NEW MEXICO
DEPARTMENT OF
HEALTH

New Mexico Department of Health

All-Hazard Emergency Operations Plan

Hazard Annex A-7:

Ebola Virus Disease Response Plan

27 February 2015

Contents

Introduction

Approval and Implementation

The New Mexico Department of Health (NMDOH) All-Hazard Emergency Operations Plan (EOP) Hazard Annex A-7: **Ebola Virus Disease Response Plan** describes the management and coordination of NMDOH and statewide resources and personnel during an Ebola-related response scenario. Planning teams, comprised of subject matter experts, planners and representatives of stakeholder organizations contributed to this plan.

This plan supplements the NMDOH All Hazard EOP (basic plan) by providing Ebola-specific preparedness planning details. This plan will be updated as needed as the response to Ebola Virus Disease (EVD) progresses. This plan does not repeat information already included in the basic plan or other annex plans (e.g., volunteer management, medical countermeasures, functional needs and risk communications). This plan incorporates guidance from the U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), Office of the Assistant Secretary for Preparedness and Response (ASPR), U.S. Department of Homeland Security (DHS) and Federal Emergency Management Agency (FEMA). It also builds on lessons learned from planned events, disasters, emergencies, trainings and exercises.

This **Ebola Virus Disease Response Response Plan** is hereby approved. This plan is effective immediately and supersedes all previous editions. The following signatories agree to support and carry out their functional responsibilities described in this plan.

Michael Landen, MD, MPH State Epidemiologist and Director, Epidemiology and Response Division	Date	Lee Collen Deputy Director, Epidemiology and Response Division	Date
Christopher Emory, MPH Chief, Bureau of Health Emergency Management	Date	Joan Baumbach, MD, MPH Deputy State Epidemiologist and Chief, Infectious Disease Epidemiology Bureau	Date

Record of Changes

The NMDOH Epidemiology and Response Division has the authority to authorize changes to the NMDOH **Ebola Virus Disease Response Plan**. Change notifications are sent to those on the distribution list.

To annotate changes:

1. Add new pages and destroy obsolete pages.
2. Make minor pen and ink changes as identified by letter.
3. Record changes on this page.
4. File copies of change notifications behind the last page of this EOP.

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Acknowledgement of Receipt

I, _____, certify that I have received the New Mexico Department of Health **Ebola Virus Disease Response Plan**, or the changes to the plan listed below. In the event of any questions, please contact the Bureau of Health Emergency Management (BHEM) Planning Manager.

Change Number	Description of Change	Date of Change

_____ _____
Signature Date

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Tribal Government			
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	Cochiti Pueblo	Emergency Manager	
	Isleta Pueblo	Emergency Manager	
	Jemez Pueblo	Emergency Manager	
	Jicarilla Apache Nation	Emergency Manager	
	Laguna Pueblo	Emergency Manager	
	Mescalero Apache Nation	Emergency Manager	
	Nambe Pueblo	Emergency Manager	
	Navajo Nation	Emergency Manager	
	Ohkay Owingeh Pueblo	Emergency Manager	
	Picuris Pueblo	Emergency Manager	
	Pojoaque Pueblo	Emergency Manager	
	San Felipe Pueblo	Emergency Manager	
	San Ildefonso Pueblo	Emergency Manager	
	Sandia Pueblo	Emergency Manager	
	Santa Ana Pueblo	Emergency Manager	
	Santa Clara Pueblo	Emergency Manager	
	Santo Domingo Pueblo	Emergency Manager	
	Taos Pueblo	Emergency Manager	
	Tesuque Pueblo	Emergency Manager	
	Ysleta del Sur Pueblo	Emergency Manager	
	Zia Pueblo	Emergency Manager	

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County Government			
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	Catron County	Emergency Manager	
	Chaves County	Emergency Manager	
	Cibola County	Emergency Manager	
	Colfax County	Emergency Manager	
	Curry County	Emergency Manager	
	De Baca County	Emergency Manager	
	Dona Ana County	Emergency Manager	
	Eddy County	Emergency Manager	
	Grant County	Emergency Manager	
	Guadalupe County	Emergency Manager	
	Harding County	Emergency Manager	
	Hidalgo County	Emergency Manager	
	Lea County	Emergency Manager	
	Lincoln County	Emergency Manager	
	Los Alamos County	Emergency Manager	
	Luna County	Emergency Manager	
	McKinley County	Emergency Manager	
	Mora County	Emergency Manager	
	Otero County	Emergency Manager	
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	Roosevelt County	Emergency Manager	
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	Union County	Emergency Manager	
Municipal Government			
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	Albuquerque, City of	Emergency Manager	
	Belen, City of	Emergency Manager	
	City of Gallup	Emergency Manager	
	Cloudcroft, Village of	Emergency Manager	
	Deming, City of	Emergency Manager	
	Elephant Butte, City of	Emergency Manager	
	Espanola, City of	Emergency Manager	
	Los Lunas, Village of	Emergency Manager	
	Los Ranchos, Village of	Emergency Manager	
	Milan, City of	Emergency Manager	
	Red River, Village of	Emergency Manager	
	Rio Rancho, City of	Emergency Manager	
	Ruidoso, Village of	Emergency Manager	
	Santa Fe, City of	Emergency Manager	
	T or C, City of	Emergency Manager	
Non-Governmental Organizations (NGO)			

Purpose, Scope and Situation Overview

Purpose

It is the purpose of this plan to define the actions and roles necessary to provide a coordinated response to Ebola virus disease within the State of New Mexico. This plan provides guidance to agencies within the State of New Mexico with respect to potential emergency assignments before, during, and following emergency situations. It also provides for the systematic integration of emergency resources when activated and does not replace county or local emergency operations plans or procedures.

Scope

This plan applies to all participating departments and agencies of the jurisdictions contained within the geographical boundary of the State of New Mexico.

Situation Overview

1. Ebola Virus Disease (EVD)

Background

Ebola virus disease (EVD), previously known as Ebola hemorrhagic fever, is a rare and deadly disease caused by infection with one of the Ebola virus strains. Ebola can cause disease in humans and nonhuman primates (monkeys, gorillas, and chimpanzees).

EVD is caused by infection with a virus of the family Filoviridae, genus Ebolavirus. There are five identified Ebola virus species, four of which are known to cause disease in humans: Ebola virus (Zaire ebolavirus); Sudan virus (Sudan ebolavirus); Taï Forest virus (Taï Forest ebolavirus, formerly Côte d'Ivoire ebolavirus); and Bundibugyo virus (Bundibugyo ebolavirus). The fifth, Reston virus (Reston ebolavirus), has caused disease in nonhuman primates, but not in humans.

Clinical Presentation and Clinical Course

Patients with EVD generally have an abrupt onset of fever and symptoms typically 8 to 12 days after exposure (incubation period for current outbreak has a mean of approximately 9 to 11 days). Initial signs and symptoms are nonspecific and may include fever, chills, myalgias, and malaise. Due to these nonspecific symptoms, particularly early in the course, EVD can often be confused with other more common infectious diseases such as malaria, typhoid fever, meningococcemia, and other bacterial infections (e.g., pneumonia).

Patients can progress from the initial non-specific symptoms after about 5 days to develop gastrointestinal symptoms such as severe watery diarrhea, nausea, vomiting and abdominal pain. Other symptoms such as chest pain, shortness of breath, headache or confusion, may also develop. Patients often have conjunctival injection (reddening of the eye). Hiccups have been reported. Seizures may occur, and cerebral edema has been reported. Bleeding is not universally present but can manifest later in the course as petechiae, ecchymosis (bruising), or oozing from venipuncture sites and mucosal hemorrhage. Frank hemorrhage is less common;

in the current outbreak unexplained bleeding has been reported from only 18% of patients, most often blood in the stool (about 6%). Patients may develop a diffuse erythematous maculopapular rash by day 5 to 7 (usually involving the neck, trunk, and arms) that can desquamate. Pregnant women may experience spontaneous miscarriages. The most common signs and symptoms reported from West Africa during the current outbreak from symptom-onset to the time the case was detected include: fever (87%), fatigue (76%), vomiting (68%), diarrhea (66%), and loss of appetite (65%).

Patients with fatal disease usually develop more severe clinical signs early during infection and die typically between days 6 and 16 of complications including multi-organ failure and septic shock (mean of 7.5 days from symptom-onset to death during the current outbreak in West Africa). In non-fatal cases, patients may have fever for several days and improve, typically around day 6. Patients that survive can have a prolonged convalescence. The case fatality proportion among patients in West Africa with a known outcome is about 71% (ranges from 46% in Nigeria to 69-72% in Guinea, Sierra Leone and Liberia). Risk factors significantly associated with a fatal outcome in the affected countries in West Africa include age >45 years old, unexplained bleeding, and a number of other signs and symptoms (diarrhea, chest pain, cough, difficulty breathing, difficulty swallowing, conjunctivitis, sore throat, confusion, hiccups, and coma or unconsciousness).

Pathogenesis

Ebola virus enters the patient through mucous membranes, breaks in the skin, or parenterally and infects many cell types, including monocytes, macrophages, dendritic cells, endothelial cells, fibroblasts, hepatocytes, adrenal cortical cells and epithelial cells. The incubation period may be related to the infection route (e.g., 6 days for injection versus 10 days for contact). Ebola virus migrates from the initial infection site to regional lymph nodes and subsequently to the liver, spleen and adrenal gland. Although not infected by Ebola virus, lymphocytes undergo apoptosis (cell death) resulting in decreased lymphocyte counts. Hepatocellular necrosis occurs and is associated with dysregulation of clotting factors and subsequent coagulopathy. Adrenocortical necrosis also can be found and is associated with hypotension and impaired steroid synthesis. Ebola virus appears to trigger a release of pro-inflammatory cytokines with subsequent vascular leak and impairment of clotting ultimately resulting in multi-organ failure and shock.

Laboratory Findings

Laboratory findings at admission may include leukopenia frequently with lymphopenia followed later by elevated neutrophils and a left shift. Platelet counts are often decreased in the 50,000 to 100,000 range. Amylase may be elevated, reflecting pancreatic involvement (inflammation/infection). Hepatic transaminases are elevated with aspartate aminotransferase (AST) exceeding alanine aminotransferase (ALT); these values may peak at more than 1,000 IU/L. Proteinuria may be present. Prothrombin (PT) and partial thromboplastin times (PTT) are prolonged and fibrin degradation products are elevated, consistent with disseminated intravascular coagulation (DIC).

2. Ebola Virus Disease in Africa and the United States 2014-2015

The 2014-2015 Ebola virus disease (EVD) epidemic is the largest in history, affecting multiple countries in West Africa. One imported case from Liberia, one from Guinea and associated locally acquired cases in healthcare workers have been reported in the United States. CDC, the NMDOH and partners are taking precautions to prevent the further spread of EVD within the United States.

CDC confirmed on September 30, 2014, the first laboratory-confirmed case of EVD to be diagnosed in the United States in a person who had traveled to Dallas, Texas from West Africa. The patient did not have symptoms when leaving West Africa, but developed symptoms approximately four days after arriving in the United States.

The person sought medical care at Texas Presbyterian Hospital of Dallas after developing symptoms consistent with EVD. Based on the person's travel history and symptoms, CDC recommended testing for EVD. The medical facility isolated the patient and sent specimens for testing at CDC and at a Texas laboratory. Local public health officials identified all close contacts of the person for further daily monitoring for 21 days after exposure.

On October 10, a healthcare worker at Texas Presbyterian Hospital who provided care for the index patient reported a low-grade fever and was referred for testing. The healthcare worker was isolated after the initial report of a fever. CDC confirmed that the healthcare worker was positive for EVD.

On October 14, a second healthcare worker at Texas Presbyterian Hospital who provided care for the index patient reported to the hospital with a fever and subsequently tested positive for EVD.

On October 23, a healthcare worker in New York City who had recently returned from Guinea tested positive for EVD.

Warning Level 3 travel notices remain in effect for Guinea, Liberia, and Sierra Leone advising travelers to avoid nonessential travel to these countries. For all current travel notices in effect, please visit the travel notices page. For the latest information about the Ebola outbreak in West Africa, please visit www.cdc.gov/ebola.

3. Ebola Virus Disease Risk in New Mexico

As of February 1, 2015, the risk of introduction of EVD into New Mexico is very, very low. There are currently 3 countries with ongoing EVD transmission – Liberia, Sierra Leone and Guinea. At this time introduction of EVD could only come from a traveler from one of these 3 countries. There are two groups of travelers – U.S citizens working in the 3 countries and returning to New Mexico and nationals from one of the 3 countries traveling to New Mexico. The New Mexico Department of Health (NMDOH) has only evaluated two suspect EVD cases with a positive travel history and symptoms since April 2014 and both were U.S. citizens returning from work in one of the identified countries.

The NMDOH has not evaluated any nationals with symptoms from the identified countries who traveled from those countries within the past 21 days. This coupled with the fact that 70% of the air travel from these countries is from 6 states – New York, Pennsylvania, Maryland, Virginia, New Jersey and Georgia – suggests that New Mexico is at lower risk for importation of EVD than many other states. Furthermore, active traveler monitoring started in October 2014 in New Mexico, where travelers from the identified countries arriving in New Mexico are actively monitored for fever and symptoms for 21 days from departure from those countries.

While this active traveler monitoring won't prevent a case of EVD from being imported into New Mexico, it will help assure that any traveler who develops symptoms has a timely evaluation while minimizing close contact with others while symptomatic.

Organization and Assignment of Responsibilities

Assignment of Responsibilities

1. Evaluation and Early Recognition

Early recognition and evaluation of individuals with potential Ebola virus disease (EVD) is key to limiting EVD exposure to healthcare workers, the patients, close contacts, and the community. The NMDOH advises that a travel history be taken on all patients presenting to the healthcare system for medical care. Patients with a travel history within the past 21 days to Sierra Leone, Liberia, or Guinea should also be assessed for signs and symptoms of EVD, which include fever (subjective or ≥100.4˚ F or 38˚ C), severe headache, myalgias, vomiting, diarrhea, abdominal pain, or unexplained bleeding (Appendix A).

If a patient reports a travel history within the past 21 days to Sierra Leone, Liberia, or Guinea and has any signs and symptoms of EVD, the patient should be isolated in a single room with a telephone, private bathroom and closed door. The NMDOH should be immediately consulted 24/7/365 at 505-827-0006. Standard, contact, and droplet precautions should be implemented before entering the patient room. The patient should also be assessed for potential exposures.

Healthcare providers in New Mexico are advised to follow the NMDOH EVD Evaluation Algorithm (Appendix A) and the CDC Health Care Provider Preparedness Checklist for Ebola Virus Disease (Appendix B). Figure A includes risk exposure assessment categories.

Please refer to:

- Appendix A: NMDOH Ebola Virus Disease (EVD) Evaluation Algorithm
- Appendix B: CDC Health Care Provider Preparedness Checklist for Ebola Virus Disease

2. Notification Process

The NMDOH will notify the New Mexico Department of Homeland Security and Emergency Management (NMDHSEM), the Office of the Governor, and news media of a positive EVD test result.

3. Lab Testing and Specimen Submission Guidance

The New Mexico Department of Health (NMDOH) has created laboratory-specific guidance and a risk assessment for the proper handling, routine clinical testing, transport and submission of specimens from a person suspected of having Ebola virus disease (EVD). The NMDOH Scientific Laboratory Division (SLD) is now one of the Laboratory Response Network (LRN) laboratories designated to conduct Emergency Use Authorization (EUA) EVD Testing. This test gives a presumptive result; confirmatory testing will be conducted by the CDC. As a reminder, the NMDOH must be contacted and will work with the requesting clinicians and CDC to determine whether specimens should be collected and tested for EVD. The SLD will work, in conjunction with the Epidemiology and Response Division (ERD), with the submitter, on a case-by-case basis, to determine the optimum method of transporting specimens to the lab. The SLD cannot conduct any routine rule-out testing e.g. malaria, and these tests will be performed, if indicated, at New Mexico Ebola assessment hospitals.

Please refer to Appendix D: Lab Testing and Submission Guidance

4. Healthcare System

The NMDOH advises that every patient care setting in New Mexico (e.g., EMS, hospitals, outpatient offices) ensure that it can detect a patient with EVD, protect healthcare workers so they can safely care for the patient, and respond to a case of suspected or confirmed EVD in a coordinated fashion. The NMDOH is working with healthcare providers and agencies across the spectrum of care to ensure preparedness for EVD response. All healthcare providers are advised to contact the NMDOH immediately 24/7/365 at 505-827-0006 if they ascertain a positive travel history within the past 21 days to an EVD affected country. NMDOH will work with the healthcare provider to confirm the travel history, assess for signs and symptoms, and assess risk exposure category. In addition, the NMDOH will help coordinate any necessary EVD specimen transport and testing. The NMDOH is working with hospitals to enhance the approach to care of a confirmed EVD patient or of a patient with a high-risk EVD exposure within New Mexico or out of state, in consultation with CDC. The NMDOH will assist with coordination of transfer of suspect or confirmed EVD patients to the most appropriate facility within the healthcare system. The NMDOH also has a healthcare team which is consulting with hospitals and healthcare providers on implementation of CDC and NMDOH guidance for EVD preparedness and response. Information on EVD preparedness and response for specific healthcare settings is addressed below.

a. Emergency Medical Services (EMS)

The NMDOH Emergency Medical Systems Bureau strongly recommends that EMS medical directors and EMS agency supervisory personnel prepare for the possibility of dealing with EVD by utilizing the CDC publication "**Detailed Emergency Medical Services (EMS) Checklist for Ebola Preparedness"** found at:
http://www.cdc.gov/vhf/ebola/pdf/ems-checklist-ebola-preparedness.pdf

Please refer to Appendix E: EMS Specific Guidance for 911 Call Centers, 911 EMS Response, Decontamination, and Transfer of Highly Suspected or Confirmed Ebola Patients.

b. Clinic checklist

Outpatient clinic settings should be prepared to perform early recognition of patients with Ebola virus disease (EVD). The NMDOH has advised outpatient providers to take a travel history on all patients presenting for care in New Mexico. If a patient is in an outpatient clinic and reports a positive travel history within 21 days to an Ebola affected country (i.e., Sierra Leone, Liberia, or Guinea), the patient should be assessed for signs and symptoms of EVD which include fever (subjective or $\geq$100.4˚ F or 38˚ C), severe headache, myalgias, vomiting, diarrhea, abdominal pain, or unexplained bleeding (see Appendix A and the CDC algorithm for ambulatory care at http://www.cdc.gov/vhf/ebola/hcp/index.html.

If a patient reports a travel history within the past 21 days to Sierra Leone, Liberia, or Guinea and has any signs and symptoms of EVD, the patient should be isolated in a single room with a telephone, private bathroom and closed door. The NMDOH should be immediately consulted 24/7/365 at 505-827-0006. Access to the patient room should be restricted. Only essential healthcare personnel, who are wearing appropriate personal protective equipment (standard, contact, droplet precautions), should enter. When possible, close contact with the patient should be avoided and a minimum three foot distance from the patient should be maintained.

If the patient is calling for a non-emergency appointment and reports a positive travel history within 21 days to an Ebola affected country, the outpatient clinic staff should verify the patient's physical address and contact telephone numbers. The patient should be asked to remain at

home and be told that the NMDOH will be contacting them shortly to further discuss their travel history, signs and symptoms, and potential exposure risk. If it is determined that the patient has a positive travel history within the past 21 days to an Ebola affected country and has signs and symptoms consistent with EVD, NMDOH will assist in coordinating patient transport via EMS to an appropriate hospital for further evaluation.

For either an in-person visit or a phone call with a patient with positive travel history within 21 days to an Ebola affected country, outpatient providers should contact the NMDOH 24/7/365 at 505-827-0006 for consultation. If the patient is felt to have a medical emergency, the outpatient provider should call 9-1-1 prior to notifying the NMDOH so that there is no delay in appropriate medical care and advise the dispatcher of the positive travel history and concern for EVD so that EMS personnel can take appropriate infection prevention precautions.

c. Healthcare Provider Checklists

CDC provided documents outlining additional steps for Ebola preparedness for healthcare providers and facilities at http://www.cdc.gov/vhf/ebola/hcp/index.html.

d. CDC Guidance on Personal Protective Equipment (PPE)

CDC documents provide detailed guidance on the types of personal protective equipment (PPE) to be used and on the processes for donning and doffing (i.e., putting on and removing) PPE for all healthcare workers entering the room of a patient hospitalized with confirmed EVD. The guidance reflects lessons learned from the recent experiences of U.S. hospitals caring for Ebola patients and emphasizes the importance of training, practice, competence, and observation of healthcare workers in correct donning and doffing of PPE selected by the facility.

This guidance contains the following key principles:

1. Prior to working with Ebola patients, all healthcare workers involved in the care of Ebola patients must have received repeated training and have demonstrated competency in performing all Ebola-related infection control practices and procedures, and specifically in donning/doffing proper PPE.

2. While working in PPE, healthcare workers caring for Ebola patients should have no skin exposed.

3. The overall safe care of Ebola patients in a facility must be overseen by an onsite manager at all times, and each step of every PPE donning/doffing procedure must be supervised by a trained observer to ensure proper completion of established PPE protocols.

Please refer to Appendix F: CDC Guidance on Personal Protective Equipment

There is also CDC guidance on PPE as it relates to the tiered framework for hospital preparedness and guidance on appropriate PPE for non-inpatient hospital healthcare settings (i.e., algorithm for ambulatory care and emergency departments) which can be found at http://www.cdc.gov/vhf/ebola/hcp/index.html.

5. Contact Tracing, Contact Monitoring and Traveler Monitoring

In the event that a person with EVD is identified in New Mexico, the NMDOH will immediately initiate contact tracing to determine who came in contact with the EVD patient so that they can be monitored for illness for 21 days after exposure. If the contact develops a fever or other symptoms, they will immediately be isolated, tested, and provided medical care. Their contacts will also be identified and monitored for illness. In addition, travelers from Liberia, Sierra Leone and Guinea will be monitored for 21 days.

Please refer to Appendix G: Contact Tracing, Contact Monitoring and Traveler Monitoring Guidelines

6. Isolation and Quarantine

Please refer to “The Legal Basis of Isolation and Quarantine in New Mexico” in the Legal Authority section.

7. Social and Behavioral Health Services

When the NMDOH restricts the movement of persons through isolation and quarantine, it becomes the department’s responsibility to ensure that the basic needs of those persons are met. Multi-agency collaboration will be utilized to assure that the physical, medical, social, educational, and psychological needs are met of those whose movement would be restricted.

Trained social work personnel, using a case management approach, are best suited for fulfilling the role of case manager. Each person/household placed in quarantine should have the name and contact information for their case manager technician (CMT) and have the means to contact that technician.

Case manager technicians (CMTs) should have appropriate support staff for evaluation and monitoring, referral for additional medical care, hotlines, mental health or other social services, and delivery systems for food and supplies sufficient for one incubation period of the disease. Case manager technicians and epidemiologist staff, working as a Household Assessment (HHA) Team, will assess the household’s capacity to adequately manage home quarantine using a standardized tool to document these findings. The HHA Team will first assess the household’s own resources such as family, friends, and neighbors, and make arrangements for any additional needed resources through locally identified suppliers (e.g., their local church, grocery store, pharmacy, volunteer organization, primary physician) in collaboration with local emergency management when needed.

Agencies such as the New Mexico Department of Homeland Security Emergency Management (DHSEM), the New Mexico Department of Health (NMDOH), and the Humans Services Department (HSD) Behavioral Health Services Division (BHSD) together bring statewide services to the community and are in the unique position to assist in this mission by virtue of their thorough knowledge of the resources and partnerships in the community. These agencies will assist in identifying additional needed resources in response to requests of the HHA Team on behalf of the affected household, and attempt to obtain the resources within the local community. All resource requests are routed through the New Mexico Emergency Operations Center (NM EOC).

The Behavioral Health Services Division (BHSD) of the New Mexico Human Services Department (HSD) serves as the State authority for mental health and substance abuse. The BHSD addresses need, provides services, and conducts planning, monitoring and continuous quality systemically across the state. The BHSD is the key NMDOH partner in assuring provision of adequate social and mental health support to those individuals impacted, directly and indirectly, by Ebola virus disease (EVD), including the safety and well-being of anyone with EVD, their contacts, personnel providing services, and the public. Specifically, BHSD, in collaboration with healthcare providers, will provide the following psychosocial prevention and treatment services: acute episode (individual) treatment (substance and mental health); 24/7 telephone call services; crisis counseling; crisis intervention; referral services; consumer education; risk communication expertise; training; continuity of services; health emergency response planning collaboration/ coordination for substance abuse and mental health consumers; school health Medicaid service coordination; and collaboration with the public and private sectors as needed.

8. Environmental Infection Control

Ebola virus disease is transmitted through direct contact with a needle or syringe that is contaminated with the virus or through broken skin or mucous membranes (the eyes, nose or mouth) that come in contact with blood or body fluids (saliva, sweat, urine, feces, vomit, breast milk or semen) of a person who has the virus.

Healthcare personnel can be exposed through a patient's body fluids, contaminated medical supplies and equipment, contaminated environmental surfaces, splashes to unprotected mucous membranes or procedures that increase environmental contamination with infectious material or create aerosols.

- Ensure environmental services staff wear recommended personal protective equipment (PPE)(http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html) to protect against direct skin and mucous membrane exposure of cleaning chemicals, contamination, and splashes or spatters during environmental cleaning and disinfection activities.
- Ensure staff is instructed in the proper use of personal protective equipment including safe removal to prevent contaminating themselves or others in the process.
- If reusable heavy-duty gloves are used for cleaning and disinfecting, they should be disinfected and kept in the room or anteroom.
- Use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) is used to disinfect environmental surfaces in rooms of patients under investigation (PUIs) or patients with confirmed EVD. Although there are no products with specific label claims against the Ebola virus, enveloped viruses such as Ebola are susceptible to a broad range of hospital disinfectants used to disinfect hard, non-porous surfaces. In contrast, non-enveloped viruses are more resistant to disinfectants. As a precaution, selection of a disinfectant product with a higher potency than what is normally required for an enveloped virus is being recommended at this time. EPA-registered hospital disinfectants with label claims against non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) are broadly antiviral and capable of inactivating both enveloped and non-enveloped viruses.

- 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. Do not place PUIs or patients with confirmed EVD in carpeted rooms. Remove all upholstered furniture and decorative curtains from patient rooms before use.
- Routine cleaning of the PPE doffing area should be performed at least once per day and after the doffing of grossly contaminated PPE. Cleaning should be performed by a healthcare worker (HCW) wearing clean PPE. An EPA-registered hospital disinfectant with label claims against non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) should be used for disinfection. When cleaning and disinfection are complete, the HCW should carefully doff PPE and perform hand hygiene.
- To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, non-fluid-impermeable pillows or mattresses, and textile privacy curtains into the waste stream and disposed of appropriately.
- Contaminated equipment is disposed of appropriately; any disposable materials generated in the care of the EVD patient are placed in leak-proof containers.

Ebola virus is a classified as a 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). Any item transported offsite for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, used healthcare products such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets; and used PPE (gowns, masks, gloves, goggles, face shields, respirators, booties, etc.) or byproducts of cleaning contaminated or suspected of being contaminated with a Category A infectious substance. http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/hospitals.html

Below are links to relevant CDC, OSHA and DOT information:

http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html
http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/infection-control.html
http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html
http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/waste-management.html
http://phmsa.dot.gov/portal/site/PHMSA/menuitem

DOT Hazardous Materials Regulations 49 CFR Parts 100-1999; 49 CFR 172.700; 49 CFR 173.134(a)(5): http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title49/49cfrv2_02.tpl

9. Cleaning of the Home

There are two levels of cleaning and decontamination for the home and contents of a person who has been confirmed to be infected with the Ebola virus (EVD). This depends on the symptoms that the person was experiencing while in residence at the home.

A. If the person only had a fever, with no gastrointestinal (e.g., vomiting and/or diarrhea) or hemorrhagic (bleeding) symptoms, the residence should not be contaminated. Therefore, the remaining residents would clean and launder as normal using detergent and/or disinfectant.

B. If the person with EVD had symptoms of diarrhea, vomiting and/or bleeding while at the residence; the residence may be contaminated. The NMDOH will contact a qualified

Hazardous Material (HazMat) company to determine and manage the correct decontamination and disposal procedures.

The qualified HazMat companies have trained personnel and follow Occupational Safety and Health Administration (OSHA) standards, and state and federal guidelines with regard to the safe handling, treatment, transport and disposal of EVD contaminated waste.

These standards and guidelines include: protection of the personnel by using the correct Personal Protective Equipment (PPE) to prevent exposure to EVD via mucus membranes and broken skin or through the inhalation of bio–aerosols. An Environment Protection Agency (EPA) registered hospital disinfectant, that meets the Center for Disease Control (CDC) criteria for use against the Ebola virus, should be used to clean hard, non-porous surfaces. Waste material should be placed in double, leak proof bags and stored in rigid, leak proof containers.

Below are links to relevant CDC and OSHA information:
http://www.cdc.gov/vhf/ebola/hcp/residental-decontamination.html
https://www.osha.gov/Publications/OSHA_FS-3766.pdf

10. Transportation of Biomedical Hazardous Waste

Waste contaminated with Ebola virus is a considered a Category A infectious substance, and is regulated as a hazardous material under the U.S. Department of Transportation (DOT) Hazardous Materials Regulations (HMR; 49 C.F.R., Parts 171-180).

The DOT issues a special permit for the safe transport of Ebola-infected waste for disposal, to a biomedical waste transportation company. This special permit extends to the removal of household hazardous material. Any interstate transport of Ebola-infected waste is coordinated with the CDC.

The New Mexico Environment Department (NMENV), Solid Waste Bureau, regulates the transportation of biomedical hazardous waste in New Mexico.

The transport and handling of any Ebola-infected waste generated in New Mexico must adhere to the New Mexico Administrative Code (20.9.20.9.10 NMAC).

Ebola-associated waste that has been appropriately inactivated or incinerated is no longer infectious.

Below are links to relevant CDC and DOT information:
http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/waste-management.html
http://phmsa.dot.gov/portal/site/PHMSA/menuitem
DOT Hazardous Materials Regulations 49 CFR Parts 100-1999; 49 CFR 172.700; 49 CFR 173.134(a)(5): http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title49/49cfrv2_02.tpl

11. Safe Handling of Human Remains

Follow the step-by-step CDC Guideline for Postmortem Preparation
http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html

The virus can be detected throughout the body of a person who dies of the Ebola virus. Therefore, handling of the body should be kept to a minimum and only trained personnel

wearing the appropriate Personal Protective Equipment (PPE) should touch, or move any Ebola –infected remains.

At the site of death, personnel wearing appropriate PPE wrap the body in a plastic shroud. The body is not washed or cleaned, in order to minimize contamination with blood or body fluids. After wrapping of the shroud, the body is placed into two thick; zipper closed, leak-proof plastic body bags. The surface of the outside bag is decontaminated with an Environment Protection Agency (EPA) registered disinfectant and transported to the morgue. After removal of the body, the room is cleaned and disinfected by personnel wearing the appropriate PPE.

PPE is not required for people driving or riding in a vehicle carrying human remains, provided that they will not be handling the remains and that the remains are safely contained in the two decontaminated body bags.

Mortuary personnel must wear the appropriate PPE. The body bags are not opened and embalming is not preformed. The human remains are cremated or buried in a standard metal casket. No PPE is required when handling the cremated remains or the sealed casket.

http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html

http://www.cdc.gov/vhf/ebola/pdf/postmortom-preparation.pdf

Please refer to Appendix H: OMI Recommendations to Healthcare Facilities for the Preparation of Decedents with Possible Viral Hemorrhagic Fevers.

Direction, Control and Coordination

Authority to Initiate Actions

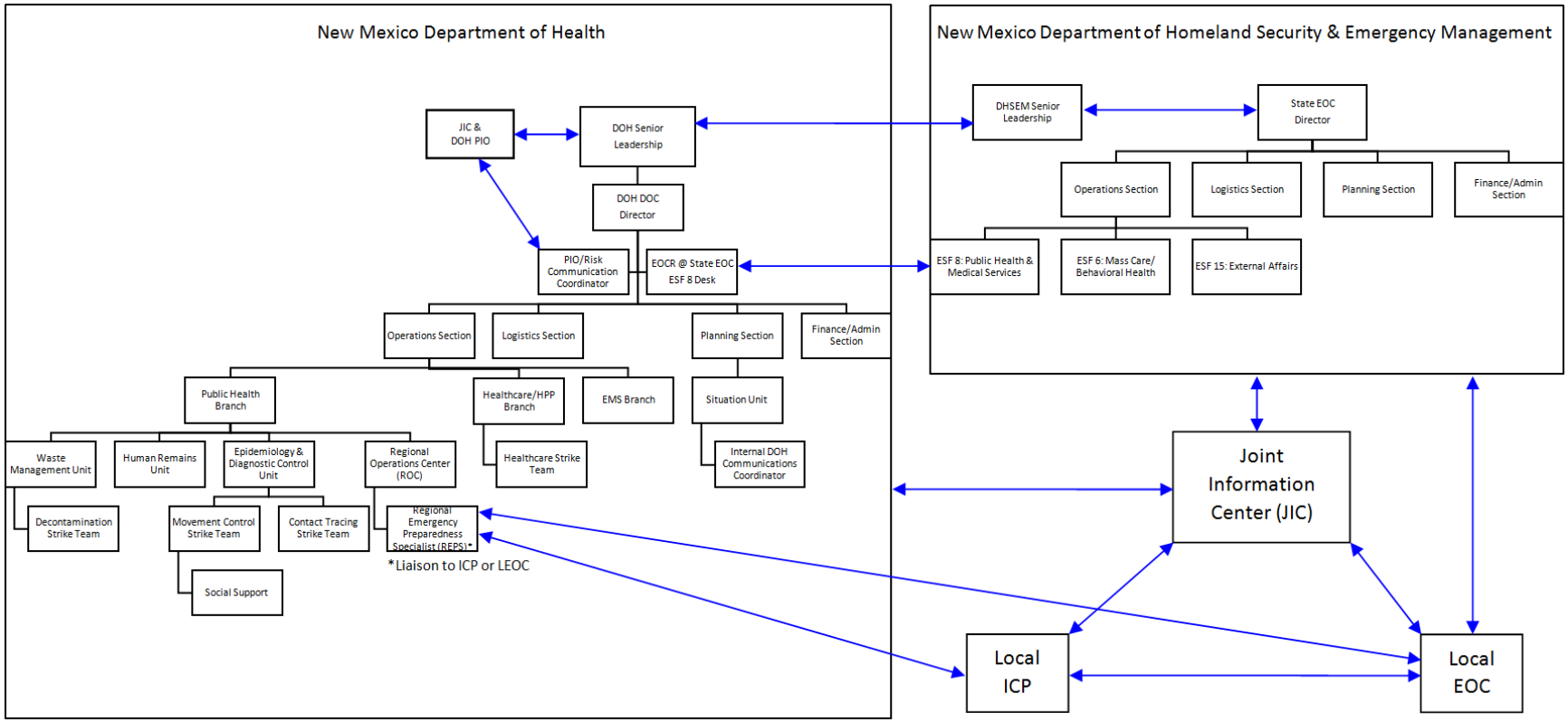
The Governor of New Mexico or Governor's Authorized Representative (GAR) has the sole authority to declare a public health emergency, which may or may not be necessary in the event of an Ebola virus disease case.

Command Responsibility for Specific Actions

Upon confirmation of an Ebola virus disease case in New Mexico, the Department of Homeland Security and Emergency Management will activate the State Emergency Operations Center (EOC). The NMDOH will activate the Department Operations Center (DOC), and a local Emergency Operations Center (LEOC) and Incident Command Post (ICP) will likely also be activated.

Incident Command System (ICS)

Potential* ICS Organization for a New Mexico Ebola Response:



Blue arrows represent lines of communication in addition to existing ICS organizational lines.

Please refer to the NMDOH All-Hazard EOP (basic plan), p.17-21 for additional examples of potential ICS organization.

** This is only an example; the actual ICS organization may vary according to situational requirements.*

Information Sharing and Communications

Please see the NMDOH All-Hazard Emergency Operations Plan (EOP Basic Plan) Information Sharing and Communications sections.

Administration, Finance and Logistics

Please see the NMDOH All-Hazard Emergency Operations Plan (EOP Basic Plan) Administration, Finance, and Logistics sections.

Annex Plan Development and Maintenance

This plan is a living document and may be updated or revised at any time.

Please see the NMDOH All-Hazard Emergency Operations Plan (EOP Basic Plan) Development and Maintenance section.

Legal Authority

Background

The New Mexico Department of Health (NMDOH) has the authority and responsibility to investigate, control and abate disease, especially epidemics and sources of mortality and other conditions of public health, and it may establish or require isolation or quarantine of any animal, person, institution, community or region (N.M. Stat. Ann. § 24-1-3.C and N.M. Stat. Ann. § 24-1-3.D, respectively). Isolation and quarantine can help protect the public by preventing exposure to people who have or may have a contagious disease. Isolation separates and restricts the movement of sick people with a contagious disease from people who are not sick with that disease. Quarantine is the separation and restriction of movement of people who have potentially been exposed to a contagious disease, until it can be determined whether they become sick or no longer pose a risk to others (e.g., based on time elapsed from their potential exposure).

While the Secretary of the NMDOH may isolate or quarantine a person as necessary during a public health emergency, using the procedures set forth in the Public Health Emergency Response Act (PHERA) (N.M. Stat. Ann. § 12-10A-8 to 12-10A-11), this approach would only be instituted if all other voluntary approaches were to fail. While broad public health police powers exist in New Mexico, limitations on those powers also exist and are respected by the NMDOH. For example, the NMDOH, in any procedures employed--if it deemed that isolation and/or quarantine were necessary--would comply with its legal responsibility that “isolation or quarantine shall be by the least restrictive means necessary to protect against the spread of a threatening, or potentially threatening, communicable to others and may include confinement to a private home or other private or public premises” (N.M. Stat. Ann. § 12-10A-8). There also exists legal job protections such that “an employer or an agent of an employer shall not discharge from employment a person who is placed in isolation or quarantine” (N.M. Stat. Ann. § 12-10A-16 (2003). New Mexico law also contains provisions for mandatory medical treatment (24-1-15.1).

Procedures

The NMDOH has adopted, and monitors for any updates, the definitions developed and utilized by the Centers for Disease Control and Prevention (CDC) to identify potential Ebola cases and their contacts, as well as to categorize persons having been in a country in which an EVD outbreak has occurred within the past 21 days and their exposure levels. Procedures for contact monitoring, traveler monitoring and movement restrictions are described in Appendix G.

In the event that involuntary detention is felt to be necessary, the following provides the legal underpinnings for obtaining an **Ex Parte Order** or issuance of a **Public Health Order**:

Legal Authority for Isolation and Quarantine in New Mexico

Voluntary Isolation or Quarantine

A person with, or having a substantial likelihood of having, a threatening communicable disease, shall be advised of the risks and rights, and requested to voluntarily remain in isolation or quarantine. Only in the event that reasonable attempts to achieve voluntary isolation or quarantine fail, will legal steps be taken. Voluntary agreement should be executed under applicable statute (Public Health Act or Public Health Emergency Response Act).

Involuntary Isolation or Quarantine

A healthcare provider or law enforcement official will **contact the New Mexico Department of Health at 505-827-0006** if they believe involuntary isolation or quarantine is necessary. The department's public health official will consult with the department's Office of General Counsel to determine whether to obtain an order for isolation or quarantine.

1. Involuntary Isolation or Quarantine - Public Health Emergency Not Declared.

    a. ***NMSA 24-1-15 (Health and Safety - Public Health Act - Reporting of Contagious Diseases)*** indicates that:

        i. A **public health official** shall petition the court, and the court shall immediately grant a **temporary ex parte order of protection** to isolate or quarantine an individual if there is a substantial threat to the public health and safety. The petition must show that the individual:

            1. Is actively infectious with a threatening communicable disease, or presents a substantial likelihood of having a threatening communicable disease based on credible medical evidence;

            2. Poses a substantial likelihood of transmission because of inadequate separation from others; and

            3. Has refused voluntary treatment.

        ii. While in temporary isolation or quarantine a person shall be entitled to legal representation, and permitted to communicate on any matter in a way that does not create a risk of infection for others.

        iii. An evidentiary hearing shall be held within 5 days. After the hearing, the court may continue the order of protection with regular review of the order within 90 days and every 90 days thereafter.

        iv. The order of protection shall be terminated and the person released if:

            1. The person is certified by a public health official to pose no further risk of infecting others;

            2. At a hearing, it can no longer be shown that the person is infected or that the person will not comply with voluntary treatment and contagion precautions; or,

3. There are exceptional circumstances.

2. Involuntary Isolation or Quarantine – Public Health Emergency Declared pursuant to the Public Health Emergency Response Act.

a. ***NMSA 12-10A-7 (Procedures for isolation or quarantine of persons)*** indicates:

i. Before isolating or quarantining a person, **the secretary of health** shall apply for and obtain a written **ex parte order** of protection from a court.

ii. Notice shall be given to the affected person(s) unless immediate and irreparable injury, loss or damage will result.

iii. The court shall grant the ex parte order of protection if clear and convincing evidence exists that isolation or quarantine is warranted.

iv. The petition must:

1. state the specific facts justifying the isolation or quarantine;

2. state the persons, group or class of persons affected;

3. state that the affected person(s) have the right to a court hearing with legal representation; and

4. be served as soon as practicable.

v. The secretary of health shall coordinate with the secretary of public safety and the state director of homeland security and emergency management regarding execution of the order.

vi. A person who is isolated or quarantined can request a hearing at any time before the expiration of the ex parte order of protection. However, a person cannot be isolated or quarantined pursuant to an ex parte order of protection for longer than five days without a court hearing.

vii. The isolation or quarantine shall automatically terminate when the order expires, or if the secretary of health notifies the court that it is no longer needed.

b. ***NMSA 12-10A-8 (Isolation or quarantine authorized; protection of a person isolated or quarantined)*** indicates:

i. Conditions of isolation or quarantine:

1. Isolation or quarantine is by the least restrictive means and may include confinement to a private home or other private/public premises;

2. Isolated persons are confined separately from quarantined persons;

3. Health status is monitored regularly to determine the need to continue isolation or quarantine;
4. There is a reliable means to communicate at all times with health officials, family and others, and to call for emergency health services;
5. If a quarantined person becomes actively infectious or presents a substantial likelihood of being infectious, they will be isolated pursuant to the Public Health Act or the Public Health Emergency Response Act;
6. Adequate food, clothing, shelter, sanitation, medication and treatment, and medical and mental health care, will be provided;
7. Methods of communication with others are provided, accommodations are made for religious practice, and updates on the status of the public health emergency are made available;
8. The premises used for isolation or quarantine are safe and hygienic and are designed to minimize the likelihood of transmission of infection or other injury; and
9. Forms are provided for the person to document consent or objection to the isolation or quarantine.

ii. A person who is isolated or quarantined may request a court hearing regarding treatment or the terms and conditions of isolation or quarantine pursuant to NMSA 12-10A-11. If such a petition is filed, a hearing must be held within seven days. A request for a hearing does not alter an order for isolation or quarantine.

iii. A person in isolation or quarantine has the right to refuse treatment, testing, examination, vaccination, specimen collection and preventive treatment programs; however, refusal may prolong isolation or quarantine.

iv. Unauthorized persons shall not enter the isolation or quarantine area, and if doing so creates danger to public health, those persons may be subject to isolation or quarantine.

v. Household or family members have a right to enter an isolation or quarantine area if they sign a consent form stating the potential health risks, the isolation and quarantine guidelines, and the consequences of entering the area, including possible isolation or quarantine, and the state shall not be held responsible for those consequences.

c. ***NMSA 12-10A-9 (Temporary hold on secretary of health's order)*** indicates:

i. If a delay in isolating or quarantining a person will significantly jeopardize the department's ability to prevent or limit the transmission of a threatening communicable disease, then the secretary of health may issue a **public**

health order to isolate or quarantine a person without first obtaining court order.

ii. An **ex parte order** of protection must be applied for within 24 hours following the procedures of the Public Health Emergency Response Act. The petition must state the facts in support of the need to issue a temporary hold by public health order.

d. ***NMSA 12-10A-10 (Court hearing to contest isolation or quarantine)***:

i. A person who is isolated or quarantined under a temporary hold, ex parte order, or continuing order may petition the court to contest detainment at any time prior to the expiration of the order or hold.

ii. A hearing shall be held within three days of the petition being filed, but filing of a petition does not stay an order of isolation or quarantine.

iii. The secretary of health may petition the court to extend an order for isolation or quarantine beyond the time stated in the temporary hold, ex parte order, or continuing order. Notice of a hearing on the extension must be served at least three days prior to the hearing. A court may order an extension of isolation or quarantine if there is clear and convincing evidence that failure to do so would result in an imminent health threat to others.

iv. Isolation or quarantine shall not continue for longer than thirty days from the date of a court order unless the secretary of health petitions for an extension.

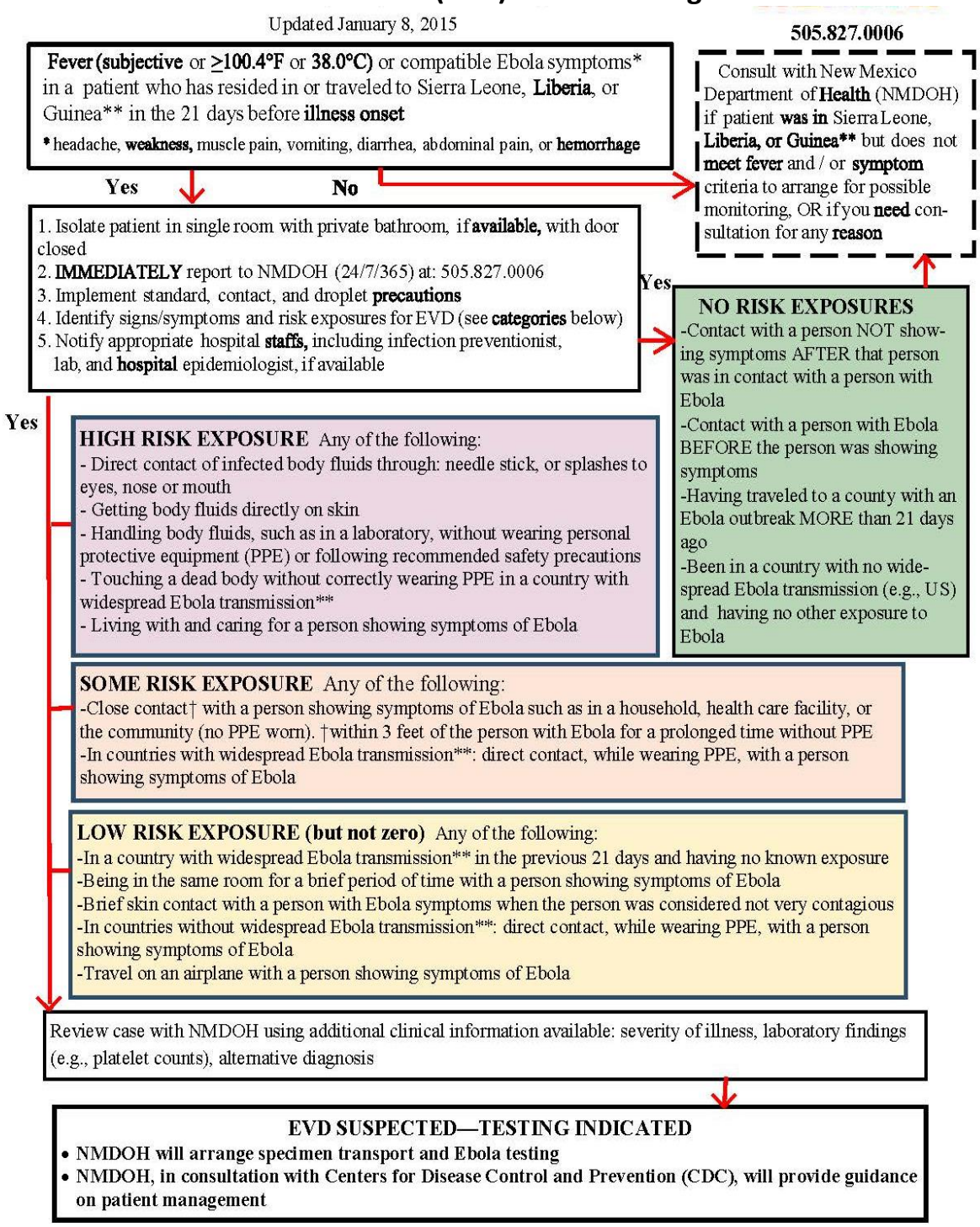
v. Isolation or quarantine will be terminated when the secretary of health notifies the court that the conditions warranting isolation or quarantine no longer exist.

e. ***NMSA 12-10A-16 (Job protection for a person who is isolated or quarantined)***:

i. An individual who is isolated or quarantined pursuant to the Public Health Emergency Response Act may not be discharged from employment by an employer or agent of an employer.

Appendixes

A. NMDOH Ebola Virus Disease (EVD) Evaluation Algorithm



****For current Ebola-affected areas (as well as guidelines for infection control and additional Ebola-related information) see CDC website at: www.cdc.gov/ebola.**

The New Mexico Department of Health is available for Ebola consultation 24/7 at 505-827-0006.

B. Health Care Provider Preparedness Checklist for Ebola Virus Disease

The latest CDC guidance for healthcare workers and settings can be found at: http://www.cdc.gov/vhf/ebola/hcp/index.html.

The U.S. Department of Health and Human Services' (DHHS) Centers for Disease Control and Prevention (CDC) and Office of the Assistant Secretary for Preparedness and Response (ASPR), in addition to other federal, state, and local partners, aim to increase understanding and encourage the preparedness for U.S. hospitals managing patients with Ebola Virus Disease (EVD).

The following checklist highlights some key areas health care providers to review in preparation that a person with EVD arrives for medical care. The checklist format is not intended to set forth mandatory requirements or establish national standards. In this checklist healthcare personnel (HCP) refers all persons, paid and unpaid, working in healthcare settings who have the potential for exposure to patients and/or to infectious materials, including blood and body fluids, contaminated medical supplies and equipment, and contaminated environmental surfaces. HCP include, but are not limited to, physicians, nurses, nursing assistants, therapists, technicians, students and trainees, laboratory personnel, contractual personnel, emergency medical services personnel, and persons not directly involved in patient care (e.g., house-keeping, laundry).

*More detailed checklists including practical and specific suggestions to ensure your hospital is able to **detect** possible EVD cases, **protect** your employees, and **respond** appropriately can be found here: http://www.cdc.gov/vhf/ebola/pdf/hospital-checklist-ebola-preparedness.pdf*

- ☐ Stay up to date on the latest information about risk factors, signs, symptoms, and diagnostic testing for EVD (http://www.cdc.gov/vhf/ebola/index.html)
- ☐ Be alert for patients with signs and symptoms of EVD or who may have traveled recently to one of the affected countries (http://www.cdc.gov/vhf/ebola/symptoms/index.html)
- ☐ Review facility infection control policies for consistency with the Centers for Disease Control and Prevention's Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected EVD in U.S. Hospitals (http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html) to include recommendations for:
- ☐ Assessment and triage of patients with suspected EVD
- ☐ Patient placement
- ☐ Visitor management and exclusion
- ☐ Personal protective equipment (PPE) for healthcare personnel
- ☐ Promptly apply standard, contact, and droplet precautions for any suspected or confirmed EVD patients before transport or upon entry to the facility, and triage using the facility plans (e.g., place in private room) for evaluation (http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html)

- ☐ Know how to report a potential EVD case to your facility infection control leads
- ☐ Know the points of contact within your facility responsible for communicating with state and local public health officials. Remember: EVD is a nationally notifiable disease and must be immediately reported to local, state, and federal public health authorities. A list of state epidemiologists can be found here: (http://www.cste.org/?page=StateEpi)
- ☐ Know who to notify in your facility after an unprotected exposure (i.e., not wearing recommended PPE at the time of patient contact or through direct contact with blood or body fluids) to a suspected or confirmed EVD patient.
- ☐ Know how and where to seek medical evaluation following an unprotected exposure.
- ☐ Do not report to work if you become ill after an unprotected exposure (i.e. not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with EVD.

Additional Resources

- Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in U.S. Hospitals: http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html
- Safe Management of Patients with Ebola Virus Disease (EVD) in U.S. Hospitals: http://www.cdc.gov/vhf/ebola/hcp/patient-management-us-hospitals.html
- Guidance for Safe Handling of Human Remains of Ebola Patients at U.S. Hospitals and Mortuaries: http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html
- Interim Guidance for 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
- U.S. Department of Health and Human Services Assistant Secretary for Preparedness and Response: http://phe.gov

C. CDC Patient Evaluation Checklist

The latest CDC guidance for healthcare workers and settings can be found at: http://www.cdc.gov/vhf/ebola/hcp/index.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States

Upon arrival to clinical setting/triage

- ❑ Assess the patient for a fever (subjective or ≥ 100.4°F / 38.0°C)
- ❑ Determine if the patient has symptoms compatible EVD such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage
- ❑ Assess if the patient has a potential exposure from traveling to a country with widespread Ebola transmission* or having contact with an Ebola patient in the 21 days before illness onset
  Suspect Ebola if fever or compatible Ebola symptoms and an exposure are present
  See next steps in this checklist and the Algorithm for Evaluation of the Returned Traveler for Ebola at http://www.cdc.gov/vhf/ebola/pdf/ebola-algorithm.pdf

Upon initial assessment

- ❑ Isolate patient in single room with a private bathroom and with the door to hallway closed
- ❑ Implement standard, contact, & droplet precautions
- ❑ Notify the hospital Infection Control Program at _____
- ❑ Report to the health department at _____

Conduct a risk assessment for: High-risk exposures

- ❑ Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids from an EVD patient
- ❑ Direct skin contact with skin, blood or body fluids from an EVD patient
- ❑ Processing blood or body fluids from an EVD patient without appropriate PPE
- ❑ Direct contact with a dead body in an Ebola-affected area without appropriate PPE

Low-risk exposures

- ❑ Household members of an EVD patient or others who had brief direct contact (e.g., shaking hands) with an EVD patient without appropriate PPE
- ❑ Healthcare personnel in facilities with EVD patients who have been in care areas of EVD patients without recommended PPE

Refer to *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)* **(hyperlink:** http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)

During aerosol-generating procedures

- ❑ Limit number of personnel present
- ❑ Conduct in an airborne infection isolation room
- ❑ Don PPE as described in 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)* (hyperlink: http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)

Patient placement and care considerations

- ❑ Maintain log of all persons entering patient's room
- ❑ Use dedicated disposable medical equipment (if possible)
- ❑ Limit the use of needles and other sharps
- ❑ Limit phlebotomy and laboratory testing to those procedures essential for diagnostics and medical care
- ❑ Carefully dispose of all needles and sharps in puncture-proof sealed containers
- ❑ Avoid aerosol-generating procedures if possible
- ❑ Wear PPE (detailed in center box) during environmental cleaning and use an EPA-registered hospital disinfectant with a label claim for non-enveloped viruses**

Initial patient management

- ❑ Consult with health department about diagnostic EVD RT-PCR testing***
- ❑ Consider, test for, and treat (when appropriate) other possible infectious causes of symptoms (e.g., malaria, bacterial infections)
- ❑ Provide aggressive supportive care including aggressive IV fluid resuscitation if warranted
- ❑ Assess for electrolyte abnormalities and replete
- ❑ Evaluate for evidence of bleeding and assess hematologic and coagulation parameters
- ❑ Symptomatic management of fever, nausea, vomiting, diarrhea, and abdominal pain
- ❑ Consult health department regarding other treatment options

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

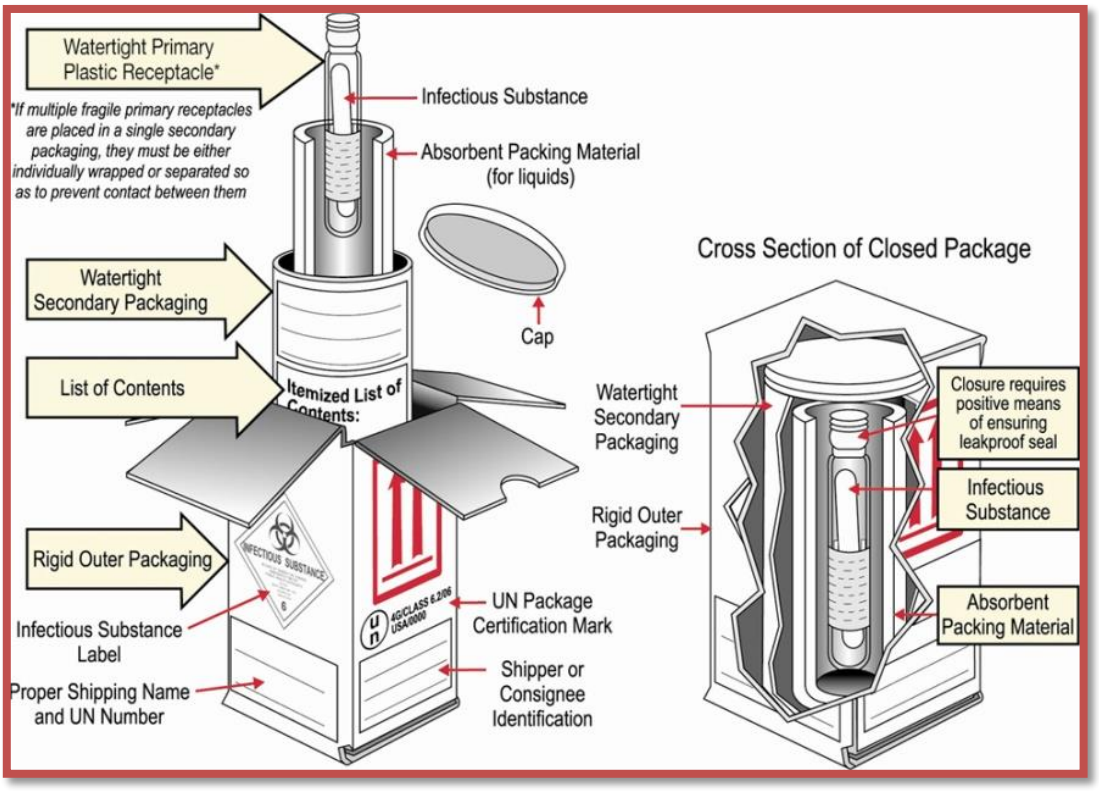
* See 2014 Ebola Outbreak in West Africa—Case Counts or http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html to determine if a country has widespread Ebola transmission
** See Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus or http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html
*** See Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Persons Under Investigation for Ebola Virus Disease in the United States or http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html

D. Lab Testing and Specimen Submission Guidance for Ebola Assessment Facilities

The New Mexico Department of Health (NMDOH) has created a laboratory-specific guidance and risk assessment for the proper handling, routine clinical testing, transport and submission of specimens from a person suspected of having Ebola Virus Disease. The Scientific Laboratory Division (SLD) is now one of the Laboratory Response Network (LRN) laboratories designated to conduct Emergency Use Authorization (EUA) Ebola Testing. This test gives a presumptive result; confirmatory testing will be conducted by the CDC. As a reminder, the NMDOH must be contacted and will work with the requesting clinicians and CDC to determine whether specimens should be collected and tested for Ebola. The SLD will work, in conjunction with the Epidemiology and Response Division (ERD), with the submitter, on a case-by-case basis, to determine the optimum method of transporting specimens to the lab.

Specimen Submission

- The Scientific Laboratory Division (SLD) will not accept specimens that have not previously been approved for submission by the Epidemiology and Response Division (ERD)
- Shipments must follow IATA regulations for Category A substances.



- Training and certification are required by transportation agencies in the U.S. to package and ship infectious substances, a class of hazardous materials.

- Anyone involved in the packaging or shipping of hazardous materials must be certified.
- The employer decides what satisfies the requirements, provides or verifies appropriate training in hazmat, safety and security, tests, documents training and certifies employees.
- Packing & shipping guidelines for clinical labs are available here: http://www.asm.org/images/PSAB/PackAndShip.pdf.

- How to acquire training that will help meet regulatory requirements?
  - NMDOH employees may take a (free) online course: http://training/moodle/login/index.php. Use your NMDOH login, click on "PHD Training Online", select Subcategory "CLIA Training", then CLIA III: Shipping and Handling Division 6.2 Hazardous Materials.
  - A simple Google search (try "Division 6.2 training") will reveal a number of commercially available trainings. Additional training options can be found on pgs. 17-19 of the American Society for Microbiology's "Packing and Shipping Infectious Substances" guidelines (http://www.asm.org/images/PSAB/PackAndShip.pdf)
  - In-house training – You can develop your own program, as long as it meets the USPS, DOT, IATA and WHO regulatory requirements (and CAP, CLIA, JCAHO, OSHA, your courier service, etc.).

Collection Of Suspect Ebola Specimens	• Get ERD approval prior to collection (505-827-0006) • TWO tubes with a minimum 4mL each of Whole Blood in a Plastic Collection Tube • EDTA Preferred, SPS, Citrate, or w/Clot Activator OK
Do Not Submit in Glass or Heparinized Collection Tubes!	• No Centrifugation is required • Two forms of personal identifiers should be applied to both the Specimen & to the Test Request Form
All Collections Must Follow OSHA Bloodborne Pathogen Standards	• Decontaminate each tube, place in separate specimen bags with absorbent packing material; decontaminate outside of bag • Specimens should be placed in a watertight secondary container with leakproof seal • Decontaminate secondary container before placing in the rigid outer packaging; put form in outer packaging not inside secondary container
SLD General Clinical Request Form	• Fill Out all Highlighted Areas on SLD's Clinical Request Form; http://archive.sld.health.state.nm.us/Documents/bsbform.pdf • In Serology, Analysis Requested area select "Other" and write in Ebola: ☑ Other: Ebola
CDC 50.34 Form	• Fill out the CDC form as completely as possible • Attach the form to the SLD General Clinical Request Form • CDC form located at http://www.cdc.gov/laboratory/specimen-submission/form.html
Ship specimens at 2-8°C or frozen on cold packs to the Scientific Laboratory Division.	• Use the technical name "suspected Category A infectious substance" if a shipper's declaration is required by the carrier
Shipping Address	• Send To: SLD, Attn: Virology/Serology 1101 Camino de Salud, NE Albuquerque, NM 87102

Risk Assessment for the Safe Handling and Testing of Specimens at Hospital and Other Clinical Laboratories

Ebola virus is a high consequence pathogen and there is limited experience in handling specimens that could contain such a pathogen within a clinical laboratory setting, using currently common specimen handling procedures and automated instrumentation. This risk assessment is presented for enhanced precautions in handling specimens from patients who may be at risk of having an Ebola virus infection and represents reasonable precautions for this level of risk, but given the lack of experience and data, laboratories may want to elevate precautions further based on their individual assessments and resources. If more information becomes available on the risk of transmission, this risk assessment may change.

The CDC has released Interim Guidance for Specimen Collection, Transport, Testing, and Submission of Specimens for Patients under investigation for Ebola virus disease (EVD) in the United States. This laboratory risk assessment is based on these guidelines. Please see the link below:

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

Collection of Specimens in the Isolation Room

Potential Hazard(s)	Percutaneous injuries/needlesticks.
	Contamination of the external surfaces of the container.
Control	✓ Alert laboratory that potentially hazardous specimens are being collected.
	✓ Patient is in contact and droplet precautions.
	✓ PPE for phlebotomy: full face shield or goggles and mask to cover all of nose and mouth, gloves, fluid resistant or impermeable back-closing gowns. Additional PPE may be required in certain situations.
	✓ Limit the use of sharps. Collect specimens in plastic containers. Avoid glass.
	✓ Before packaging specimens for transport to the lab, wipe down all containers with a hospital disinfectant effective against non-enveloped viruses (check manufacturer's label). Ensure label can still be read.
	✓ Place specimens in sealed plastic bags with absorbent material
	✓ Wipe the outside of the plastic bags with hospital disinfectant.
	✓ Place plastic bags into a durable, leak proof secondary container for transport within the hospital
	✓ Wipe the outside of the secondary container with hospital disinfectant before it leaves the room.
Comment	☆ Establish a communication protocol between the lab, providers, and clinical units. Include relevant leadership e.g., lab, infection control, infectious diseases, emergency department, & nursing. The laboratory must be alerted so that special precautions are in place.
	☆ Wiping down the surfaces requires all surfaces be wet and that the contact time is sufficient to kill the virus. Use for example a bucket of 10% bleach or a spray bottle (minimum contact time = 10 minutes) and use disinfectant saturated pad(s).

Transport of Specimens

Potential Hazard(s)	Breakage of the specimen container.
Control	✓ Specimens should be transported in a clearly labeled, durable, leak-proof secondary container directly to the specimen handling area of the laboratory.
	✓ Hand carry all specimens to the laboratory.
Comment	☆ Do not use pneumatic tube or other automated transport systems.

Preparation of Specimens for Testing

Potential Hazard(s)	Aerosolization/Splash/Splatter
	Breakage of the specimen container
Control	✓ Minimize the number of workers handling the specimens
	✓ The following PPE must be used: fluid resistant back-closing gown, double gloves, N95 respirator or mask, goggles or full face shield, (eyes and mucous membranes covered).
	✓ Work inside a certified class II Biosafety Cabinet (BSC) with the sash at the appropriate level. Alternatively, work behind a plexiglass splash guard.
	✓ Limit the traffic around the BSC.
	✓ In the BSC, work over a disinfectant moistened paper towel.
	✓ Use only pipette tips with barrier filters.
	✓ Have a dedicated sharps container in the BSC to which you have added disinfectant.
	✓ Smear preparation: Fix smears inside the BSC. Wipe underside of slide with disinfectant before removing from BSC.
	✓ Aliquot tubes: wipe outside of primary and aliquot tubes before removing from BSC
	✓ Inoculation of sample to cartridges: Perform all steps in BSC as above. Wipe outside of cartridge before removing from BSC
Comment	☆ No exposed skin inside the BSC.
	☆ Immediately change gloves if contamination is visible or suspected.
	☆ Bring all necessary material into the BSC before starting to work. Do not enter and re-enter BSC once specimen processing begins. A co-worker in full PPE should bring additional materials to the BSC if necessary.
	☆ If using 10% bleach it must be freshly prepared every 24 hours
	☆ Minimize use of sharps. Dispose of all pipette tips and sharps in the dedicated container in the BSC
	☆ Specimens and materials must be decontaminated before removing from BSC
	☆ Blood smears (e.g., for malaria) are not infectious for Ebola after fixation in solvents.
	☆ DO NOT set up any viral cultures
	☆ By using the PPE listed and working in the BSC, BSL-3 practices in a BSL-2 environment are followed.

Centrifugation

Potential Hazard(s)	Breakage and aerosolization
Control	✓ Look for alternatives to centrifugation when possible.
	✓ Load centrifugation buckets inside the BSC.
	✓ Centrifuge specimens using aerosol safe containers with O-ring sealable tops.
	✓ After centrifugation, bring sealed buckets back to the BSC and open the buckets inside the BSC.
Comment	☆ Centrifuge these specimens separately (no other patient specimen in the centrifuge run).
	☆ Be alert to any potential malfunction during the centrifugation run.

After Specimen Processing is complete and before removing from BSC

Potential Hazard(s)	Accidental transfer of contaminated material from the BSC.
Control	✓ Remove and replace gloves after specimen handling.
	✓ All waste must be discarded and contained inside the BSC.
	✓ Wipe all tubes with disinfectant before removing from BSC.
	✓ Place specimens in sealed plastic bags (new bags). Wipe the outside of the bags with disinfectant. Place specimen bags into a rigid leak proof container. Wipe outside of container with disinfectant.
	✓ Remove gloves and dispose inside biohazard waste container in the BSC.
	✓ Don new gloves.
	✓ Wipe all trash with disinfectant Remove decontaminated items from the BSC including specimens in sealed bags and waste materials in their containers or bags
Comment	☆ Disinfectant for containers and work surfaces: Any hospital-approved disinfectant such as quaternary ammonia, 10% bleach or phenolic. Ensure the minimum contact time per manufacturer instructions. Disinfect waste and sharps containers before removing them from the BSC. Use a dedicated waste bag for gloves and other non-sharps waste.

BSC Decontamination

Potential Hazard(s)	Contamination of BSC surfaces
Control	✓ Wipe the inside of the BSC with disinfectant.
	✓ Remove all PPE and discard into medical waste stream
Comment	☆ If bleach disinfectant is used: contact time = 10 minutes. Follow by wiping down all surfaces in the BSC with 70% alcohol. Allow to air dry.
	☆ Other hospital-approved disinfectant such as quaternary ammonia or phenolic: ensure the minimum contact time per manufacturer instructions

Testing Specimens on Automated Instruments

Potential Hazard(s)	Aerosolization/Splash/Splatter
	Contamination of Equipment
Control	✓ The use of automated instruments, the lab environment where they are located, the risk for aerosolization, and the ease of decontaminating the instrument and work space are all issues that need to be carefully considered and dealt with before utilizing automated instruments.
	✓ Consider the use of PPE: fluid resistant back-closing gown, gloves, mask or N95 respirator, goggles or full face shield (eyes and other mucous membranes covered). Work behind plexiglass splash guard when possible. Consider decontamination of automated instruments after the test run.
	✓ Microscopes: Use approved disinfectant to wipe all surfaces of the scope and work area. Dispose of slides in sharps container
Comment	☆ Point of care testing is advisable to avoid running chemistry and hematology tests in the core lab, increasing potential exposures.
	☆ The manufacturer recommendations should be followed regarding decontamination of instruments and waste.

Storage and Disposal of Specimens

Potential Hazard(s)	Breakage and aerosolization
Control	✓ All specimens should be isolated from other specimens in the laboratory and disposed of in an appropriate manner as soon as testing is completed.
	✓ Autoclave specimens if available. Alternatively, inactivate specimens in 10% bleach for 24 hours, then place in standard biohazard infectious waste disposal.
Comment	☆ This is to reduce the risk of contamination after the specimens leave the lab.
	☆ Use of automated track systems may require special steps to retrieve specimens after testing.

Select Agent Regulations

Ebola virus is regulated as a "select agent" in accordance with the HHS Select Agent Regulations (42 CFR Part 73). The CDC has an interim guidance regarding compliance with Select Agent Regulations for those handling patient specimens that are known or suspected to contain Ebola virus: http://www.cdc.gov/vhf/ebola/hcp/select-agent-regulations.html

E. Emergency Medical Services (EMS) Guidance

Updated 01/22/2015

Emergency Medical Services (EMS) Ebola Preparedness and Guidance for 911 Call Centers, 911 EMS Response, Decontamination, and Transfer of Highly Suspected or Confirmed Ebola Patients

The New Mexico Department of Health Emergency Medical Systems Bureau strongly recommends that EMS Medical Directors and EMS Agency supervisory personnel prepare for the possibility of dealing with Ebola by utilizing the CDC publication "**Detailed Emergency Medical Services (EMS) Checklist for Ebola Preparedness"** found at:

http://www.cdc.gov/vhf/ebola/pdf/ems-checklist-ebola-preparedness.pdf

The information provided here referenced the CDC publication **"Interim Guidance for EMS System and 911 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) and other CDC publications where noted.

911 (PSAP) and other EMS Call Centers

- When taking a call, all PSAP call takers should screen callers for a positive travel history, within 21 days of their present complaint, to Sierra Leone, Guinea, or Liberia.
    - If PSAP call takers have information alerting them to a person with a positive travel history, they should make sure any first responders and EMS personnel enroute to the call are made confidentially aware (i.e., cell phone or data message) of the potential for Ebola before the responders arrive on scene.
    - Once the responders are notified of the positive travel history for possible Ebola, the call taker should contact the New Mexico Department of Health at (505) 827-0006 and advise the NMDOH of the situation.
    - If responding at an airport or other port of entry to the United States, the PSAP should notify the CDC Quarantine Station for the port of entry. Contact information for CDC Quarantine Stations can be accessed at the following link: http://www.cdc.gov/quarantine/quarantinestationcontactlistfull.html(http://www.cdc.gov/quarantine/quarantinestationcontactlistfull.html)

- If the screening questions do not indicate a positive travel history for Ebola, the call taker should proceed as per normal procedures and pre-arrival instruction guidelines.

911 EMS Response and Transport

- The New Mexico Department of Health EMS Bureau recommends that, especially in larger services, a limited number of crews and units be designated for response to a caller with a positive Ebola history in order to limit exposure to as few as individuals as possible.
- If advised of a call taker's concern about the possibility of Ebola while enroute to a patient's location, EMS caregivers should don appropriate personal protection equipment (PPE) that meets the CDC guideline described in document **"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)"** found at http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html. Briefly, this includes:
    - Powered Air Purifying Respirator (PAPR) with a full face shield, helmet, or headpiece or a disposable N95 respirator.
        - If the PAPR used has a reusable helmet or headpiece, it must be covered with a compatible single use surgical hood that extends to the shoulders and fully covers the neck.
        - If using the N95 respirator, it must be used in combination with a single use surgical hood that extends to the shoulders and fully covers the neck.
    - Fluid resistant or impermeable gown that extends to at least mid-calf, or coverall without an integrated hood.
    - Caregivers should double glove with nitrile examination gloves with extended cuffs.
    - Single use fluid resistant or impermeable boot and leg covers that extend to at least mid-calf.
    - If large amounts of blood and/or body fluids are present, the CDC recommends a single use, fluid resistant/impermeable apron that covers the torso to the level of the mid-calf.
- Upon arrival, assure the scene is safe. It should be noted that as with many medical and traumatic conditions, Ebola illness can cause delirium, with erratic behavior that can place EMS personnel at risk of infection.

  - Once patient contact is made, keep the patient separated from other persons as much as possible.

- When assessing a patient (with or without a call taker's Ebola concern being communicated), the assessment should include ascertaining a positive travel history within the previous three weeks to Sierra Leone, Guinea, or Liberia
- If no travel history or other Ebola risk is identified, patient care should be continued per local treatment and transport guidelines.
- If a risk for Ebola is found, the closest appropriate receiving hospital should be notified so that appropriate infection control precautions may be prepared prior to patient arrival.
- During transport of a patient with a positive travel history for Ebola, isolate the driver from the patient compartment. Also, particular attention should be paid to protecting the caregivers' mucous membranes of the eyes, nose, and mouth from splashes of infectious material, or self-inoculation from soiled gloves. Additionally,
  - Limit activities, especially during transport that can increase the risk of exposure to infectious material (e.g., airway management, cardiopulmonary resuscitation, use of needles).
  - Limit the use of needles and other sharps as much as possible. All needles and sharps should be handled with extreme care and disposed of in puncture-proof, sealed containers.
  - Phlebotomy, procedures, and laboratory testing should be limited to the minimum necessary for essential diagnostic evaluation and medical care.
- If blood, body fluids, secretions, or excretions from a patient with suspected Ebola come into direct contact with the EMS provider's skin or mucous membranes, then the EMS provider should, after the call is completed, immediately stop working. They should wash the affected skin surfaces with soap and water and report exposure to an occupational health provider or supervisor for follow-up. Further follow up guidance is provided later in this document.
- Donning and doffing of PPE should follow the latest guidance published on www.CDC.gov, **"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)"** found at http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html.
- Documentation of patient care should be done after EMS providers have completed their personal cleaning and decontamination of equipment and vehicle. Any written

documentation should match the verbal communication given to the emergency department providers at time of patient handover.

- EMS documentation should include a listing of public safety providers involved in the response and level of contact with the patient (such as, no contact with patient, provided direct patient care). This documentation may need to be shared with the New Mexico Department of Health.CDC guidance for follow-up and/or reporting by EMS personnel after caring for a suspected or confirmed Ebola patient can be found in the **"Interim Guidance for 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". Check www.CDC.gov often for updates to this and other documents.**

Decontamination of Vehicle

- The following are general CDC guidelines taken from **"Interim Guidance for EMS System and 911 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) for cleaning or maintaining EMS transport vehicles and equipment after transporting a patient with suspected or confirmed Ebola:
    - EMS personnel performing cleaning and disinfection should wear recommended PPE (described above) and consider use of additional barriers (e.g., rubber boots or shoe and leg coverings) if needed. Face protection (facemask with goggles or face shield) should be worn since tasks such as liquid waste disposal can generate splashes.
    - Patient-care surfaces (including stretchers, railings, medical equipment control panels, and adjacent flooring, walls and work surfaces) are likely to become contaminated and should be cleaned and disinfected after transport.
    - A blood spill or spill of other body fluid or substance (e.g., feces or vomit) should be managed 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.
    - An EPA-registered hospital disinfectant with label claims for viruses that share some technical similarities to Ebola (such as, norovirus, rotavirus, adenovirus, poliovirus) 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 in the bullet above.

- Contaminated reusable patient care equipment 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.

- The Ebola virus is a 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). Any item transported for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, and used health care products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used Personal Protection Equipment [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.

Follow-up Measures by EMS Providers after Caring for a Suspected or Confirmed Ebola Patient

- EMS agencies should develop policies for monitoring and management of EMS providers potentially exposed to Ebola virus. Call the New Mexico Department of Health for guidance if necessary. Further CDC information on this can be found on the CDC website at http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html.
- EMS agencies should develop sick leave policies for EMS providers that are non-punitive, flexible and consistent with public health guidance
- Ensure all EMS providers, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick leave policies.
- EMS providers with exposure to blood, bodily fluids, secretions, or excretions from a suspected or confirmed Ebola patient should immediately:
  - Stop working and wash the affected skin surfaces with a cleansing or antiseptic solution and mucous membranes (such as, conjunctiva of the eye) should be irrigated with a

large amount of water or eyewash solution, as per usual protocols. All wipes and solution should be placed in a biohazard bag.

- Contact occupational health/supervisor/designated infection control officer for immediate assessment and access to post-exposure management services.
- Receive medical evaluation and follow-up care, based upon EMS agency policy and consultation with the New Mexico Department of Health.

Guidance for Scheduled Transfer of a Confirmed Ebola Patient

- The possibility exists that an EMS agency may be asked to transfer a suspected or confirmed Ebola patient between healthcare facilities. This transfer must be carefully planned to assure the safety of the patient, transfer crews, hospital personnel, and the public.

- Prior to the scheduling of the transfer, the physicians and other care team members from the sending facility, the receiving facility, and the EMS agency must have coordinated the transfer, working with the New Mexico Department of Health and CDC.

- Identify EMS agency supervisory personnel and caregivers to oversee the preparation of the rig, the acquisition of additional necessary equipment, monitor the transfer process, and provide information and support to the transfer crews. The preparation and acquisition of equipment may take a significant amount of time; allow 24 hours or more.

- The patient will be confirmed to be stable enough for transfer, and all treatment the patient will require during the transfer will be defined (medications, ventilator, and other modalities). This will allow for assurance that the care needed does not exceed the scope of practice of the caregivers of the EMS agency, and if so, make arrangements for additional clinicians who can perform the necessary care. In the alternative, a different EMS agency capable of accepting the transfer can be contacted. Please note, no New Mexico based air ambulance services are currently capable of transporting high risk or known Ebola patients.

- Confirm the timing of the pick-up and drop off of the patient at the sending and receiving facilities, assuring that the care teams at both locations are prepared for their respective roles in the transfer.

- PPE should meet the standards found in the document **"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)" found at http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html.

- Preparation of the ambulance patient compartment should be done with the purpose of segregating the cab of the vehicle from the patient compartment. Additionally, the cabinetry/shelving, ceiling, seating, and floor areas should be covered with an impermeable barrier

- Guidance for ground services engaging in transfers of suspected or confirmed Ebola patients can be found in several CDC publications found at www.CDC.gov . Decontamination and follow up should meet the standards recommended by the CDC, as described earlier in this document.

Please note: There are a few EMS agencies in the United States that have transported confirmed Ebola patients. These and other large EMS agencies have developed comprehensive guidelines for transport of known or suspected Ebola patients, as well as subsequent decontamination. These agencies may be willing to share their preparation information, as well as their transport, care, and decontamination experiences and protocols. For instance, American Medical Response has made available their comprehensive preparation guidelines available via their website at www.AMR.net/Ebola. Local EMS medical directors and supervisory personnel may want to consider contacting one or more of these agencies, or referencing their websites.

F. CDC Guidance on Personal Protective Equipment (PPE) in U.S. Hospitals

Please refer to the Centers for Disease Control and Prevention (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

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CDC • Ebola (Ebola Virus Disease) • Healthcare Workers

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)

Recommend Tweet Share

This guidance is current as of October 20, 2014

The following procedures provide detailed guidance on the types of personal protective equipment (PPE) to be used and on the processes for donning and doffing (i.e., putting on and removing) PPE for all healthcare workers entering the room of a patient hospitalized with Ebola virus disease (Ebola). The guidance in this document reflects lessons learned from the recent experiences of U.S. hospitals caring for Ebola patients and emphasizes the importance of **training, practice, competence, and observation** of healthcare workers in correct donning and doffing of PPE selected by the facility.

This guidance contains the following key principles:

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

In healthcare settings, Ebola is spread through direct contact (e.g., through broken skin or through mucous membranes of the eyes, nose, or mouth) with blood or body fluids of a person who is sick with Ebola or with objects (e.g., needles, syringes) that have been contaminated with the virus. For all healthcare workers caring for Ebola patients, PPE with full body coverage is recommended to further reduce the risk of self-contamination.

To protect healthcare workers during care of an Ebola patient, healthcare facilities must provide onsite management and oversight on the safe use of PPE and implement administrative and environmental controls with continuous safety checks through direct observation of healthcare workers during the PPE donning and doffing processes.

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- Recommended Administrative and Environmental Controls for Healthcare Facilities
- Principles of PPE
- Training on Correct Use of PPE
- Use of a Trained Observer
- Designating Areas for PPE Donning and Doffing
- Selection of PPE for Healthcare Workers during Management of Ebola Patients
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- Preparing for Doffing

External (Non-CDC) Resources on PPE

- Emory Healthcare: Ebola Preparedness Protocols

G. Contact Tracing, Contact Monitoring and Traveler Monitoring Guidelines

In the event that a person with Ebola virus disease (EVD) is identified in New Mexico, the New Mexico Department of Health (NMDOH) will immediately initiate contact tracing to determine who came in contact with the EVD patient so that they can be monitored for illness for 21 days after last exposure. Close contacts will be identified and categorized per Centers for Disease Control and Prevention (CDC) exposure category definitions. Travelers from Sierra Leone, Liberia, and Guinea in the past 21 days will also be categorized by exposure category and monitored for illness for 21 days after the last exposure. CDC's Interim Guidance for Monitoring and Movement of People Exposed to Ebola virus (see table below) will be used as the basis for assigning exposure category, public health actions, and movement restrictions; but recommendations for specific travelers and exposures may need to be provided on a case by case basis by NMDOH staff.

Investigation and Monitoring of High Risk, Some Risk, and Low (but not zero) Risk Persons

The first actions in an investigation will determine:

1. if the person has signs or symptoms consistent with EVD and
2. the level of exposure risk of the person.

This will be based upon the CDC's Interim Guidance for Monitoring and Movement of People Exposed to Ebola Virus (see table below). This will determine further public health action.

Persons will be evaluated using the following steps:

1. Persons will first be contacted by telephone and a questionnaire will be administered over the telephone to help assess exposure risk level and if the person is symptomatic.
2. The initial step in the assessment will be to have the person take their temperature (using a FDA-regulated thermometer) and does not require entry into the residence or location that the person is in. For persons in the "some risk" or "high risk" categories, direct active monitoring (see definition below) will be initiated while persons in the "low but not zero risk" category will have active monitoring.
3. If the person has a fever or other symptoms consistent with EVD, they are considered a Person Under Investigation (PUI) and he or she will immediately be isolated in their home (or their current location) in a private room (preferably with an attached private bathroom). The door to their private room will be kept closed. A medical evaluation will be conducted by NMDOH medical epidemiology personnel (in consultation with CDC clinical staff) to determine if the person needs to be transported to an assessment hospital for further testing and evaluation.
4. If it is determined that the PUI needs to receive further evaluation and testing at an assessment hospital, EMS will be contacted for patient transport to the designated hospital. EMS will be notified about the patient being an EVD contact and having signs and symptoms so that EMS can take appropriate standard, contact, and droplet precautions. The receiving hospital also will be immediately notified so they can prepare to receive the patient with infection prevention precautions in place. The symptomatic person will be tested and isolated at the hospital while receiving appropriate medical care.

5. The NMDOH will report any suspect cases to the CDC Emergency Operations Center (EOC).

Active and Direct Active Monitoring

Persons exposed to an Ebola confirmed case or returned travelers from Liberia, Sierra Leone, or Guinea in the last 21 days with be followed either by active or direct active monitoring. Active monitoring means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed individuals, including checking daily to assess for the presence of symptoms and fever, rather than relying solely on individuals to self-monitor and report symptoms if they develop. Direct active monitoring means the public health authority conducts active monitoring through direct observation. The purpose of active (or direct active) monitoring is to ensure that, if individuals with epidemiologic risk factors become ill, they are identified as soon as possible after symptom onset so they can be rapidly isolated and evaluated. Active (or direct active) monitoring could be conducted on a voluntary basis or compelled by legal order. Active (or direct active) monitoring and prompt follow-up should continue and be uninterrupted if the person travels out of the jurisdiction.

Active monitoring consists of daily reporting of measured temperatures and symptoms consistent with Ebola (including severe headache, fatigue, muscle pain, weakness, diarrhea, vomiting, abdominal pain, or unexplained hemorrhage) by the individual to the NMDOH staff assigned to conduct the monitoring. Temperature is measured using a Food and Drug Administration-regulated thermometer (e.g. oral, tympanic or noncontact). People being actively monitored should measure their temperature twice daily, monitor themselves for symptoms and report via phone or email as directed by NMDOH; and immediately notify NMDOH at 505-827-0006 if they develop fever or other symptoms. Clinical criteria for required medical evaluation according to exposure level have been defined (see CDC table below) and should result in immediate isolation and evaluation. Medical evaluation may be recommended for lower temperatures or nonspecific symptoms based on exposure level and clinical presentation.

For direct active monitoring, NMDOH staff will directly observe (either in-person or via electronic video such as FaceTime or Skype) the individual at least once daily to review symptom status and monitor temperature; a second follow-up per day may be conducted by telephone or email in lieu of a second direct observation. The direct active monitoring should include discussion of plans to work, travel, take public conveyances, or be present in congregate locations. Depending on the nature and duration of these activities, they may be permitted if the individual has been consistent with direct active monitoring (including recording and reporting of a second temperature reading each day), has a normal temperature and no symptoms whatsoever and can ensure uninterrupted direct active monitoring by NMDOH staff. People being direct actively monitored should measure their temperature twice daily and monitor themselves for symptoms; and immediately notify NMDOH at 505-827-0006 if they develop fever or other symptoms. Clinical criteria for required medical evaluation according to exposure level have been defined (see CDC table below) and should result in immediate isolation and evaluation. Medical evaluation may be recommended for lower temperatures or nonspecific symptoms based on exposure level and clinical presentation.

Summary of CDC Interim Guidance for Monitoring and Movement of People Exposed to Ebola Virus

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

Exposure Category	Clinical Criteria	Public Health Actions

High risk includes any of the following:
• Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of a person with Ebola while the person was symptomatic
• Exposure to the blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, and semen) of a person with Ebola while the person was symptomatic without appropriate personal protective equipment (PPE)
• Processing blood or body fluids of a person with Ebola while the person was symptomatic without appropriate PPE or standard biosafety precautions
• Direct contact with a dead body without appropriate PPE in a country with widespread transmission or cases in urban settings with uncertain control measures
• Having lived in the immediate household and provided direct care to a person with Ebola while the person was symptomatic
	Fever (subjective fever or measured temperature ≥100.4°F/38°C) OR any of the following:*
	• severe headache
	• muscle pain
	• vomiting
	• diarrhea
	• stomach pain
	• unexplained bruising or bleeding
		• Implement rapid isolation with immediate contact of public health authorities to arrange for safe transport to an appropriate healthcare facility for Ebola evaluation
		• Medical evaluation is required.
		  ○ Isolation orders may be used to ensure compliance
		  ○ Air travel is permitted only by air medical transport
		• If medically evaluated and discharged with a diagnosis other than Ebola, conditions as outlined for asymptomatic individuals in this exposure category will apply

	Asymptomatic (no fever or other symptoms consistent with Ebola)	• Direct active monitoring
		• Public health authority will ensure, through orders as necessary, the following minimum restrictions:
		  ○ Controlled movement: exclusion from all long-distance and local public conveyances (aircraft, ship, train, bus and subway)
		  ○ Exclusion from public places (e.g., shopping centers, movie theaters), and congregate gatherings
		  ○ Exclusion from workplaces for the duration of the public health order, unless approved by the state or local health department (telework is permitted)
		• Non-congregate public activities while maintaining a 3-foot distance from others may be permitted (e.g., jogging in a park)
		• Federal public health travel restrictions (Do Not Board) will be implemented to enforce controlled movement
		• If travel is allowed, individuals are subject to controlled movement
		  ○ Travel by noncommercial conveyances only
		  ○ Coordinated with public health authorities at both origin and destination
		  ○ Uninterrupted direct active monitoring

* The temperature and symptoms thresholds provided are for the purpose of requiring medical evaluation. Isolation or medical evaluation may be recommended for lower temperatures or nonspecific symptoms (e.g., fatigue) based on exposure level and clinical presentation.

Exposure Category	Clinical Criteria	Public Health Actions

Some risk includes any of the following:
• In countries with widespread transmission or cases in urban settings with uncertain control measures:
  ○ direct contact while using appropriate PPE with a person with Ebola while the person was symptomatic or with the person's body fluids
  ○ any direct patient care in other healthcare settings
• Close contact in households, healthcare facilities, or community settings with a person with Ebola while the person was symptomatic
  ○ Close contact is defined as being for a prolonged period of time while not wearing appropriate PPE within approximately 3 feet (1 meter) of a person with Ebola while the person was symptomatic
  ○ any direct patient care in other healthcare settings
	Fever (subjective fever or measured temperature ≥100.4°F/38°C) OR any of the following:*
	• severe headache
	• muscle pain
	• vomiting
	• diarrhea
	• stomach pain
	• unexplained bruising or bleeding
		• Implement rapid isolation with immediate contact of public health authorities to arrange for safe transport to an appropriate healthcare facility for Ebola evaluation
		• Medical evaluation is required.
		  ○ Isolation orders may be used to ensure compliance
		  ○ Air travel is permitted only by air medical transport
		• If medically evaluated and discharged with a diagnosis other than Ebola, conditions as outlined for asymptomatic individuals in this exposure category will apply

	Asymptomatic (no fever or other symptoms consistent with Ebola)	• Direct active monitoring
		• The public health authority, based on a specific assessment of the individual's situation, will determine whether additional restrictions are appropriate, including:
		  ○ Controlled movement: exclusion from long-distance commercial conveyances (aircraft, ship, train, bus) or local public conveyances (e.g., bus, subway)
		  ○ Exclusion from public places (e.g., shopping centers, movie theaters), and congregate gatherings
		  ○ Exclusion from workplaces for the duration of a public health order, unless approved by the state or local health department (telework is permitted)
		• If the above restrictions are applied, non-congregate public activities while maintaining a 3-foot distance from others may be permitted (e.g., jogging in a park)
		• Other activities should be assessed as needs and circumstances change to determine whether these activities may be undertaken
		• Any travel will be coordinated with public health authorities to ensure
		• uninterrupted direct active monitoring
		• Federal public health travel restrictions (Do Not Board) may be implemented based on an assessment of the particular circumstance
		  ○ For travelers arriving in the United States, implementation of federal public health travel restrictions would occur after the traveler reaches the final destination of the itinerary

Exposure Category	Clinical Criteria	Public Health Actions

Low (but not zero) risk includes any of the following:
• Having been in a country with widespread transmission or cases in urban settings with uncertain control measures within the past 21 days and having had no known exposures
• Having brief direct contact (e.g., shaking hands), while not wearing appropriate PPE, with a person with Ebola while the person was in the early stage of disease
• Brief proximity, such as being in the same room (not an Ebola patient care area) for a brief period of time, with a person with Ebola while the person was symptomatic
• In countries without widespread transmission or cases in urban settings with uncertain control measures: direct contact while using appropriate PPE with a person with Ebola while the person was symptomatic or with the person's body fluids
• Traveled on an aircraft with a person with Ebola while the person was symptomatic
	Fever (subjective fever or measured temperature ≥100.4°F/38°C) OR any of the following:*
	• severe headache
	• muscle pain
	• vomiting
	• diarrhea
	• stomach pain
	• unexplained bruising or bleeding
		• Implement rapid isolation with immediate contact of public health authorities to arrange for safe transport to an appropriate healthcare facility for Ebola evaluation
		• Medical evaluation is required.
		  ○ Isolation orders may be used to ensure compliance
		  ○ Air travel is permitted only by air medical transport
		• If medically evaluated and discharged with a diagnosis other than Ebola, conditions as outlined for asymptomatic individuals in this exposure category will apply

	Asymptomatic (no fever or other symptoms consistent with Ebola)	• No restrictions on travel, work, public conveyances, or congregate gatherings
		• Direct active monitoring for:
		  ○ U.S.-based healthcare workers caring for symptomatic Ebola patients while wearing appropriate PPE
		  ○ Travelers on an aircraft with, and sitting within 3 feet of, a person with Ebola
		• Active monitoring for all others in this category

* The temperature and symptoms thresholds provided are for the purpose of requiring medical evaluation. Isolation or medical evaluation may be recommended for lower temperatures or nonspecific symptoms (e.g., fatigue) based on exposure level and clinical presentation.

Exposure Category	Clinical Criteria	Public Health Actions
No identifiable risk includes: • Contact with an asymptomatic person who had contact with person with Ebola Contact with a person with Ebola before the person developed symptoms Having been more than 21 days previously in a country with widespread transmission or cases in urban settings with uncertain control measures Having been in a country with Ebola cases, but without widespread transmission or cases in urban settings with uncertain control measures, and not having any other exposures as defined above Having remained on or in the immediate vicinity of an aircraft or ship during the entire time that the conveyance was present in a country with widespread transmission or cases in urban settings with uncertain control measures, and having had no direct contact with anyone from the community	Fever (subjective fever or measured temperature ≥100.4°F/38°C) OR any of the following:* • severe headache • muscle pain • vomiting • diarrhea • stomach pain • unexplained bruising or bleeding	Routine medical evaluation and management of ill persons, as needed
	Asymptomatic (no fever or other symptoms consistent with Ebola)	No actions needed

* The temperature and symptoms thresholds provided are for the purpose of requiring medical evaluation. Isolation or medical evaluation may be recommended for lower temperatures or nonspecific symptoms (e.g., fatigue) based on exposure level and clinical presentation.

Documentation

The NMDOH will coordinate contact tracing and contact/traveler monitoring to assure all persons are being appropriately followed. A secure database with information on all contacts and travelers will be updated daily. Weekly aggregate reports on “low but not zero risk” persons will be sent to CDC while daily reports will be sent to CDC on “some risk” or “high risk” travelers. If there is an Ebola case in New Mexico, there will be a daily meeting to assess the contact tracing progress and discuss whether there is a need for any changes to the process. Tracing and monitoring should begin within one day after determining that there is a suspect EVD case or the NMDOH is notified of a person arriving in New Mexico after traveling to a country (Guinea, Liberia and Sierra Leone at this time) in which an EVD outbreak occurred within the last 21 days.

H. OMI Recommendations to Healthcare Facilities for the Preparation of Decedents with Possible Viral Hemorrhagic Fevers

UNM Office of the Medical Investigator

Document Owner: Michelle Aurelius	Date Created: 08/19/2014
Approver(s): Chief Medical Investigator or designee	Date Approved: 09/08/2014

Description/Overview: Viral hemorrhagic fevers (VHFs) refer to a group of severe multisystem (affects multiple organ systems) illnesses caused by several families of viruses. Characteristically, the vessels are damaged and the body's ability to regulate itself is impaired. Common presenting complaints are fever, body aches, weakness persisting after rehydration, diarrhea, muscle pain, and back pain. The patients can present with hemorrhage (bleeding). VHF's are caused by viruses of four distinct families: arenaviruses (e.g., Lassa), filoviruses (e.g., Ebola, Marburg), bunyaviruses, and flaviviruses.

Ebola, Marburg, Lassa and Crimean-Congo hemorrhagic fever viruses are examples of VHF's that can be spread from one person to another through close contact with infected people or their body fluids. Infection can also occur indirectly through contact with objects contaminated with infected body fluids. There is risk of transmission when a VHF patient dies because the bodies and body fluids of the deceased VHF patients remain contagious for several days after death.

Spread of infection through the handling of the deceased with confirmed or suspected cases of VHF can be prevented using standard, contact, and droplet transmission protocols as is often used in the care of tubercululosis (TB) patients.

This section will describe how to:

- Prepare bodies of the deceased VHF patients
- Transport the body safely to the final disposition

Areas of Responsibility

- Morphology
- Health care facilities deceased body care
- Investigations
- Body transporters
- Security

Procedure

1.0 General Points

I. Family and community members are at risk if burial practices involve touching and washing the body. This should be limited. Explain to the family that viewing the body is not possible.

II. Cremation is strongly recommended due to infectious risk.

III. No autopsies on suspected or confirmed VHF will be performed at the OMI due to the health risk it poses at the OMI.

IV. Do not consent for autopsy. The OMI will not perform an autopsy.

V. The body will be prepared for transport by health care personnel.

VI. The body will be directly transported to the funeral home from the health care facility.

1.1 Prepare the Body Safely

VII. General recommendations to the health care facility staff:

a. Prepare the body safely.

b. Be aware of the family's cultural practices and religious beliefs. Help the family understand why some practices cannot be done because they place the family or others at risk for exposure.

c. Counsel the family about why special steps need to be taken to protect the family and community from illness.

d. Be sure the family members avoid dangerous practices such as washing or touching the body.

e. Report any injury or unusual incidents immediately to the appropriate manager(s).

f. Train staff on handling decedents with suspected or confirmed VHF.

VIII. Recommendations for preparation of the body in the healthcare facility:

a. Items that will be needed include:

i. Two body bags

ii. Personal protective equipment

iii. One OMI identification zipper lock

iv. At least two individuals to move and prepare the decedent

v. Red 8.5 x 11 cm paper labeled with "DO NOT OPEN" in large letters

vi. Plastic sleeve for paper

vii. Tape

viii. Absorbent pads (e.g. blue pads, towels, blanket, sheet)

b. Check the decedent's identification band(s) to ensure appropriate identification. Document that this has been done prior to placing the decedent in the body bags.

c. Wear protective clothing as recommended for staff in the patient isolation area using standard, contact, and droplet transmission prevention protocols. Use two layers of gloves.

d. Spray the body and the area around it with 1:10 industrial bleach solution.

e. Place the body in the first body bag. Spray the outside of the first body bag with 1:10 industrial bleach solution (front and back).

f. Open a second body bag and lay it out on a separate gurney. Line the bottom inside of the bag with absorbent pads.

g. Place the body already in the first body bag within the second body bag on the separate gurney and close it securely. Spray the outside of the body bag with 1:10 industrial bleach solution (front and back).

h. Place an OMI identification lock through the zipper's interlocking loops. Label the OMI identification zipper lock/seal with the decedent's information.

i. Once the front of the body bag is dried, place the red paper labeled "DO NOT OPEN" inside the plastic sleeve. Tape plastic sleeve over the front of the body bag over the zipper in the region of the decedent's chest/abdomen

j. Discard the potentially biohazardous material (personal protective equipment) in the biohazard trash.

k. Be prepared to utilize the separate spill protocol with 1:10 industrial bleach solution if needed.

IX. Transportation of a decedent will occur directly to the funeral home from the health care facility. This should be arranged promptly with a funeral home designated to handle EVD decedents. Direct cremation is recommended to prevent exposure to funeral home workers and additional family members. Viewing and a wake is not recommended.

1.2 Transport the Body Safely

I. VHF isolation precautions should remain in force when the body is being transported to the funeral home.
   a. Take the shortest route possible for security purposes and limit any possibility of disease transmission through accidental contact.
   b. Any health facility staff who must touch or carry the body (body bag) during transport should wear the same protective clothing as is worn in the isolation area
   c. The driver does not need to wear protective clothing if there is no contact with the body (body bag).
   d. Remove all food or drink from the vehicle prior to transportation of the decedent.

II. Create a small spill kit that includes a closed container or sprayer with 1:10 industrial bleach solution in the event of any accidental contact with the body or infectious body fluids.
   a. See separate spill procedure.
   b. Use kit to clean up spills in the transport vehicle. If a mop is used to clean up fluids, dispose of the mop head in biohazard trash.
   c. Any injury or unusual incidents should be reported immediately to the appropriate manager(s).

III. Report any injury or unusual incidents immediately to the appropriate manager(s).

Resources/Training

http://www.who.int/csr/resources/publications/ebola/whoemcesr982sec7-9.pdf

http://www.cdc.gov/ncidod/dvrd/spb/mnpages/dispages/vhf.htm

http://www.cdc.gov/vhf/ebola/pdf/ppe-poster.pdf

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

http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html

I. Letter to Board of Funeral Services Licensees

New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
Board of Funeral Services
Toney Anaya Building ▪ 2550 Cerrillos Road ▪ Santa Fe, New Mexico 87505
(505) 476-4622 ▪ Fax (505) 476-4545 ▪ www.rld.state.nm.us

Susana Martinez
GOVERNOR

Robert "Mike" Unthank
SUPERINTENDENT

James C. McKay
GENERAL COUNSEL

Lorie Wrobel
DIRECTOR

October 21, 2014

Dear Board of Funeral Services Licensees,

The primary function of the Funeral Service Board is to handle matters of regulation, licensing and compliance with the New Mexico Statutes that govern Funeral Services. Generally, the New Mexico Department of Health is tasked with health-related issues. However, in support of the New Mexico Department of Health, the Funeral Service Board has chosen to extend this communique for the safety and well-being of all mortuary personnel as well as the general public. The Centers for Disease Control have released guidelines for healthcare and mortuary staff. This information can be found online at www.cdc.gov. Once the CDC site is open, you may click the main link for EBOLA UPDATE. Scroll down on this page to find Important Clinical Guidance; then locate and click on the following link: Guidance for Safe Handling of Human Remains of Ebola Patients in U.S. Hospitals and Mortuaries. This link provides clear and concise steps for protecting all persons who may have contact with a deceased person infected with Ebola Virus Disease.

Thank you to all mortuary personnel for your dedication to the families you serve.

http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html

J. Guidance for Safe Handling of Human Remains of Ebola Patients in U. S. Hospitals and Mortuaries

These recommendations give guidance on the safe handling of human remains that may contain Ebola virus and are for use by personnel who perform postmortem care in U.S. hospitals and mortuaries. In patients who die of Ebola virus infection, virus can be detected throughout the body. Ebola virus can be transmitted in postmortem care settings by laceration and puncture with contaminated instruments used during postmortem care, through direct handling of human remains without appropriate personal protective equipment, and through splashes of blood or other body fluids (e.g. urine, saliva, feces) to unprotected mucosa (e.g., eyes, nose, or mouth) which occur during postmortem care.

- Ebola virus can be transmitted in postmortem care settings through unsafe handling of remains.
- Ensure that only personnel trained in handling infected human remains and wearing recommended PPE touch or move any remains that contain Ebola virus.
- Do not wash or clean the body.
- Do not embalm the body.
- Do not perform an autopsy. If an autopsy is necessary, consult the state health department and CDC regarding necessary precautions.
- Do not remove any inserted medical equipment from the body such as intravenous (IV) lines, endotracheal or other tubing, or implanted electronic medical devices.
- Cremate the body. If cremation cannot be done because of safety concerns, the body should be buried in a standard metal casket or other comparable burial method.

Definitions for Terms Used in this Guidance

Cremation: The act of reducing human remains to ash by intense heat.

Leakproof bag: A body bag that is puncture-resistant and sealed in a manner so as to contain all contents and prevent leakage of fluids during handling, transport, or shipping.

Personal Protective Equipment (PPE) for Postmortem Care Personnel

CDC guidance on PPE: http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html

Web based training: http://www.cdc.gov/vhf/ebola/hcp/ppe-training/index.html

CDC factsheet: http://www.cdc.gov/media/releases/2014/fs1020-ebola-personal-protective-equipment.html

- Prior to working with Ebola patients, all healthcare workers involved in the care of Ebola patients must have received repeated training and have demonstrated competency in performing all Ebola-related infection control practices and procedures, and specifically in donning/doffing proper PPE.
- While working in PPE, healthcare workers caring for Ebola patients should have no skin exposed.

- The overall safe care of Ebola patients in a facility must be overseen by an onsite manager at all times, and each step of every PPE donning/doffing procedure must be supervised by a trained observer to ensure proper completion of established PPE protocols.

Principles of PPE

Healthcare workers must understand the following basic principles to ensure safe and effective PPE use, which include that no skin may be exposed while working in PPE:

- Donning
  - PPE must be donned correctly in proper order before entry into the patient care area and not be later modified while in the patient care area. The donning activities must be directly observed by a trained observer.
- During Patient Care
  - PPE must remain in place and be worn correctly for the duration of exposure to potentially contaminated areas. PPE should not be adjusted during patient care.
  - Healthcare workers should perform frequent disinfection of gloved hands using an alcohol-based hand rub (ABHR), particularly after handling body fluids.
  - If during patient care a partial or total breach in PPE (e.g., gloves separate from sleeves leaving exposed skin, a tear develops in an outer glove, a needle stick) occurs, the healthcare worker must move immediately to the doffing area to assess the exposure. Implement the facility exposure plan, if indicated by assessment.
- Doffing
  - The removal of used PPE is a high-risk process that requires a structured procedure, a trained observer, and a designated area for removal to ensure protection
  - PPE must be removed slowly and deliberately in the correct sequence to reduce the possibility of self-contamination or other exposure to Ebola virus
  - A stepwise process should be developed and used during training and daily practice

Double gloving provides an extra layer of safety during direct patient care and during the PPE removal process. Beyond this, more layers of PPE may make it more difficult to perform patient care duties and put healthcare workers at greater risk for percutaneous injury (e.g., needle sticks), self-contamination during care or doffing, or other exposures to Ebola. If healthcare facilities decide to add additional PPE or modify this PPE guidance, they must consider the risk/benefit of any modification, and train healthcare workers on correct donning and doffing in the modified procedures.

http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html

Postmortem preparation

Follow the step-by-step CDC Guideline for Postmortem Preparation
http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html

The following points are important considerations for postmortem preparation of human remains containing Ebola virus:

- Ensure that workers handling the body and the trained observer wear the recommended PPE and follow all of the procedures in CDC's Guidance on Personal Protective Equipment for Healthcare Workers (http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html).
- Follow the cleaning and disinfecting recommendations found in CDC's Guidance for Environmental Infection Control in Hospitals for Ebola Virus (http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/infection-control.html). According to this guidance, PPE surfaces, equipment, or patient care area surfaces that become visibly soiled should be decontaminated immediately using a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for use against a nonenveloped virus.
- Place all waste produced during postmortem preparation and decontamination into red biohazard bags in the hot zone, following the CDC Guidelines for Ebola-Associated Waste Management(http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/waste-management.html).

For more information on environmental infection control, please refer to "Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus." (http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html).

Mortuary Care and Disposition of Remains

- Ensure that anyone handling the body bag wears single-use (disposable) gloves with extended cuffs and a long-sleeved disposable gown.
- Do not open the body bags.
- Do not embalm the body.
- Do not remove any implanted medical devices.
- Cremate the remains. An oversized cremation container may be needed to contain the bagged body for cremation. Cremated remains are no longer infectious and can be handled and provided to the family using normal procedures.
- Bury the remains in instances where cremation cannot be safely performed. For example, some crematoriums may have concerns about cremating bodies containing implanted electronic medical devices. Some of these medical devices can explode, potentially damaging the retort. Other medical devices can normally be cremated safely. Where damage to the retort is a concern, the body should be buried in a standard metal casket or other comparable burial method in accordance with state and local burial requirements. The casket containing the bagged remains can be handled without PPE.

http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html
http://www.cdc.gov/vhf/ebola/pdf/postmortom-preparation.pdf

Transportation of Human Remains

- Follow the CDC step-by-step guidance: http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html
- Ensure that anyone handling the body bag wears single-use (disposable) gloves with extended cuffs and a long-sleeved disposable gown.
- Minimize transportation of remains that contain Ebola virus to the extent possible.
- Coordinate all transportation, including local transport for mortuary care or burial, with relevant local and state authorities in advance.
- Coordinate interstate transport with CDC by calling the Emergency Operations Center at (770) 488-7100.
- Avoid transporting noncremated remains via aircraft.
- Human remains transported for interment, cremation, or medical research at a college, hospital, or laboratory are excepted from the U.S. Department of Transportation's Hazardous Materials Regulations (49 C.F.R., Parts 171-180). See §173.134(b)(14).

Department of Transportation guidance:
http://phmsa.dot.gov/portal/site/PHMSA/menuitem.6f23687cf7b00b0f22e4c6962d9c8789/?vgnextoid=4d1800e36b978410VgnVCM100000d2c97898RCRD&quotvgnextchannel=d248724dd7d6c010VgnVCM10000080e8a8c0RCRD&quotvgnext

CDC guidance:
http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html

[Event/incident Name]

K. Lessons Learned Template

Date:	
Author:	
Job Title:	
Email:	
Phone:	
ICS/Response Role:	
Division:	
Bureau/Office:	

Lessons learned purpose and objectives

Throughout each event/incident life cycle, lessons are learned and opportunities for improvement are discovered. As part of a continuous improvement process, documenting lessons learned helps the event/incident team discover the root causes of problems that occurred and avoid those problems in future events/incidents. Data for this Lessons Learned document is gathered and recorded throughout the event/incident and is summarized in the tables on the following page/s.

The objective of this document is to gather all relevant information *both during and after* an event/incident to include in the After-Action Report/Improvement Plan (AAR/IP), thereby improving overall preparedness through improved planning, resources, training and exercise. Please refer to the **ERD AAR/IP Procedure** (April 2014) for further guidance.

Lessons learned questions

- What worked well—or didn't work well—either for this event/incident or for the team?
- What needs to be done over or differently?
- What surprises did the team have to deal with?
- What circumstances were not anticipated?
- Were the goals attained? If not, what changes need to be made to meet goals in the future?
- What changes need to be made to plans and procedures to improve performance?
- What changes need to be made to organizational structures to improve performance?
- What changes need to be made to management processes to improve performance?
- What changes to equipment or resources are needed to improve performance?
- What training is needed to improve performance?
- What exercises (hseep.dhs.gov or https://hseep.preptoolkit.org: seminar, workshop, drill, tabletop, functional and/or full-scale) are needed to improve performance?
- What are the lessons learned for approaching similar problems in the future?

[Event/incident Name]

Highlights (add lines as necessary)

Significant Successes

Success	Factors That Supported Success

Other Notable Successes

Success	Factors That Supported Success

Shortcomings/Gaps and Solutions

Shortcoming/Gaps	Recommended Solutions

Approvals

Prepared by: _____ **Date:** _____
[Name, Title]

Approved by: _____ **Date:** _____
[Name, Title]

_____ **Date:** _____
[Name, Title]

Please keep a copy for your records and return this completed form to:
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L. Governor Directs DOH to Coordinate Ebola Preparedness

State of New Mexico
Office of the Governor

Susana Martinez
Governor

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Governor Susana Martinez Directs Department of Health to Coordinate New Mexico's Ebola Preparedness Plan

Santa Fe — Governor Susana Martinez has directed the New Mexico Department of Health (DOH) to coordinate the state's Ebola preparedness plan to be ready in the unlikely event there is an Ebola case diagnosed in New Mexico. DOH will coordinate the state's Ebola preparedness plan between state agencies like the Department of Homeland Security and Emergency Management (DHSEM), as well as local governments, hospitals, and healthcare providers throughout the state to ensure New Mexico is ready to handle any potential cases of Ebola.

"The risk of New Mexicans contracting Ebola is very, very low, but I want to assure everyone that we are taking the necessary steps to prepare for the unlikely event of cases in New Mexico," said Governor Martinez. "The Department of Health and the Department of Homeland Security and Emergency Management are monitoring developments very closely, and our Emergency Operation Center can be activated within minutes, if necessary."

The Department participates in daily conference calls with the U.S. Centers for Disease Control and Prevention (CDC) to stay up to date with the latest information concerning the U.S. government's preparations for and response to Ebola. Additionally, the State Emergency Operations Center (EOC) has staff on standby 24/7 and has access to state resources if they need to be deployed quickly to affected areas anywhere in New Mexico.

DOH is in regular contact with healthcare personnel across the state providing information and conducting webinars and enhanced training to help them prepare them for a possible Ebola patient. The Department has provided hospitals, clinics, and emergency medical services statewide with guidelines for evaluation of potential Ebola patients.

"We are working closely with healthcare workers to provide information and education about Ebola," said Department of Health Secretary Retta Ward, MPH. "The Department has on-call epidemiologists available 24 hours a day, seven days a week to answer any questions healthcare providers may have, and to give guidance on what steps to take if a patient with symptoms shows up in their facility."

Ebola is a virus spread through direct contact with the body fluids of a person who is sick with the virus. Ebola is not spread through the air or by food or water, and anyone carrying the Ebola virus is not contagious until symptoms appear.

Acronyms

A

ACP	Access Control Point
AC	Area Command
AG	Attorney General
ARC	American Red Cross
ARES	Amateur Radio Emergency Services
ASD	Administrative Services Division (NMDOH)
ASPR	Assistant Secretary for Preparedness and Response, Office of (HHS)

B

BHEM	Bureau of Health Emergency Management (NMDOH)
BHSD	Behavioral Health Services Division (NMDOH)
BLM	Bureau of Land Management (U.S.)
BIA	Bureau of Indian Affairs (U.S.)

C

CAP	Civil Air Patrol
CAT	Crisis Action Team
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CEP	Civil Emergency Preparedness
CERCLA	Comprehensive Environmental Response, Compensation, and Liability Act
CFR	Code of Federal Regulations
CID	Construction Industries Division
CISM	Critical Incident Stress Management
COG	Continuity of Government
COOP	Continuity of Operations Plan
CRI	Cities Readiness Initiative
CYFD	Children, Youth and Families Department

D

DAC	Disaster Assistance Center
DAP	Disaster Assistance Program
DFA	Department of Finance & Administration
DFO	Disaster Field Office
DHS	Department of Homeland Security (U.S.)
DHSEM	Department of Homeland Security and Emergency Management
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DOC	Department Operations Center
DOD	Department of Defense
DOE	Department of Energy
DOH	Department of Health
DOT	Department of Transportation
DPS	Department of Public Safety
DSR	Damage Survey Report
DUA	Disaster Unemployment Assistance

E

EAS	Emergency Alert System
ECT	Emergency Coordination Team
ED	Environment Department
EDD	Economic Development Division
EMAC	Emergency Management Assistance Compact
EMC	Emergency Management Center
EMS	Emergency Medical Service
EMSB	Emergency Medical Systems Bureau
EMSCOM	Emergency Medical Services Communications System
EMT	Emergency Medical Technician
EMNRD	Energy, Minerals and Natural Resources Department
EOC	Emergency Operations Center
EOCR	Emergency Operations Center Representative
EOP	Emergency Operations Plan
EPA	Environmental Protection Agency
EPLO	Emergency Preparedness Liaison Officer
ERD	Epidemiology and Response Division
ERO	Emergency Response Officer
ERT-A	Emergency Response Team – Advance Element
ERTL	Emergency Response Team Leader
ESF	Emergency Support Function
EVD	Ebola Virus Disease

F

FBI	Federal Bureau of Investigation
FCO	Federal Coordinating Officer
FEMA	Federal Emergency Management Agency
FIA	Federal Insurance Administration
FMS	Federal Medical Station

G

GAR	Governor's Authorized Representative
GCO	Grant Coordinating Officer
GSD	General Services Department

H

HAN	Health Alert Network
HazMat	Hazardous Materials
HCC	Healthcare Coalition
HCO	Healthcare Organization
HHS	Health and Human Services, Department of (U.S.)
HMERP	Hazardous Materials Emergency Response Plan
HPP	Hospital/Healthcare Preparedness Program
HSD	Human Services Department

I

IC	Incident Commander
ICP	Incident Command Post
ICS	Incident Command System
IDEB	Infectious Disease and Epidemiology Bureau

IFG Individual Family Grant
IHS Indian Health Service
IMAS Intrastate Mutual Aid System
ISO Information Systems Officer

J
JFO Joint Field Office
JIC Joint Information Center
JIS Joint Information System

K
KAFB Kirtland Air Force Base

L
LAN Local Area Network
LEA New Mexico Law Enforcement Academy
LEOC Local Emergency Operations Center
LEPC Local Emergency Planning Committee
LGH Local Government Handbook
LTSD Long Term Services Division (NMDOH)

M
MAC Multi-Agency Coordination (Group or System)
MCM Medical Countermeasures
MOU Memorandum of Understanding
MRC Medical Reserve Corps
MSCA Military Support to Civil Authorities
MTD Motor Transportation Division

N
NAWAS National Warning System
NMDOH New Mexico Department of Health
NFIP National Flood Insurance Program
NGO Non-Governmental Organization
NIMS National Incident Management System
NMANG New Mexico Air National Guard
NMARNG New Mexico Army National Guard
NMEOC New Mexico Emergency Operations Center (State EOC)
NMCD New Mexico Corrections Department
NMDA New Mexico Department of Agriculture
NMLB New Mexico Livestock Board
NMNG New Mexico National Guard
NMSA New Mexico Statutes, annotated
NRF National Response Framework
NRT National Response Team
NTAS National Terrorism Advisory System
NWS National Weather Service

O
OCA Office of Cultural Affairs
OGC Office of General Counsel

OMI	Office of the Medical Investigator
ONRT	Office of Natural Resource Trustee
OSHA	Occupational Safety and Health Act

P

PIO	Public Information Officer
PDA	Preliminary Damage Assessment
PHD	Public Health Division (NMDOH)
PHEP	Public Health Emergency Preparedness
PHERA	Public Health Emergency Response Act
PHS	Public Health Services
POC	Point of Contact
POD	Point of Dispensing
PPE	Personal Protective Equipment
PRC	Public Regulatory Commission

R

RACES	Radio Amateur Civil Emergency Services
RADEF	Radiological Defense
REPS	Regional Emergency Preparedness Specialist (PHD)
RLD	Regulation and Licensing Department
ROC	Regional Operations Center (PHD)
RPP	Radiological Protection Program
RSS	Receipt, Stage and Store (site)

S

SAR	Search and Rescue
SARA	Super Amendment Reauthorization Act
SARDA	State and Regional Disaster Airlift
SAT	Situational Analysis Team
SCM	Survivable Crisis Management
SCO	State Coordinating Officer
SEO	State Engineer Office
SEOP	State Emergency Operations Plan
SFHA	Special Flood Hazard Area
SITREP	Situation Report
SLD	Scientific Laboratory Division (NMDOH)
SNS	Strategic National Stockpile
SPO	State Personnel Office
SOG	Standard Operating Guidelines
SOP	Standard Operating Procedures
SRCA	State Records Center and Archives

T

TAGNM	The Adjutant General of New Mexico
TRD	Taxation and Revenue Department

U

UAC	Unified Area Command
UC	Unified Command
UCG	Unified Coordination Group

UHF	Ultra-High Frequency
UNM	University of New Mexico
UNMH	University of New Mexico Hospital
USDA	United States Department of Agriculture
USGS	United States Geological Survey

V

VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration (U.S. Dept. of Veterans Affairs)
VHF	Very High Frequency
VHF	Viral Hemorrhagic Fever
VOAD	Volunteer Organizations Active in Disaster

W

WIPP	Waste Isolation Pilot Plant
WSMR	White Sands Missile Range