State of New Hampshire
High Threat Infectious Disease (HTID) Plan
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1. Acknowledgements

Portions of content from this plan were adapted from the following plans:

- Infectious Disease Emergency Response Plan, Utah Department of Health
- Ebola Virus Disease Investigation Plan, Utah Department of Health
- Ebola and Other Special Pathogens Regional Coordination and Response Plan, United States Department of Health and Human Services (US HHS) Region I

2. HTID Overview

2.1. Background

High threat infectious diseases (HTIDs) have the potential to cause severe and/or widespread illness. Examples of HTIDs include, but are not limited to, Ebola virus disease and other viral hemorrhagic diseases, syndromes caused by novel corona viruses (e.g., MERS, SARS), diseases caused by highly drug-resistant microorganisms (e.g., XDR-TB), and novel influenza. HTIDs can result from naturally occurring outbreaks of existing or emerging infectious diseases, or intentional acts of bioterrorism. The characteristics of a HTID patient, outbreak, or epidemic can vary by type of agent, scale of exposure, mode of transmission, and more.

The New Hampshire Department of Health and Human Services (NH DHHS), Division of Public Health Services (DPHS), Bureau of Infectious Disease Control (BIDC) developed this plan as a framework with the flexibility to respond to any HTID incident.

2.2. Purpose

DPHS will utilize the policies and procedures in this plan to coordinate response efforts to incidents of HTIDs in NH.

This plan describes the basic strategies, assumptions, operational goals, objectives, and mechanisms through which DPHS will coordinate, prioritize, and mobilize resources and conduct activities to guide and support local and State efforts in response to a HTID patient, outbreak, or epidemic.

DPHS will use this document in conjunction with the State of NH Public Health Services Emergency Annex (PHSEA) and DPHS Incident Management Team (IMT) Standard Operating Procedures. In addition, this plan will be used in conjunction with the HHS Region I Ebola and Other Special Pathogens Regional Coordination and Response Plan (“HHS Region I Plan”), when activated. The HHS Region I Plan provides a Concept of Operations (CONOPS) for safe and efficient patient management and transport across state lines to the Regional Ebola and Special Pathogens Treatment Center (RESPTC).

2.3. Assumptions

- Local governments have the primary responsibility to provide initial emergency response and Emergency Medical Services (EMS) within their jurisdictions.
- Upon request, State government will provide and/or augment emergency response services that exceed the capabilities of local governments as per the State Emergency Operations Plan (SEOP).
- State resources may not be sufficient for response, which may result in a request for Federal resources.
- The State Emergency Operations Center (SEOC) will be activated to a level commensurate
with the incident.
● The SEOC may establish an incident in WebEOC to facilitate immediate support requested by and/or for local and state agencies.
● Depending on the causative agent, other plans may need to be activated (e.g., Isolation and Quarantine, Pandemic Influenza).
● Depending on the causative agent, federal and international authorities may place restrictions on entry into the US. Guidance on these restrictions will be provided by federal agencies.
● Depending on the causative agent, diagnostic laboratory testing may or may not be available at the NH Public Health Laboratories (PHL) or federal laboratories.
● Timely detection of a disease, illness, or injury relies upon prompt and accurate reporting by healthcare providers, laboratories, and other entities. Even with such reporting, hostile, manmade, and/or naturally occurring incidents may initially be indistinguishable. It may be several days before an emerging threat is recognized as such. Recognition that an emerging threat is the result of a hostile attack could take several more days.

3. Response Structure
3.1. Response Organization
In response to a HTID patient, outbreak, or epidemic, DPHS will activate the DPHS IMT to assume the lead role in the response.

Depending on the scenario, the Governor may declare a State of Emergency or the Commissioner of DHHS may declare a Public Health Incident. Per the PHSEA, such action will result in the activation of SEOC ESF-8.

The Governor or the Commissioner of NH DHHS may activate the SEOP under the direction of the Director of Homeland Security & Emergency Management (HSEM). This would result in the activation of the SEOC and State Joint Information Center (JIC) (See NH Joint Information Center Plan, 2016.) Activation of the SEOC would include the activation of some or all Emergency Support Functions (ESFs). Example roles of each ESF, as needed, include:

ESF 1: Transportation
● Assist local and state officials with traffic management
● Coordinate with public transportation services
● Keep transportation corridors open

ESF 4: Firefighting
● Provide local Fire Departments with situational awareness and info on best practices and protective measures

ESF 5: Emergency Management
● Activate SEOC to appropriate level
● Conduct municipal and regional conference calls to obtain and provide information
● Initiate WebEOC situational reporting and resource requesting from State, municipal, and private sector agencies
● Department of Safety (DOS):
  ○ Establish activity code for tracking expenses
ESF 6: Mass Care & Sheltering

- Coordinate with municipal officials, Medical Reserve Corps (MRC) units, and Voluntary Organizations Active in Disasters (VOAD) partners to provide comfort kits and other needed resources (e.g., food, prescription medications, medical equipment) to quarantined persons
- Department of Education (DOE):
  - Determine continuity of education for quarantined school children
  - Disseminate HTID educational information to public, private, and charter schools; child care centers; and colleges and universities

ESF 7: Resource Support

- Ensure necessary contracts are in place

ESF 8: Health & Medical

- DHHS/DPHS:
  - Serve as lead agency to ensure appropriate medical management, including diagnosis, treatment, infection control, and investigation
  - Ensure appropriate education of healthcare providers regarding treatment protocols, PPE levels, and handling of remains through development and dissemination of clinical guidance
  - In coordination with Manchester Health Department (MHD) and Nashua Health Department (NHD), monitor and support quarantined persons
  - Identify needed food, medicines, etc. for individuals under quarantine and coordinate with appropriate ESF to ensure individuals are receiving needed support
  - Activate the Disaster Behavioral Health Response Team (DBHRT)
- DPHS BIDC:
  - Conduct notifications and share situational updates to appropriate federal, State, regional, and local partners
  - Conduct epidemiological investigation and initiate contact tracing
  - Determine the appropriate level of restricted movement for those under quarantine or isolation
  - Identify community sources of infection and provide consultation for decontamination, in coordination with CDC, DHHS, and Department of Environmental Services (DES)
- Bureau of Emergency Medical Services (BEMS):
  - Educate pre-hospital providers on decontamination and current infection control procedures
  - Provide guidance on just-in-time (JIT) training development

ESF 10: HazMat

- Coordinate and disseminate guidance and information for regional Hazardous Materials (HazMat) teams
- Provide on-site command and control for decontamination and remediation
- Remove persons from contaminated sites, as directed by DPHS
• Provide subject matter experts (SMEs) on decontamination procedures

**ESF 11: Agriculture & Natural Resources**

• Provide resources support to ESFs 6 and 8
• Advise on sheltering, transportation, and care for pets of hospitalized or quarantined contacts in facilities using methods approved by the State Veterinarian

**ESF 13: Law Enforcement**

• Division of State Police:
  ○ Provide public safety utilizing law enforcement assets
  ○ Provide escorts for transportation
• Department of Justice (DOJ):
  ○ Support ESFs with quarantine and isolation orders

**ESF 14: Volunteer & Donations Management**

• Coordinate volunteer groups to meet the needs of the incident

**ESF 15: Public Information**

• Coordinate with the Governor’s Office and key Departments in the development and dissemination of public information
• Establish the JIC

For more information about the management of public health incidents, including HTID outbreaks and epidemics, see the *PHSEA*.

4. **Plan Activation/Deactivation**

4.1. **Plan Activation**

This plan may be activated when:

• A State of Emergency or Public Health Incident is declared in response to a HTID patient, outbreak, or epidemic; OR
• A patient, outbreak, or epidemic of a HTID is suspected or confirmed in NH; OR
• NH is at risk for a patient, outbreak, or epidemic of a HTID.

Plan activation will follow the process described in the *DPHS IMT Standard Operating Procedures*.

4.2. **Notification**

Notification of IMT members will occur according to the *DPHS IMT Standard Operating Procedures*.

The Director of DPHS or IMT IC (or designee) will direct the initial notifications of external response partners. DPHS will determine the level of notifications that will occur once the plan is activated. Extent of notifications may depend upon factors such as:

• Number of suspected vs. confirmed patient(s)
• Severity
• Infectiousness
● Population susceptibility  
● Potential link to terrorism  
● Novelty  
● Anticipated scale of response needed

Examples of HTIDs that would require immediate notification of partners based on a suspect patient include Ebola and Anthrax.

Partners to be notified may include:  
● NH HSEM/SEOC  
● Public Health Networks  
● Manchester and Nashua Health Departments  
● Healthcare partners  
● Health officers  
● DHHS Region I states and partners (see HHS Region I plan)  
● CDC Emergency Operations Center  
● Federal Bureau of Investigations (FBI) and law enforcement (for potential bioterrorism threats)

The IC will notify the DHHS Commissioner, who will notify the Governor’s office.

DPHS will also notify healthcare and emergency response partners using procedures laid out in the PHSEA (e.g., Health Alert Network (HAN) and clinician conference calls). HAN messages sent to healthcare facilities will include information to assist them in identifying and isolating a suspect HTID patient, and informing DPHS (e.g., recommended screening questions).

4.3. Plan Deactivation  
IMT command staff, in consultation with the SEOC, will determine when it is appropriate to deactivate. Once the decision to deactivate has been made, all staff and partners will be informed. DPHS will ensure that activated staff have access to appropriate medical and behavioral health support, as needed. Following deactivation, an After Action Report (AAR) will be developed and current plans will be revised accordingly.

5. Response  
Depending on the HTID, a disease-specific appendix to this plan may exist. Otherwise, a disease-specific appendix should be developed using the template in Appendix A. Current disease-specific appendices include:

● Appendix B: Ebola Response Plan

5.1. Disease and Epidemiology  
Upon identification of a suspect or confirmed HTID patient, outbreak, or epidemic, DPHS will compile and notify partners of known information about the HTID, including:

● Clinical description  
● Causative agent  
● Differential diagnosis  
● Laboratory identification  
● Treatment
● Transmission
● Susceptibility
● Incubation period
● Period of communicability

5.2. Case Investigation

5.2.1. Initial Investigation, Isolation, and Reporting
An individual with a suspected HTID (Person Under Investigation, or PUI) could be detected at any level of the health or public health system (e.g., hospital, local healthcare facility, EMS, e9-1-1 telecommunications, public health monitoring of exposed/at-risk individuals). Therefore, all NH healthcare facilities and healthcare providers must be able to promptly identify and isolate a patient presenting signs and symptoms and a history consistent with a HTID. Once the patient has been isolated, healthcare facilities should inform DPHS of a suspect HTID patient by calling the BIDC at 603-271-4496, or after hours at 603-271-5300 and request the public health nurse on-call.

5.2.2. Case Investigation & Contact Monitoring
DPHS, MHD, and NHD may decide to monitor those who had contact with suspected and/or confirmed HTID patients, including healthcare personnel. DPHS will provide standard operating procedures for staff responsible for monitoring these individuals, including length of time that they will be monitored for, including mechanism for monitoring (e.g., telephone, video, or in-person). DPHS will also lead the effort to identify those individuals indicated for monitoring.

DPHS may choose to use live video monitoring using V-DAM (Video for Direct Active Monitoring). V-DAM allows DPHS staff to monitor individuals who have potentially been exposed to a HTID without traveling to the individual's residence. See Guidelines for Implementing Live V-DAM of Travelers Returning from Countries Affected by Ebola, NH DPHS, BIDC Policy for more information.

If DPHS staff have contact with patients or samples and need to be monitored, DPHS will use the Occupational Health Contract to meet the needs of the employee(s).

5.2.3. Lab Testing & Case Confirmation
DPHS will work with healthcare providers to determine whether or not a laboratory test is appropriate for a patient suspected to have a HTID. Depending on the causative agent, there may not be a lab test developed.

If lab testing is appropriate, the following steps will be taken:

● The hospital will collect and properly package the sample for transport to the NH PHL. Additional samples may be taken to send to CDC for further analysis. DPHS will coordinate the transport of the samples to the appropriate lab. Depending on the HTID, samples may be sent to the NH PHL, a CDC-certified Laboratory Response Network (LRN) lab, the CDC, or another identified lab. The need to send samples to federal labs will result in a delay in obtaining results.
● Once results are known, the testing lab will inform DPHS of the results. DPHS will share the results with the healthcare provider and the hospital.
High Threat Infectious Disease Plan

- Some HTIDs may result in a negative result early in the infection. DPHS will provide guidance, depending on the HTID, on whether or not the test should be repeated to confirm the absence of the HTID.

Healthcare providers, specifically laboratories, may be asked to do look back studies for identification of missed cases.

The lines of communication to the Massachusetts Department of Public Health (MDPH) should begin once a determination is made to test a patient for a HTID.

5.3. Public Health Control Measures

5.3.1. Isolation & Quarantine

The purpose of isolation and quarantine is to control the spread of infectious diseases.

Isolation is the separation of persons who are ill with specific contagious (infectious) illness from those who are healthy to stop the spread of that disease. Isolation also allows for specialized medical care for people who are ill. People in isolation may be cared for in hospitals, in their homes, or in designated healthcare facilities. Persons may be placed in isolation if they have possible symptoms of a HTID and may have been exposed to a HTID, even if disease has not yet been confirmed.

Quarantine is the separation and restriction of asymptomatic persons who may have been exposed to an infectious agent and may be infectious, but who are not ill. Quarantine can include a range of disease control strategies that may be used individually or in combination, including: short-term, voluntary home confinement; restrictions on travel by those who may have been exposed; and restrictions on passage into and out of a geographic area. Quarantined individuals with potential exposure to a HTID may be monitored for signs and symptoms of illness for a length of time equivalent to the incubation period of the HTID in question.

Both isolation and quarantine are common practices in public health, and both aim to prevent the exposure of well persons to infected or potentially-infected persons. Isolation and quarantine in NH are typically instituted voluntarily, however, both may be compelled by the NH DHHS, if necessary. If an individual refuses isolation or quarantine, NH DHHS has the authority in NH to issue legal orders. The legal authority and processes for issuing and enforcing orders under RSA 141-C are set forth in RSA 141-C:9,II; RSA 141-C:11; and RSA 141-C:12, as well as in administrative rule He-P 301.

Depending on the HTID, pets may also need to be isolated or quarantined. The State Veterinarian and the State Public Health Veterinarian would be key partners in this scenario.

5.3.2. Clinical Management Guidance

DPHS may issue guidance to healthcare facilities regarding the clinical management of patients with HTIDs, including appropriate patient placement, worker protection, and pediatric patients, or refer healthcare facilities to existing guidance.
For the purpose of Ebola planning, the CDC developed a three-tiered system of hospitals regarding the identification, isolation, and care of a patient with suspect or confirmed Ebola Virus Disease (EVD). *HHS Region I Plan* applies these tiers to other HTIDs beyond Ebola. The three tiers of hospitals are defined as follows:

**Frontline Hospitals** are responsible for identifying and isolating a patient with a potential HTID and providing care to the patient for 12-24 hours. There are 24 Frontline Hospitals in NH.

**Assessment Hospitals** are responsible for receiving and isolating patients suspected of having a HTID, providing immediate laboratory evaluation and coordination for testing, and providing patient care for up to 96 hours. There are 2 designated Assessment Hospitals in NH: Frisbie Memorial Hospital and Dartmouth-Hitchcock Medical Center.

**Treatment Hospitals** are responsible for providing care to confirmed HTID patients for the duration of their illness. There are no Treatment Hospitals in NH. There are 3 Treatment Centers in Massachusetts and 2 in Connecticut. Massachusetts General Hospital (MGH) in Boston, MA has been designated as the RESPTC and is, most likely, the hospital a confirmed HTID patient would be transferred to if the patient’s needs exceeded that of NH hospitals.

However, in the event of a HTID case, DPHS will work with NH hospitals to assess their capabilities and determine the most appropriate place for treatment of the patient. For example, for some HTIDs, a Frontline Hospital may be capable of providing care beyond 24 hours or an Assessment Hospital may be capable of providing care to the patient for the duration of their illness.

### 5.3.3. Infection Prevention Measures within a Healthcare Setting

DPHS will issue guidance regarding the appropriate prevention measures that should be taken in healthcare settings. Guidance should include PPE recommendations for the provider and patient, whether or not aerosol-generation procedures should be performed, any quarantine requirements for healthcare providers who provide care to the HTID patient, protocols for PPE or infection control breaches, treatment of patient and medical waste, decontamination procedures, and visiting policies.

DPHS may also provide, either directly or through contract, trainings for providers on PPE and other prevention measures. If DPHS contract out trainings or train-the-trainer sessions, DPHS will oversee the development of the curricula or develop the materials for the trainers to use.

### 5.3.4. Prophylaxis

Depending on the HTID, prophylaxis may be indicated. For some infectious agents, no prophylactic treatment is available.

Each Regional Public Health Network has plans in place to administer vaccine or dispense medication to residents of their region in the event of the need for a large-scale prophylaxis campaign. In addition, the CDC’s Strategic National Stockpile (SNS) consists of medications, antidotes, medical supplies, and medical equipment that can
support public health emergency response operations when local and state resources are insufficient. More information is available in the State of New Hampshire ESF-8 SNS Annex.

5.3.5. Patient Transport
EMS may be responsible for transportation of a suspect or confirmed HTID patient under 3 circumstances: transport from a scene to a NH Frontline/Assessment Hospital; transport from NH Frontline Hospital to NH Assessment Hospital; or transport from NH Frontline/Assessment Hospital to RESPTC. DPHS will work with the EMS provider to assess their capabilities for transport.

- **Transport from a scene to a NH Frontline/Assessment Hospital:**
  - When EMS and medical control suspect a HTID, DPHS should be immediately notified. However, depending on the number of cases, DPHS may decide that notification for each case is no longer appropriate.
  - If possible, the patient should self-transport. The feasibility of this option will be determined on a case-by-case basis in consultation with DPHS’ Medical SMEs.
  - If EMS suspects a HTID upon arrival on scene, EMS should don the appropriate PPE, consult with Medical Control, and decide with Medical Control if DPHS should be notified.
  - It is possible that the patient will be transported from the scene to a NH Assessment Hospital, even if a Frontline Hospital is closer. This decision will be made collaboratively between DPHS, the NH Frontline Hospital, the NH Assessment Hospital, and the EMS provider.

- **Transport from NH Frontline Hospital to NH Assessment Hospital:** For transport of a HTID patient from a NH Frontline Hospital to a NH Assessment Hospital, the receiving Assessment Hospital will be responsible for transport. If the Assessment Hospital is unable to provide transport, American Medical Response (AMR) will serve as backup.

- **Transport from NH Frontline/Assessment Hospital to RESPTC:** In the event a patient needs to be transported from a NH Frontline/Assessment Hospital to the RESPTC, the HHS Region I Plan (currently under development) describes a primary and two back-up methods for transportation of the patient from the NH Frontline/Assessment Hospital to the RESPTC, which include:
  - Primary: NH DHHS will request that the MGH-contracted ambulance transport the patient.
  - Back-up 1: NH DHHS will request that AMR transport the patient.
  - Back-up 2: NH DHHS will request that the NH Assessment Hospital transport the patient.

In the event security is required to escort a suspect or confirmed HTID patient, NH DPHS will request the support of the NH State Police through the SEOC.
5.3.6. Infectious Waste
Infectious waste is regulated by NH DES under RSA 149-M and its implementing regulations Env-Sw 100-2100, specifically Part Env-Sw 904, Infectious Waste.

DPHS will work with DES to distribute guidance for HTIDs requiring infectious waste disposal practices exceeding those included in Ebv-Sw 904. Guidance will include information regarding packaging, storage, transportation, disposal, and untreated sewage.

5.3.7. Handling Human Remains
Unless otherwise directed by DPHS, standard precautions should be used when handling human remains. When needed, DPHS will issue guidance to personnel who perform postmortem care in hospitals and mortuaries regarding the safe handling and disposal of the human remains of a HTID patient. Depending on the HTID, human remains may still be infectious disease and could 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/or through splashes of blood or other body fluids (e.g., urine, saliva, feces) to unprotected mucosa (e.g., eyes, nose, mouth) which occur during postmortem care.

Depending on the scale and severity of the epidemic, the State of New Hampshire Naturally Occurring Disease Event Mass Fatality Management Plan may be activated to ensure timely processing of a large number of fatalities.
## Attachment 1: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAR</td>
<td>After Action Report</td>
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<tr>
<td>BEMS</td>
<td>Bureau of Emergency Medical Services</td>
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<tr>
<td>BIDC</td>
<td>Bureau of Infectious Disease Control</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CONOPS</td>
<td>Concept of Operations</td>
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<td>DBHRT</td>
<td>Disaster Behavioral Health Response Team</td>
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<td>DES</td>
<td>NH Department of Environmental Services</td>
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<td>DHHS</td>
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<td>ESF</td>
<td>Emergency Support Function</td>
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<td>EVD</td>
<td>Ebola Virus Disease</td>
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<tr>
<td>FBI</td>
<td>Federal Bureau of Investigations</td>
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<td>HAN</td>
<td>Health Alert Network</td>
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<td>HazMat</td>
<td>Hazardous Materials</td>
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<td>HHS</td>
<td>US Department of Health and Human Services</td>
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<td>Homeland Security &amp; Emergency Management</td>
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<td>IMT</td>
<td>Incident Management Team</td>
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<td>Joint Information Center</td>
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<td>Just-in-Time</td>
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<td>Laboratory Response Network</td>
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<td>Nashua Health Department</td>
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<td>Public Health Laboratories</td>
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<td>NH Public Health Services Emergency Annex</td>
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<td>PIO</td>
<td>Public Information Officer</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
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<tr>
<td>PUI</td>
<td>Patient or Person Under Investigation</td>
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<tr>
<td>RESPTC</td>
<td>Regional Ebola and Other Special Pathogens Treatment Center</td>
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<tr>
<td>RSA</td>
<td>Revised Statutes Annotated</td>
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<td>SEOC</td>
<td>State Emergency Operations Center</td>
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<td>SEOP</td>
<td>State Emergency Operations Plan</td>
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<td>Subject Matter Expert</td>
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<td>V-DAM</td>
<td>Video for Direct Active Monitoring</td>
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<td>VOAD</td>
<td>Voluntary Organizations Active in Disasters</td>
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<td>Web Emergency Operations Center</td>
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</table>
Attachment X: Other Attachments TBD
State of New Hampshire

High Threat Infectious Disease (HTID) Plan

Appendix 0: Disease-specific Response Plan Template

Developed <insert date>
Updated <insert date>
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This Disease-specific Response Plan Template is included to assist in the rapid development of a Response Plan for a HTID for which a plan has not already been developed. Content included in the disease-specific plan template should augment information in the HTID with information specific to the infectious agent in question. Once a plan has been developed for a HTID, it should be included as an additional Appendix to the HTID plan.

This disease-specific appendix is a supplement to the *NH High Threat Infectious Disease Plan* and should be used on conjunction with this plan.

<table>
<thead>
<tr>
<th>Disease &amp; Epidemiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Description</td>
</tr>
<tr>
<td>Include information such as symptoms and the speed of onset of symptoms</td>
</tr>
<tr>
<td>Causative Agent</td>
</tr>
<tr>
<td>Differential Diagnosis</td>
</tr>
<tr>
<td>Laboratory Identification</td>
</tr>
<tr>
<td>Treatment</td>
</tr>
<tr>
<td>Transmission</td>
</tr>
<tr>
<td>Susceptibility</td>
</tr>
<tr>
<td>Incubation Period</td>
</tr>
<tr>
<td>Period of Communicability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Identification, Isolation, &amp; Reporting</td>
</tr>
<tr>
<td>Case Definition</td>
</tr>
<tr>
<td>Include criteria for epidemiologic linkage, etc.</td>
</tr>
<tr>
<td>Case Investigation &amp; Contact Monitoring</td>
</tr>
<tr>
<td>Laboratory Testing</td>
</tr>
<tr>
<td>Include information on relevant diagnostic tests, samples required, specimen collection, preparation and storage requirements, etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public Health Control Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolation &amp; Quarantine</td>
</tr>
<tr>
<td>Clinical Management Guidance &amp; Infection Prevention Measures</td>
</tr>
<tr>
<td>Prevention Measures within a Healthcare Setting: Include information such as precautions to be followed, recommended PPE, etc.</td>
</tr>
<tr>
<td>Prophylaxis/Proactive Measures</td>
</tr>
<tr>
<td>Indicate whether chemoprophylaxis or a vaccine is available for this HTID</td>
</tr>
</tbody>
</table>
### Appendix 0: Disease-specific Response Plan Template

<table>
<thead>
<tr>
<th>Vaccine</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Transport</td>
<td></td>
</tr>
</tbody>
</table>
  - Transport from a scene to a NH Frontline/Assessment Hospital:  
  - Transport from NH Frontline Assessment Hospital to NH Assessment Hospital:  
  - Transport from NH Frontline/Assessment Hospital to RESPTC:  |

| Infectious Waste |  |
| Handling Human Remains |  |

| Public Information | Suggested key messages:  
  - <Insert>  |

| Plan Activation |  |
| Notification | Include information on whether or not partners (e.g., Governor, HSEM) will be notified immediately upon identification of a suspect case or once the case has been confirmed |

| Assumptions |  |

| References & Resources |  |
| Acronyms & Definitions |  |
| Resources |  |
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   Causative Agent .................................................................................... 3
   Differential Diagnosis .......................................................................... 3
   Laboratory Identification ..................................................................... 3
   Treatment ............................................................................................ 3
   Transmission ....................................................................................... 4
   Susceptibility ....................................................................................... 4
   Incubation Period ............................................................................... 4
   Period of Communicability ............................................................... 4
Case Investigation ......................................................................................... 4
   Initial Identification, Isolation, & Reporting ............................................. 4
   Case Definition ................................................................................... 5
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   Patient Transport ............................................................................... 7
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This disease-specific appendix is a supplement to the *NH High Threat Infectious Disease Plan* and should be used in conjunction with this plan.

### Disease & Epidemiology

<table>
<thead>
<tr>
<th><strong>Clinical Description</strong></th>
<th>Symptoms occur in a typical sequence and include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Fever</td>
</tr>
<tr>
<td></td>
<td>- Severe headache</td>
</tr>
<tr>
<td></td>
<td>- Joint and muscle pain</td>
</tr>
<tr>
<td></td>
<td>- Weakness and fatigue</td>
</tr>
<tr>
<td></td>
<td>- Diarrhea</td>
</tr>
<tr>
<td></td>
<td>- Vomiting</td>
</tr>
<tr>
<td></td>
<td>- Abdominal (stomach) pain</td>
</tr>
<tr>
<td></td>
<td>- Unexplained hemorrhage (bleeding or bruising)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Causative Agent</strong></th>
<th>Ebola virus, a member of the Filoviridae virus family.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are five identified Ebola virus species, four of which are known to cause disease in humans: Tai Forest (formerly Ivory Coast), Sudan, Zaire, and Bundibugyo. Reston is not known to cause disease in humans.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Differential Diagnosis</strong></th>
<th>Differential diagnosis depends on the likely geographic origin of infection and epidemiological history, and may include: 1-Malaria; 2-Leptospirosis; 3-Typhoid fever; 4-Meningococcal sepsis; 5-Rickettsial diseases; 6-Shigellosis; and 7-other viral hemorrhagic fevers (e.g, Hantavirus hemorrhagic fever, yellow fever, dengue hemorrhagic fever). Ebola Virus Disease (EVD) may also mimic intra-abdominal surgical emergencies.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Definitive diagnosis of EVD is made through laboratory testing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Laboratory Identification</strong></th>
<th>Laboratory diagnosis of EVD is achieved in two ways: specific detection of nucleic acids by reverse transcriptase polymerase chain reaction (RT-PCR) and serologic measurement of immune responses by immunoglobulin M (IgM)/immunoglobulin G (IgG) detection. Confirmation of EVD can be done through any of the tests mentioned below.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Test</strong></th>
<th><strong>Timing after illness</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>RT-PCR</td>
<td>Day 3-16</td>
</tr>
<tr>
<td>IgM antibody assay</td>
<td>Day 5 to 1 month</td>
</tr>
<tr>
<td>IgG or neutralizing antibody assay showing rising titers</td>
<td>Day 10 to years Two samples separated by 14 days, where first sample is collected after day 7</td>
</tr>
</tbody>
</table>

If a negative PCR is obtained early in the clinical course, a second test should be done at least 48 hours later.

<table>
<thead>
<tr>
<th><strong>Treatment</strong></th>
<th>No Food and Drug Administration (FDA)-approved vaccine or medication (i.e., antiviral drug) is available for EVD. Experimental vaccines and treatments for EVD are under development, but they have not yet been fully tested for safety or effectiveness. Symptoms of EVD and complications secondary to infection are treated as they appear. The following basic interventions, when used early, can significantly improve the chances of survival:</th>
</tr>
</thead>
</table>
• Providing intravenous fluids and balancing electrolytes (body salts);
• Maintaining oxygen status and blood pressure; and
• Treating other infections, if they occur.

| Transmission | The likelihood of contracting EVD is extremely low unless a person has direct unprotected exposure to the body fluids of a person with Ebola, or has direct handling of bats or nonhuman primates from areas where Ebola is endemic. More specifically, EVD is transmitted through:
  
  • Blood or body fluids (including, but not limited to, urine, saliva, sweat, feces, vomit, breast milk, and semen) of a person who is sick with or has died from EVD
  
  • Objects (such as needles and syringes) that have been contaminated with body fluids from a person who is sick with EVD or the body of a person who has died from EVD
  
  • Infected fruit bats or primates (apes and monkeys)
  
  • Contact with semen from a man who has recovered from EVD (strong possibility, but not yet proven)

  Ebola is killed with hospital-grade disinfectants (such as household bleach). Ebola on dry surfaces, such as doorknobs and countertops, can survive for several hours; however, the virus in body fluids (such as blood) can survive up to several days at room temperature. |

| Susceptibility | Persons at highest risk for EVD include healthcare workers and family and friends of infected patients. Sexual partners of male survivors of EVD may be at risk via sexual transmission. |

| Incubation Period | Symptoms may appear anywhere from 2 to 21 days after exposure to Ebola virus, but the average is 8 to 10 days. |

| Period of Communicability | Persons are not contagious until they develop symptoms. The person remains infectious as long as the blood and body fluids (including seminal fluid and breastfeeding) contain the virus. This includes the post-mortem period. |

| Case Investigation | Healthcare providers at a local healthcare facility, Emergency Medical Service (EMS) providers, or e9-1-1 telecommunications may identify a suspect EVD patient based on presenting signs and symptoms with a consistent travel history to an affected country with active EVD transmission. Suspect cases may also be identified by public health staff during daily monitoring of persons potentially exposed to Ebola.

  The healthcare provider should immediately isolate the patient, provide them with a mask in a single room, and report the suspect case to the New Hampshire (NH) Bureau of Infectious Disease Control (BIDC) at 603-271-4496 or after hours at 603-271-5300 (see HTID Plan for notification information). The healthcare provider should not have direct contact with the suspect EVD patient without appropriate Personal Protective Equipment (PPE) (see Clinical Management Guidance below).

  The individual is immediately identified as a suspect case of EVD if the NH Division of Public Health Services (DPHS) determines that testing is warranted based on risk factors and signs/symptoms of illness. The patient will then be maintained in isolation with necessary PPE. The patient will be transported, if necessary and as
clinically prudent, to an Assessment Hospital or the Regional Ebola and Other Special Pathogens Treatment Center (RESPTC) for further evaluation, testing, and management.

A symptomatic suspect case will remain in isolation with all healthcare workers using appropriate PPE while awaiting test results.

**Case Definition**

**Confirmed Case:** Laboratory-confirmed diagnostic evidence of Ebola virus infection.

**Suspect Case:** A person under investigation (PUI) for EVD who has signs and symptoms that may be consistent with EVD AND has had close contact with a confirmed/suspect case or traveled to Ebola-affected country(ies) within 21 days before onset of symptoms.

**Case Investigation & Contact Monitoring**

The Public Health Nurse (PHN) on-call will use internal BIDC protocols to determine whether a patient is suspect for EVD. The PHN will advise the patient and/or associated health care providers appropriately, based on the location of the patient (e.g., patient’s home, outpatient setting, or a hospital). The PHN will then use the Centers for Disease Control and Prevention (CDC) patient evaluation algorithm and consult with the physician on-call and the CDC Emergency Operations Center (EOC) to determine if the patient should be tested.

If a patient is confirmed to have EVD, further investigation and response is required for all contacts, including pets. This includes evaluation of healthcare personnel who may have cared for the patient during the infectious period and investigation into airline or other travel contacts, if appropriate. CDC will assist the DPHS with the case investigation and contact tracing. Risk categories are outlined in Attachment 6: Isolation, Quarantine, and Public Health Monitoring of Persons Potentially-Exposed to Ebola Interim Plan.

Any persons who are not ill but were potentially exposed to the suspect EVD patient while s/he was symptomatic will be monitored by DPHS, Manchester Health Department, and Nashua Health Department staff in their respective jurisdiction for 21 days following their last possible exposure. Public health monitoring activities are divided into four risk exposure categories: High Risk Exposure, Some Risk Exposure, Low/Negligible Risk Exposure, and Low/Negligible Risk Exposure. Further detail can be found in Attachment 6: Isolation, Quarantine, and Public Health Monitoring of Persons Potentially-Exposed to Ebola Interim Plan.

**Laboratory Testing**

Diagnostic testing for Ebola virus is available at the NH Public Health Laboratories (PHL). Prior to sending a sample, the facility should consult with BIDC. BIDC will determine whether the suspect case requires lab testing for Ebola. The hospital is responsible for collecting and properly packaging the sample for transport to the PHL. PHL will contact and coordinate with the courier. The results will be reported to the healthcare provider, BIDC, and the CDC with in 4-6 hours from specimen receipt. A duplicate sample will be shipped to the CDC for confirmatory testing when a specimen is tested positive by RT-PCR in the PHL. CDC test results can take up to 24 hours to be reported.

Because the Ebola test can be negative during the early symptomatic period, if the first test result from a suspect case who has been symptomatic for < 72 hours is...
negative, a second Ebola test is required ≥ 72 hours after the onset of symptoms.

Specimen Requirements
The PHL uses two CDC assays that are run simultaneously for which acceptable specimen types are whole blood, serum, plasma, and urine. However, urine is not recommended as the sole specimen to be tested from a patient. Urine should be tested with another sample, such as a blood specimen, from the patient.

If testing specimen types not listed in an assay’s intended use is medically indicated, the PHL will consult with CDC.

<table>
<thead>
<tr>
<th>Public Health Control Measures</th>
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<tbody>
<tr>
<td><strong>Isolation &amp; Quarantine</strong></td>
</tr>
<tr>
<td>Isolation and Quarantine processes are outlined in Attachment 6: Isolation, Quarantine, and Public Health Monitoring of Persons Potentially-Exposed to Ebola Interim Plan.</td>
</tr>
<tr>
<td>Persons with EVD will be isolated at a hospital by hospital personnel. If a patient who requires isolation refuses isolation, a public health order will be served following protocols outlined in Attachment 6: Isolation, Quarantine, and Public Health Monitoring of Persons Potentially-Exposed to Ebola Interim Plan.</td>
</tr>
<tr>
<td>While all contacts who are not ill but were potentially exposed to a symptomatic EVD patient will be monitored, only those individuals in certain risk exposure categories require quarantine. DPHS may quarantine a suspect case at their discretion. Contacts with a high risk exposure will require mandatory at-home quarantine. Contacts with some risk exposure will be recommended for voluntary at-home quarantine. Contacts with low/negligible risk exposures are not required to be in quarantine.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infection Prevention Measures &amp; Clinical Management Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPHS recommends that NH healthcare settings follow CDC guidance as it relates to prevention measures, including PPE protocols. Adaptations for NH plans are noted where applicable.</td>
</tr>
<tr>
<td>• Patients should be placed in a single room with a private bathroom or bedside commode and have dedicated medical equipment.</td>
</tr>
<tr>
<td>• Visitor entry should be avoided. However, exceptions may apply and should adhere to strict monitoring practices and hospital protocols.</td>
</tr>
<tr>
<td>• Aerosol-generating procedures should be avoided, and use of sharps (e.g., needles) should be limited.</td>
</tr>
<tr>
<td>• Healthcare personnel must prevent direct contact or splashes with blood and body fluids, contaminated equipment, and soiled environmental surfaces.</td>
</tr>
<tr>
<td>Two CDC guidance documents provide guidance related to PPE for US hospital workers who may evaluate or care for Ebola patients:</td>
</tr>
<tr>
<td>• Guidance on PPE to be Used by Healthcare Workers during Management of Patients with Confirmed Ebola or Persons Under Investigation (PUIs) for Ebola who are Clinically Unstable or Have Bleeding, Vomiting, or Diarrhea in U.S. Hospitals, Including Procedures for Donning and Doffing PPE, which is recommended when evaluating and caring for a person who meets the definition of a PUI for EVD and is exhibiting obvious bleeding, vomiting, or</td>
</tr>
</tbody>
</table>
## Appendix 1: Ebola Response Plan

<table>
<thead>
<tr>
<th>Prophylaxis/Vaccine</th>
<th>There is no FDA-approved vaccine or medication available for EVD. Experimental vaccines for EVD are under development, but they have not yet been fully tested for safety or effectiveness.</th>
</tr>
</thead>
</table>
| Patient Transport   | **Transport from a scene to a NH Frontline/Assessment Hospital**: Once a suspect EVD case has been reported, the PHN will consult with the on-call physician and, together, they will determine the most appropriate evaluation facility based on patient location, patient clinical condition, and ability of closest hospital to manage a suspect EVD patient at that time. Modes of transportation may include: self-transport, self-transport with law-enforcement escort, local EMS, or Assessment Hospital EMS.  

**Transport from NH Frontline Hospital to NH Assessment Hospital**: Once a suspect or confirmed case is at a NH hospital, facility transfer may occur depending upon the patient’s clinical status and hospital resources. This decision will be made in consultation with DPHS. Patient transport will follow guidelines outlined in Attachment 12: Public Health Protocol for Initial Response to Suspect Ebola Cases, the HTID Plan, and the HHS Region 1 Plan.  

**Transport from NH Frontline/Assessment Hospital to RESPTC**: If a patient is scheduled for transport to the RESPTC, procedures outlined in the HHS Region I Plan (currently under development) will be followed. Ideally, the patient will be transported by a Massachusetts (MA) EMS provider already prepared to transport EVD patients. If this option is not feasible, NH will request services from a private ambulance service in NH to provide transport. Providers will follow standards and protocols as defined by state EMS protocols, CDC and NH DHHS guidelines, and the HHS Region I Plan.  

The NH Department of Safety, Bureau of Emergency Medical Services will operate under the State Emergency Operations Center (SEOC) Emergency Support Function (ESF)-8 to coordinate transport of an EVD PUI or confirmed patient. |
| Infectious Waste    | Generated hospital waste will be managed through existing hospital procedures. All waste materials generated by patient transportation teams and the medical treatment facility will be treated as Category A infectious waste, unless laboratory analysis proves otherwise. All waste will be transported and disposed of by an }
### Handling Human Remains

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. See Attachment 17: Guidance for Safe Handling of Human Remains of Ebola Patients in NH Hospitals and Mortuaries for further guidance on the safe handling of human remains of EVD patients in NH hospitals and mortuaries.

### Public Information

Key public messages include:

- NH has a plan to respond to Ebola and keep people safe.
- The general public is at extremely low risk of contracting Ebola.
- Ebola is not spread through the air or by food or water.
- Ebola is spread only by having contact with infected blood or body fluids from a person infected with Ebola.

### Plan Activation

**Notification**

In response to US cases of Ebola, imported or locally acquired, the DPHS Incident Management Team (IMT) will be activated.

In the event of a suspect case of EVD in NH, DPHS will immediately notify partners. The Director of Public Health or designee will immediately alert and activate the IMT and notify NH Department of Safety, Homeland Security and Emergency Management via the DHHS Emergency Services Unit according to the IMT activation protocol (currently under development). The Director of Public Health will notify the Commissioner and the Governor. The IMT will coordinate and oversee the response. Initially, the IMT Operations Section will notify the Local Health Officer, as well as the Public Health Network Public Health Emergency Preparedness Coordinator, serving the town where the suspect case is located; however, as the situation develops, health officers may no longer be notified of each new suspect case.

If a decision is made that the PUI meets criteria for laboratory testing for EVD, MA Department of Public Health (MDPH) will be notified as specified in the HHS Region I Plan (currently under development). EMS providers who may be activated for the purposes of patient transport will be notified.

In the event of a suspect or confirmed case of EVD in NH, the Governor may elect to activate the State Emergency Operations Plan (SEOP), resulting in activation of the SEOC. Once the SEOC is activated, the NH DPHS IMT will operate under ESF-8.

**Assumptions**

The preferred EVD treatment location for confirmed EVD patients for states within HHS Region I is the RESPTC, located at Massachusetts General Hospital (MGH) in Boston, MA.
# References & Resources

## Acronyms & Definitions

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIDC</td>
<td>Bureau of Infectious Disease Control</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>DHHS</td>
<td>NH Department of Health and Human Services</td>
</tr>
<tr>
<td>DPHS</td>
<td>NH Division of Public Health Services</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Service</td>
</tr>
<tr>
<td>EOC</td>
<td>Emergency Operations Center</td>
</tr>
<tr>
<td>ESF</td>
<td>Emergency Support Function</td>
</tr>
<tr>
<td>EVD</td>
<td>Ebola Virus Disease</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>IgG</td>
<td>Immunoglobulin G</td>
</tr>
<tr>
<td>IgM</td>
<td>Immunoglobulin M</td>
</tr>
<tr>
<td>IMT</td>
<td>Incident Management Team</td>
</tr>
<tr>
<td>MA</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>MDPH</td>
<td>Massachusetts Department of Public Health</td>
</tr>
<tr>
<td>NH</td>
<td>New Hampshire</td>
</tr>
<tr>
<td>PHL</td>
<td>NH Public Health Laboratory</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>PUI</td>
<td>Person Under Investigation</td>
</tr>
<tr>
<td>RESPTC</td>
<td>Regional Ebola and Other Special Pathogens Treatment Center</td>
</tr>
<tr>
<td>RT-PCR</td>
<td>Reverse transcriptase polymerase chain reaction</td>
</tr>
<tr>
<td>SEOC</td>
<td>State Emergency Operations Center</td>
</tr>
<tr>
<td>SEOP</td>
<td>State Emergency Operations Plan</td>
</tr>
</tbody>
</table>

## Definitions:

**Active Monitoring:** Monitoring conducted by DPHS or designee by daily check-in by phone call unless home visit or virtual technology is necessary on a case-by-case basis

**Close Contact**

a) Being within approximately 3 feet (1 meter) of a confirmed case or within the case’s patient room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment for standard, droplet, and contact precautions

b) Having direct brief contact (e.g., shaking hands) with a confirmed case while not wearing recommended PPE.

**Direct Active Monitoring:** Monitoring conducted by DPHS or designee by daily check-in either in-person or by using face to face or virtual technology

## Resources


Appendix 1: Ebola Response Plan


List of Attachments
Grouped by target audience/topic

Healthcare Facilities:
Attachment 1: Healthcare Facilities Screening Poster
Attachment 2: Preparedness Guidance for Outpatient Healthcare Settings
Attachment 3: Ebola PPE and Environmental Infection Control FAQs, October 29, 2014
Attachment 4: PPE to Prevent Transmission of Ebola in Hospitals
Attachment 5: Healthcare Personnel Logs for Contact with Suspect or Confirmed EVD Case

Isolation & Quarantine:
Attachment 7: FAQs for Isolation & Quarantine of Persons Potentially Exposed to Ebola
Attachment 8: Guidelines for Implementing Live Video for Active Monitoring (V-DAM) of Travelers Returning from Countries Affected by Ebola

Laboratory Testing:
Attachment 9: Ebola Specimen Testing Checklist
Attachment 10: FAQs for Specimen Collection and Testing

Emergency Medical Services:
Attachment 11: Interim Guidance for EMS Systems for Management of Patients with Known or Suspected EVD in NH
Attachment 12: Preparedness Guidance for Emergency Medical Services
Attachment 13: Response Guidance for Emergency Medical Services
Attachment 14: EMS Screening Poster
Attachment 15: Tracking Log for First Responders with Potential Contact to a Suspect Ebola Case

Safe Handling Infectious Waste and Human Remains:
Attachment 16: Guidance for Infectious Waste
Attachment 17: Guidance for Safe Handling of Human Remains of Ebola Patients in NH Hospitals and Mortuaries

Schools:
Attachment 18: Guidelines for School Administrators
Attachment 19: Information for School Health Clinician
Attachment 20: Ebola Information & FAQs for Schools

Public Information Resources:
Attachment 21: Ebola Fact Sheet
Attachment 22: Ebola Fact Sheet for Parents
Attachment 23: Ebola FAQs
Attachment 24: Facts about Ebola in the US
Attachment 25: Is it Flu or Ebola?
Attachment 26: Health Advisory: Ebola
Attachment 27: The 2014 Ebola Outbreak: Lessons for DH from the Hot Zone
Attachment 28: Recommendations for Pets in New Hampshire