day sticker will be marked with a contrasting marker. Decisions regarding restrictions will be made by the Incident Commander. Employees will be directed to report to their regular work stations unless otherwise instructed.

13. No person shall be granted access into the facility without having been screened and cleared.
LABORATORY SERVICES

The Clinical Microbiology Lab uses Biosafety Level (BSL)-2 precautions and has a key role in the early detection of biological agents. AH’s Lab can test samples to rule out the presence of bioterrorism agents, or package and ship specimens to reference laboratories as instructed by the Franklin and/or Essex County DOH or NYSDOH.

Specimen Collection, Packaging, Processing, And Transport:

The Wadsworth Center will accept NYSDOH-approved specimens (physical evidence) from AH. The Lab or Department submitting a specimen shall contact Wadsworth Center before submitting a specimen. Special sample transportation may be necessary. To contact Wadsworth Center: Call 518-474-7161 during business hours, Monday – Friday, 8AM – 5PM, OR 866-881-2809 for the Public Health Duty Officer at all other hours. Refer to Directions for Shipping Specimens to NYSDOH Wadsworth Center Laboratory, for additional information.

PHARMACY SUPPORT

The Pharmacy maintains a reasonable, daily inventory of antibiotics currently recommended for the treatment of patients with suspected or diagnosed bacterial biological agents. The Pharmacy will evaluate the appropriateness and amount of medications it should maintain in a cache in case of a biological event. As a part of this assessment, both doxycycline and ciprofloxacin sufficient to prophylax staff, and our staff’s family members will be maintained as recommended and provided by regulatory authorities such as NYSDOH. For those medications which a stockpile is recommended but not provided, the Pharmacy will determine the protocol that will be implemented. A three days supply is deemed sufficient until the Strategic National Stockpile could arrive in the region and stockpile assets could be distributed.

DISCHARGE PLANNING

Patients with biological incident-related infections should not be discharged until they are deemed non-infectious.

EVIDENCE COLLECTION

The performance of evidence collection while providing required patient decontamination, triage, and treatment should be reasonable for the situation. Information gathered from the victims and first responders may aid in the epidemiological investigation and ongoing surveillance.

When a patient arrives and contamination is suspected, the procedure below shall be followed:

1. An individual bag should be labeled with the patient’s name, medical record number, and date of collection if possible without undue contamination risk or delays in providing patient care. Patients who are able to undress without assistance should be directed to place their valuables (wallets, jewelry, cell phones, etc.) in a plastic bag.

2. Use current AH valuable property form or other method i.e. electronic documentation of property received. When possible, direct the person to place a form of picture identification (e.g., driver license) in the bag so that it is visible from the outside
3. If valuables are to be transported to the FBI or local law enforcement agency, the staff member releasing the valuables shall document what was taken, who received them, where they were taken, and how the valuables will be returned to the owner.

4. Assistive devices such as glasses, canes, hearing aids, etc. and car/house keys should be kept by the patient and be decontaminated with him/her.

5. When possible, label the bag/container with patient identification and event information - Patient name, DOB, Medical record #, Date and Time, Valuables list (if known and time allows).

6. The designated decontamination leader will determine the need for decontamination of the clothing and valuables. If valuables and/or belongings are released to law enforcement, it will be their responsibility to decontaminate the articles.

7. If the patient’s valuables and belongings are not needed as evidence, the property should be released to the patient upon discharge in accordance with hospital policy. Any concerns should be referred to the Infection Control Coordinator.

MANAGING THE PSYCHOLOGICAL IMPACT

Psychological responses may include anger, fear, panic, unrealistic concerns about infection, fear of contagion, paranoia, and social isolation. The following are some points to consider:

1. Communicate clear, concise information about the infection, how it is transmitted, what treatment and preventive options are currently available, when prophylactic antibiotics, antitoxin serum or vaccines will be available, and how prophylaxis or vaccination will be distributed;

2. Provide counseling and possible anxiety-reducing medications to the worried well and victims’ family members;

3. Provide educational materials in the form of frequently asked questions (FAQ);

4. Provide home care instructions;

5. Provide information on quarantine and isolation;

6. Provide Psychological First Aid (CEMP-56);

7. Information released to the public should be coordinated with local, state, and federal health officials.

EMPLOYEE RELUCTANCE OR REFUSAL TO WORK

AH employees, as a condition of employment, do not have the right to refuse to work with certain categories of patients. Existing hospital policies shall remain in effect. The following measures shall be implemented to allay fears and reduce employee reluctance to work:

1. Department Directors will ensure that employees are equipped with incident- and activity-appropriate PPE and are trained in its use.

2. Effective communication strategies will be implemented to provide employees with the knowledge base needed to avoid undue concern regarding disease transmission.

3. Employees and their immediate families will be immunized by the hospital, at no cost to themselves, when this is an effective action during a biological incident.
4. Avoid placing employees who are themselves at unusual risk for disease (e.g., non-immunized; pregnant; or immunocompromised) in direct care positions with patients who may transmit the disease.

EQUIPMENT AND SUPPLIES
At the outset of a biological incident, or if advance warning exists, the Logistics Section Chief and Biological Incident Management Team will:

1. Evaluate the existing system for tracking medical supplies to ensure that it can detect rapid consumption and to respond to growing needs.
2. Stockpile enough consumable goods for duration of an outbreak cycle (at least six to eight weeks).
3. Determine trigger-point to order additional supplies.
4. Anticipate the need for additional antibiotics or antivirals.
5. Determine through consultation with the County OES & State OEM how to access any state-wide stockpiles (e.g., Medical Emergency Response Cache - MERC) or the Strategic National Stockpile (SNS) during an emergency.
6. Determine food supplies in the hospital – how many days’ worth in-house.
7. Estimate the need for respiratory care equipment (including mechanical ventilators), and develop a strategy for acquiring additional equipment if needed.
8. Maximize the storage capacity of fuel oil and medical gasses during this period.
9. As conditions deteriorate and/or a larger impact is anticipated, the Logistics Section Chief and Biological Incident Management Team shall:
   a. Alert Nutritional Services to stockpile appropriate non-perishable food goods.
   b. Order additional equipment, materials, and supplies as needed.

REQUESTING EXTERNAL STOCKPILE RESOURCES
When it is determined that internal pharmaceutical or other medical supplies will not be sufficient to meet the needs of hospital staff and dependents, the hospital may request resources from an external stockpile. The request is routed through Franklin County OES for the Saranac Lake site and Essex County OES for the Lake Placid site. The determination as to the source and availability of external stockpile resources, as well as the delivery process, will be coordinated by OES. In the event that OES is not activated for the incident, such requests shall be forwarded through the Franklin and/or Essex County DOH.

Management of External Stockpile Materiel
The Stockpile Unit Leader will coordinate materials received from the SNS or MERC. The shipment will be received in the hospital loading dock, accounted for, and accepted by the Stockpile Unit Leader.

Pharmaceutical stockpile goods will be stored within the secure area controlled by the Pharmacy, or at an alternate designated area if awaiting imminent distribution and security can be maintained. This facility meets all CDC/NYSDOH requirements for storage of SNS materiel. Medications
requiring environmental controls will be stored in accordance with manufacturer’s specifications. All medications will be stored securely.

The Stockpile Unit Leader shall coordinate security and storage arrangements for the stockpile with the Security Branch Director.

**Depletion of Medications/Supplies**

If medications or other equipment/supplies needed to manage the incident start to become depleted (level falls below 50 percent with no plans available for re-stock), the Incident Management Team and Pharmacy will develop a “hold strategy.” Hold strategies will be predicated on the following considerations:

- Opportunities for substitution for items in short supply be used
- Length of time before needed items arrive
- Implications of terminating the use of the item
- Ability of other facilities to provide the item and accept patient transfers
- Need for alterations to the standard of care
- The Franklin and/or Essex County OES and State Health Departments shall be told of the situation and requested to provide assistance if possible.

**FEDERAL COORDINATION**

FEMA is the lead federal agency in charge of consequence management. Consequence management includes measures to protect public health, rescue and medical treatment of casualties, evacuation of people at risk, protection of first responders, and preventing the transmission of infection. This agency also focuses on restoring essential government services and providing relief to governments, businesses, and individuals affected by the consequences of terrorism.

**THE STRATEGIC NATIONAL STOCKPILE (SNS)**

The CDC has established the Strategic National Stockpile (SNS) program as a repository of antibiotics, chemical antidotes, life support medications, IV administration sets, airway maintenance supplies including ventilators, and other medical/surgical supplies. The New York State Department of Health (NYSDOH) and the State Office of Emergency Management (OEM) are the lead state agencies for obtaining access to the SNS. The SNS is designed to supplement and re-supply state and local public health and medical response teams in the event of a biological and/or chemical terrorism incident anywhere in the U.S.

There are two phases within the SNS program. First, there are a quantity of separate, yet identical caches of pre-packaged medical supplies called 12-hour Push Packages that are fully stocked, stored in environmentally controlled and secured warehouses, and ready for immediate deployment to any affected geographical area within 12 hours of the federal decision to release the assets. These Push Packages have been pre-positioned regionally throughout the United States.

Second, if the incident requires a larger or multi-phased response, Vendor Managed Inventories (VMI) will be shipped to arrive within 24 to 36 hours after the initial Push Package. The VMI package will be comprised of pharmaceuticals and supplies tailored to a specific type of suspected or confirmed agent or combination of agents. The CDC has contractual agreements with manufacturers and vendors, throughout the United States, for each of the items in the VMI formulary. Should an
event occur which exceeds the demands of any one or all of the Push Packages, CDC will immediately notify its designated contract manufacturers to begin pulling stock and stand ready to transport VMI re-supply packages.

Currently, the SNS is activated through the normal Medical and Health Mutual Aid System. Initially, the SNS Push Package will be received by NYSDOH and OEM personnel at an air terminal near an affected community. Distribution of the Push Package to affected communities involves coordination with local, state and federal agencies. The NYSDOH and OEM are charged with developing an SNS response plan to distribute assets to local operational staging facilities. Local governments are responsible for coordinating the distribution of SNS assets to distribution sites.

It is not anticipated that healthcare facilities will be directly involved with the distribution of SNS assets. However, administrative personnel and Infection Control Coordinators should be informed of local level plans and what role, if any, they might be expected to play in the distribution of assets to the community.

**ESF8 Reference:** Emergency Support Function (ESF) #8 — Health and Medical Services provides coordinated Federal assistance to supplement State and local resources in response to public health and medical care needs following a major disaster or emergency, or during a developing potential medical situation. Assistance provided under ESF #8 is directed by the Department of Health and Human Services (HHS) through its executive agent, the Assistant Secretary for Health (ASH). Resources will be furnished when State and local resources are overwhelmed and public health and/or medical assistance is requested from the Federal Government.

**DISASTER MEDICAL ASSISTANCE TEAMS (DMAT)**

The National Disaster Medical System (NDMS), through the U.S. Public Health Service, has developed teams of professional and paraprofessional medical personnel designated to provide emergency medical care during a disaster or other event. Each team is composed of about 100 volunteers who are trained to deal with a variety of medical conditions including burns and mental health. Other specialty DMAT teams include Disaster Mortuary Operational Response Teams, Veterinary Medical Assistance Teams, and National Medical Response Teams. Each team is equipped and trained to provide medical care to victims of weapons of mass destruction.

DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a temporary or fixed medical site. In mass casualty situations, their responsibilities include triaging patients, providing medical care and preparing patients for evacuation. DMAT are designed to be a rapid-response element to supplement local medical care until other state and federal resources can be mobilized, or the situation resolved.

**COMMUNICATIONS DURING BIOLOGICAL INCIDENTS**

**Health Alert Network and Health Commerce System (HCS)**

The NYSDOH HCS is a secure web site containing specific information about bioterrorism and disaster planning and preparedness (https://commerce.health.state.ny.us/hpn/). The Emergency Preparedness Coordinator and the Compliance Officer share the responsibility as the hospital’s HCS coordinators. To receive an ID and password, authorized AH staff, including command and general staff members of the Incident Management Team, must contact one of the hospital’s HCS coordinators, complete the appropriate paperwork, and submit the paperwork to the New York State Department of Health, Office of Health Systems Management.
During an incident, the HERDS system will be accessed by the ICC as needed to obtain ongoing current information regarding incident status. HERDS surveys will be completed daily, or as required, by the HCS Coordinator. The Communications Directory is updated regularly as conditions warrant.

When an urgent HCS alert arrives, the recipient shall immediately notify pertinent staff and assure administration is aware of the issue. The PCC and/or AOD will determine the need for additional notifications.

RISK COMMUNICATION: SHARING INFORMATION WITH STAFF

At the outset of a biological incident, or if advance warning exists, the Incident Management Team will:

1. Review and update communications plans, including contact information and methods

2. Notify employees of availability of the Biological Incident Annex (CEMP-17), relevant appendices, and where they can be obtained.

3. Communicate to hospital staff information including:
   a. Nature of the current outbreak, and reason for the CEMP activation
   b. Status of routine hospital activities
   c. Special measures being planned or implemented, and staff’s roles in carrying them out
   d. Altered policies or procedures, including resource security and rationing
   e. Availability of staff support and behavioral health services
   f. Any other relevant information

4. Provide media briefing information on the potential incident and pathogen (if known) for Executive Leadership, Medical Director, Nursing Leadership, Infection Control staff, Community Relations staff, physicians, nurses, and Department Directors

5. Consider integrating off-site staff and facilities into the hospital phone and notification system to prepare for a speedy response to external inquiries and issues

6. Assure the availability of current email addresses and phone numbers of all county health and social service agencies

7. Assure the routine communication system between hospital community relations leadership and colleague agencies, County and State DOH, and federal CDC is operating normally.

8. Establish routine coordination with local EMS agencies to ensure their inclusion in the biological incident planning and response processes and familiarity with AH plans

9. Use internal resources (newsletters, e-mail, meetings, postings) as a vehicle through which to communicate biologic incident news with hospital employees

10. As conditions deteriorate and/or a larger impact is anticipated, the Public Information Officer, in coordination with the ICC and the Biological Incident Management Team, will notify employees of the current biological incident status and associated HICS level. This will be done via the most appropriate method(s) providing effective communication (e.g. email, Stethoscope, presentations, bulletin boards, etc.)

11. Information will be communicated to patients and visitors regarding evolving hospital and community health conditions and how they are affected. As part of the preparedness process, AH, in collaboration with federal, state and local agencies, will use available information that can be provided to patients, families and visitors

12. Post signs for respiratory hygiene / cough etiquette in public areas (e.g. ED, waiting rooms)
13. Monitor national and CDC web sites as well as international news media. Check the HCS frequently for updates.

14. Create home-care instruction sheets for those individuals who will be turned away from the hospital. Sheets shall include instructions on home-base self-care and recommendations for obtaining other minimal supplies for a Home Care Kit, such as a thermometer, pulse oximeter, medications, pain reliever, water, nutritious liquids, masks, gloves, and hand sanitizer.

15. If needed, assemble a Communications Team to include individuals who are not critical to day-to-day crisis management and thus can focus more time to maximize risk communications. Team members may include a senior executive or vice president, infection control task force member, Community Relations staff, physician, and ambulatory care and/or clinic nurse manager. If appropriate, set up periodic (i.e. daily, 2x/week, weekly) meetings of the Communications Team. All risk communication messages to staff, executive board, or the public shall go through this team or, in a time-sensitive situation, through the PIO directly. When the Communications Team meets, review of key messages from CDC, NYSDOH, Local Health Department, and colleague agencies.

16. Agreement on modes of delivering key messages (public statements, flyers, advertisements, phone/internet, hospital media, radio, other)

17. Communications Team confirms Medical Director or alternate as clinical spokesperson, and Public Information Officer as media spokesperson

18. Notify AH personnel that all public statements from our organization need be routed through the Communications Team or the Public Information Officer (PIO)

19. The CEO or AOD should provide a statement for the local community within 48 hours of a declaration of HICS Level 2 or 3 for a biologic incident outbreak. The statement should convey:

   a. Share with the public an expression of empathy with people’s worries and fears, confirmation of known facts and action steps AH is taking, description of what we do not know at this point, steps we are taking to address the unknowns, emphasizing our constant contact with state and federal officials, statement of our commitment to be here for the long term and do all we can, where people can get information (the hotline number, web page address, press release, etc.) and what they can do to be ready

   b. Use current CDC information on prevention of transmission and management of disease symptoms to produce public service announcements, newspaper articles, website notices, and other media.

   c. Consider using our website to feature information on biologic incident and what people can do to prepare issues if/when recommended by the Communications Team. When requested, the IS department should be able to assist in placing information on website. Add a link on hospital website to appropriate CDC website(s).

20. In cooperation with local county agencies consider distributing pathogen-specific resource kits to ED and other AH locations as well as local Fire and EMS agencies.

21. If needed, post signs identifying the location of the Biological Incident Management Team.

22. Notify facilities for which AH provides back-up services (such as ambulatory care centers) when it will no longer be able to provide such services

23. Issue public statement by hospital CEO, following same format as noted above

24. Conduct frequent check-ins with communications officers at colleague agencies
25. Conduct briefings with message: empathy, current situation and numbers, what is not known, what we are doing to address unknowns, and what people should do. Notify all hospital staff and board notified

26. Keep public informed using options such as radio, newspaper, community meetings, print media releases with updates

27. As conditions improve and/or a reduced impact is experienced, the PIO shall notify hospital employees of decreased risk and when hospital returns to pre-outbreak operations, the State’s declaration of the current outbreak level, and the risk of a second wave

COMMUNICATING INCIDENT INFORMATION TO PEOPLE WITH DISABILITIES AND LIMITED ENGLISH PROFICIENCY

Consistent with existing hospital policy, public communication regarding a biological incident provided by AH shall incorporate the following considerations:

1. Information shall be in Plain English

2. Information will be made available in other languages when needed

3. Web pages and online updates shall be prepared in an ADA-compliant format wherever possible

4. When possible, video press briefings shall have the accompaniment of an ASL-trained individual for on-air translation or subtitles, or a comparable written report.

Hotline

Consider establishing a biological incident hotline for community access and information. This can serve as an effective phone triage/screening tool, reducing the patient influx to the hospital. Consider establishing a biological incident hotline phone bank or other system to respond to inquiries or work with local agencies on a regional level. Widely advertise any biological incident hotline number and assure its message is updated to provide guidance on what people should do to prepare for an outbreak in the community. Create a list of volunteers to help staff the biological incident hotline and develop training for staff on hotline and telephone triage. Consider recruiting volunteers, retired doctors and nurses, or other appropriate personnel to staff the biological incident hotline. Assure basic agreement exists on key messages, including recorded message on hotline. Update recorded message on hotline as needed. Train assigned staff on messages for hotline response. Hotline will focus on repeating key messages and linking callers with services in the community using connectivity to provide a routing to a more community based organization. The Communications Team will provide feedback on community issues and discussion on the hotline. Notify physicians and others of the hotline status.

Assist with hotline staffing which may be set-up cooperatively with local agencies including use of volunteers and employees to maintain availability for calls 24/7. The hotline will link people to community support, development of community education materials, and reporting to hospital on community feedback, detection of “mixed messages” and rumors. This should reduce pressure on ED and other departments within the organization.

Role of biologic incident hotline workers:

- Refer callers to appropriate resources in Franklin and/or Essex County or in their own community
- Report to Franklin and/or Essex Offices of Emergency Services and others where resources are needed and where they are unavailable
- Provide information on AH visitation policy, procedure, or schedule
- Screen people with medical complaints
- Do not provide direct services

**Role of the Media**

The media should be informed about biological incidents and the potential disease agents by the county or state health department, not by AH staff. Following the identification of a biological incident, the county or state health department should assume responsibility for contacting the media. If requested by local public health, the Public Information Officer will prepare a statement that details the number of patients seen at AH, the symptoms they have, and where to obtain further information.

**Regional Inter-facility Communication**

The local County Regional ESF8 Coordinating Group will establish a process for communicating current incident information with all clinical and facility stakeholders. Information to be shared includes the status of non-incident patients, as well as reporting of an infectious transferred patient.

**EMPLOYEE HEALTH SERVICE**

Employees exposed to biological agents that are communicable from person to person such as SARS, pneumonic plague, smallpox, or viral hemorrhagic fever will require immediate and ongoing medical follow-up. The employee health service should be prepared to identify, educate, treat, and provide emotional support to employees and their families.

1. Employee health service will establish a system to help facilitate monitoring for clinical symptoms as well as exposures. It may be desirable to include the following:
   - Place in the facility where exposure occurred (e.g., ED, ICU);
   - Date of exposure;
   - Family members sick with similar symptoms;
   - Specific symptoms of employee;
   - Date of onset of symptoms;
   - Type of personal protective equipment worn, if exposure occurred in the hospital;
   - Referral for medical assessment or treatment;
   - Treatment recommended (e.g., hospitalization, quarantine at home, vaccination, or antibiotic prophylaxis);
   - Notification of the local health department.

2. Employees should seek medical evaluation and/or treatment for a fever of greater than 100.4 degrees F and/or any symptoms of pneumonic plague, smallpox or viral hemorrhagic fever. The minimum criteria for employee exposure assessment should include:
   a. Pneumonic plague - unprotected contact with an infected case (no surgical mask worn within 3 feet of the infected patient); offer antibiotic prophylaxis and monitor the employee's temperature twice daily for 7 days following the last exposure date including days on antibiotic therapy.
   b. Smallpox - unprotected contact with an infected case (no N-95 Respirator worn within 7 feet and/or no gloves worn for contact with lesions); monitor employee's temperature
twice daily for 17 days following the last exposure date (including vaccination days); consult with the Franklin and/or Essex County Health Department about vaccination.

c. Viral hemorrhagic fever - unprotected contact with an infected case (no N-95 Respirator worn and patient was coughing and/or employee reports an exposure to blood or other body fluids); monitor employee's temperature twice daily for 21 days following the last exposure date.

RECOVERY CONSIDERATIONS

As the evidence of pathogen-related activity returns to pre-incident levels, the Biological Incident Management Team shall consider shifting the hospital operation to the recovery phase. In addition to the Continuity of Operations Plan (COOP) Recovery Phase activities and those itemized for each HICS position, hospital actions during the recovery phase include, but are not limited to, the following:

- Continue surveillance activity as described in anticipation of second-wave disease outbreak
- Gather data to report how many individuals were treated for the disease
- Gather data to report how many employees were treated for the disease
- Gather data of all mortality cases from the disease and/or complications of the disease
- Gather data for all hospitalized admissions for the disease
- Conduct evaluation of how surveillance plan worked and document findings on an after-action report
- Assess the effectiveness of vaccine and antiviral distribution

REFERENCES: No HFAP requirement for this policy.