

# **LOCAL PUBLIC HEALTH EMERGENCY PLAN**

**FOR**

**Carter County Health Department**

**031403**

**CARTER COUNTY HEALTH DEPARTMENT**

**LOCAL PUBLIC HEALTH EMERGENCY PLAN**

Prepared by

**CARTER COUNTY HEALTH DEPARTMENT**

In Conjunction with

Officials of Carter County and the Incorporated Cities

Date  
031403

DATE

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Carter County Health Department**

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**RECORD OF CHANGES**  
**Carter County Local Public Health Emergency Plan**

CHANGE NUMBER	DATE OF CHANGE	DATE ENTERED	ITEM CHANGED	PAGE NO.	CHANGE MADE BY (Signature)
1	111203	111203			/s/ Deborah Sandarciero
2	041505	041505			/s/ Deborah Sandarciero
3	060805	060805			/s/ Deborah Sandarciero
4	060805	060805			/s/ Deborah Sandarciero
5	071106	071106			/s/ Deborah Sandarciero
6	031607	031607			/s/ Deborah Sandarciero
7	090507	090507			/s/ Deborah Sandarciero
8	092808	092808			/s/ Deborah Sandarciero
9	060109	060109			/s/ Deborah Sandarciero
10	082909	082909			/s/ Deborah Sandarciero
11	100709	100709			/s/ Deborah Sandarciero
12	080610	080610			/s/ Deborah Sandarciero
13	030411	030411			/s/ Deborah Sandarciero
14	072011	072011			/s/ Deborah Sandarciero
15	091412	091412			/s/ Deborah Sandarciero
16	091912	091912	Record of changes, MMA Shannon Co.	4, 33-35	/s/ Deborah Sandarciero
17	041013	041013	Annex P Added		/s/Deborah Sandarciero
18	041013	041013	Appendix 4 to Annex A		/s/Deborah Sandarciero
19	041013	041013	Appendix 5 to Annex A		/s/Deborah Sandarciero
20	041013	041013	Updated TOC		/s/Deborah Sandarciero
21	041013	041013	Appendix 6 to Basic Plan Hazard Analysis		/s/Deborah Sandarciero
22	041013	041013	Appendix 2 to Annex A		/s/Deborah Sandarciero
23	041013	041013	Appendix 5 to Basic Plan		/s/Deborah Sandarciero
24	041013	041013	Appendix 1 to Basic Plan		/s/Deborah Sandarciero

25	041113	041113	Appendix 6 to the Basic Plan	/s/Deborah Sandarciero
26	041113	041113	Appendix 7 to the Basic Plan	/s/Deborah Sandarciero
27	041113	041113	Appendix 8 to the Basic Plan	/s/Deborah Sandarciero
28	041113	041113	Appendix 9 to the Basic Plan	/s/Deborah Sandarciero
29	041113	041113	Appendix 10 to the Basic Plan	/s/Deborah Sandarciero
30	041113	041113	Entire Plan re-numbered	/s/ Deborah Sandarciero
31	091014	091014	Continuity of Operations BP	/s/ Deborah Sandarciero
32	091014	091014	Appendix 1 to the Basic Plan	/s/ Deborah Sandarciero
33	091014	091014	Appendix 6 to the Basic Plan	/s/ Deborah Sandarciero
34	052715	052715	Annex A	/s/ Deborah Sandarciero
35	052715	052715	Appendix 2 to Annex A	/s/ Deborah Sandarciero
36	052715	052715	Appendix 3 to Annex A	/s/ Deborah Sandarciero
37	052715	052715	Appendix 5 to Annex A	/s/ Deborah Sandarciero
38	101915	101915	Appendix 1 to Annex B	/s/ Deborah Sandarciero
39	101915	101915	Appendix 2 to Annex B	/s/ Deborah Sandarciero
40	101915	101915	Appendix 4 to Annex B	/s/ Deborah Sandarciero
41	020316	020313	Basic Plan page 13	/s/ Deborah Sandarciero
42	020316	020316	Appendix 1 to Basic Plan	/s/ Deborah Sandarciero
43	020316	020316	Appendix 3-Annex A	/s/ Deborah Sandarciero
44	020316	020316	Appendix 5-Annex A	/s/ Deborah Sandarciero
45	020316	020316	Appendix 2-Annex A	/s/ Deborah Sandarciero
46	020316	020316	Appendix 1 – Annex B	/s/ Deborah Sandarciero
47	020316	020316	Appendix 2-Annex B	/s/ Deborah Sandarciero
48	020316	020316	Annex C page 2	/s/ Deborah Sandarciero
49	020316	020316	Annex C page 8	/s/ Deborah Sandarciero

50	020316	020316	Appendix 2- Annex C		/s/ Deborah Sandarciero
51	020316	020316	Annex H page 7		/s/ Deborah Sandarciero
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53	020316	020316	Appendix 1- Annex H		/s/ Deborah Sandarciero
54	020316	020316	Appendix 5- Annex H		/s/ Deborah Sandarciero
55	020316	020316	Appendix 5-Tab A- Annex H		/s/ Deborah Sandarciero
56	020316	020316	Appendix 6- Annex I		/s/ Deborah Sandarciero
57	020316	020316	Annex M page 1		/s/ Deborah Sandarciero
58	020316	020316	Intro- pages 5-14		/s/ Deborah Sandarciero
59	020316	020316	Basic Plan-1-37 (renumbered)		/s/ Deborah Sandarciero
60	020316	020316	Appendix 2- Annex E		/s/ Deborah Sandarciero
61	083018	08308	Annex B		/s/ Deborah Sandarciero
62	083018	08308	Annex C		/s/ Deborah Sandarciero
63	083018	08308	Annex D		/s/ Deborah Sandarciero
64	121119	121119	Annex H		/s/ Michelle Walker
65	083018	08308	Basic Plan		/s/ Deborah Sandarciero
66	100918	100918	Annex E		/s/ Deborah Sandarciero
67	100918	100918	Annex I		/s/ Deborah Sandarciero
68	100918	100918	Annex J		/s/ Deborah Sandarciero
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70	100918	100918	Annex O		/s/ Deborah Sandarciero
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75	101018	101018	Intro. & TOC		/s/ Deborah Sandarciero
76	101018	101018	Annex A		/s/ Deborah Sandarciero
77	101018	101018	Annex L		/s/ Deborah Sandarciero
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**FOREWARD**

1. This plan will outline actions to be taken by the Carter County Health Center in conjunction with local government officials and cooperating private or volunteer organizations to;
  - a. Prevent avoidable disasters and reduce the vulnerability of citizens to any disasters that create a local public health emergency;

- b. Establish capabilities for protecting citizens from the effects of public health emergencies;
  - c. Respond effectively to the actual occurrence of disasters; and
  - d. Provide for recovery in the aftermath of any local public health emergency.
2. It is not the intent of this plan to attempt to deal with those events that happen on a daily basis, which do not cause widespread problems and are handled routinely by the Health Center. It will however, attempt to deal with those contingencies that create a local public health emergency, which creates needs and causes suffering to citizens that cannot be alleviated without the assistance of government, private and voluntary resources.
3. The Carter County Health Center Emergency Plan is a multi-hazard, functional plan, broken into three components:
- a. A basic plan that serves as an overview of the Health Center's approach to a local public health emergency.
  - b. Annexes that address specific activities critical emergency response and recovery.
  - c. Appendices, which support each annex and contain technical information, details and methods for use in emergency operations.
4. Staff with assigned tasks will assist in the maintenance of their respective segments of the plan. This plan will be reviewed and updated as needed based on after actions reports from public health emergencies, deficiencies identified through drills and exercises.



## PROMULGATION STATEMENT

The Carter County Health Center, in conjunction with local governmental officials and cooperating private or volunteer organizations, have developed a local public health emergency plan that will enhance their emergency response capability. This document is the result of that effort.

This plan, when used properly and updated annually, can assist the Carter County Health Center in accomplishing one of their primary responsibilities – protecting the lives and property of citizens and property. This plan and its provisions will become official when it has been signed and dated below by the concurring officials.

/s/ Deborah S. Sandarciero, \_\_\_\_\_  
Deborah S. Sandarciero, Administrator  
Carter County Health Center

3/14/03 \_\_\_\_\_  
Date

/s/ Janice Chapman \_\_\_\_\_  
Janice Chapman  
President of Carter County Board of Trustees

3/14/03 \_\_\_\_\_  
Date

## GLOSSARY OF TERMS AND ACRONYMS

- ARES:** Amateur Radio Emergency Services
- CGENTREC:** Chemical Transportation Emergency Center
- CRP-Crisis Relocation Plan:** Plan developed for local jurisdictions in the event of a nuclear crisis. Under this planning concept, persons from “risk” areas (potential nuclear attack targets) would relocate to safer “host” areas should enough time be given to allow for such a movement. The risk are would be given an evacuation plan outlining the travel route to the host area, as well as what to take with them, etc. The host area has identified registration centers, shelters, and mass feeding facilities for these evacuees, as well as other facilities and services necessary.
- CSP-Community Shelter Plan:** Plan developed for local jurisdictions in the event of a nuclear attack with little or no warning. Under this planning concept, a brochure has been developed describing protective measures and identifying the best possible protective shelter available for the local residents.
- DAC- Disaster Assistance Center:** Place where disaster victims can come and find out what types of assistance are available to them. These centers will be manned by local, state, and federal agencies and organizations.
- CCHC:** Carter County Health Center
- Direction and Control Staff:** Comprised of the functional coordinators found in each annex of this plan. The Direction and Control staff are members of the overall EOC staff.
- DISASTER:** For the purpose of this plan, a disaster can be described as any type of situation that endangers the life and/or property to a degree that a concentrated effort of emergency services must be coordinated on a large scale to contain the situation. Examples include tornadoes, floods, earthquakes, hazardous materials incidents, etc.
- DNR:** (Missouri) Department of Natural Resources
- EAS- Emergency Broadcast System:** Emergency Alert System (formerly known as the Emergency Broadcast System). A communication and warning system set up by the federal government in order for

emergency messages to be broadcast via radio and television stations.

**EMA- Emergency Management Agency**

**EPI:** Emergency Public Information

**EOC- Emergency Operations Center:** A centralized location for direction and control in an emergency/disaster situation. Information is collected, evaluated, and displayed in this facility. Also, this is where coordination of emergency response agencies and resources takes place.

**EOC STAFF:** Includes Direction and Control Staff, supporting agencies/organizations, clerical staff, plotters, etc. (i.e., all persons working in the EOC).

**EOP:** Emergency Operations Plan

**EXERCISE:** An activity designed to promote emergency preparedness. Tests or evaluates an emergency operations plan, including standard operating procedures. Trains personnel in their emergency response duties and demonstrates the jurisdiction's operational capability. There are three (3) specific types of exercises—tabletop, functional, and full-scale.

**FEMA- Federal Emergency Management Agency:** An agency established in 1979 which consolidated emergency agencies and functions into one organization. Among these agencies—DCPA, FIA, FPA, FDAA, and NFA.

**HAZ-MAT:** Hazardous Material(s)

**LEPC- Local Emergency Planning Committee:** Local committees required to be established under SARA, Title III legislation concerning hazardous materials.

**LPHEP- Local Public Health Emergency Plan:** Developed to assist the Carter County Health Center in protecting the health and safety of its citizens should a local public health emergency, be it natural or deliberate, affect the community.

**MAA:** Mutual Aid Agreement

- MARS:** Military Affiliate Radio System
- MERC:** Missouri Emergency Response Commission
- MFDA:** Missouri Funeral Directors Association
- MOA:** Memorandum of Agreement
- MULES:** Missouri Uniform Law Enforcement System. A hard wire landline computer system where information, such as weather, road conditions, hazardous materials incidents, and train derailments can be transmitted to all receiving points (about 250 in the state). This system has the capability to communicate with all 50 states.
- NAWAS:** National Warning system. A landline network for transmitting and receiving emergency information to federal, state, and local agencies that have NAWAS drops (phones). It was designed specifically for warning in the event of a national emergency; now it is used in transmitting and receiving other emergency information, such as severe weather.
- NFS- National Facility Survey:** A computerized printout of fallout shelters which have been identified and surveyed by the federal government (FEMA and the U.S. Army Corps of Engineers).
- SNS:** Strategic National Stockpile
- NRC:** National Response Center
- PIO:** Public Information Officer
- POA- Point of Arrival:** Designated locations within or near the disaster-affected area where newly arrived staff, supplies, and equipment can be initially directed.
- RACES:** Radio Amateur Civil Emergency Services
- RADEF- Radiological Defense:** Organized effort, through warning, detection, and preventive/remedial measures to minimize the effects of nuclear radiation on people and property. Now called Radiological Protection Program (RPP).
- RDO- Radiological Defense Officer:** Responsible for establishing and administering a RADEF system at the local level. This person may also be referred to as the Radiological Officer (RO).
- SARA:** Superfund Amendments and Reauthorization Act of 1988 (PL 94-499)

**SAVE:** Structural Assessment and Visual Evaluation Coalition

**SCM:** Survivable Crisis Management Program

**SEMA- State Emergency Management Agency:** Prepares and maintains the State of Missouri's Emergency Operations Plan and the state EOC and assists local government in developing and maintaining their emergency operations plan and the EOC's. this agency is also responsible for RADEF, damage assessment, and emergency public information.

**SOP/SOG:** Standard Operating Procedures/Guides. A ready and continuous reference to those procedure/guides which are unique to a situation and which are used for accomplishing specialized functions.

**VMI:** Vendor Managed Inventory: Refers to the National Pharmaceutical Stockpile. Supplies can be ordered directly from vendors and delivered directly to the site.

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**LOCAL PUBLIC HEALTH EMERGENCY BASIC PLAN**

## **I. PURPOSE**

This local public health emergency plan has been developed to assist the Carter County Health Center in protecting the health and safety of its citizens should a local public health emergency, be it natural or deliberate, affect the community.

## **II. SITUATION AND ASSUMPTIONS**

- A. Carter County is located in the South Central region of the state. Counties that border Carter County are Reynolds to the north, Wayne and Butler to the east, Shannon to the west, and Ripley and Oregon to the south.
- B. According to the 2010 U.S. census, Carter County has a total population of 6,265.  
The incorporated subdivision of Cities of Carter County are; Van Buren which is the county seat (pop.819), Ellsinore (pop.446), and Grandin (pop.243).
- C. Other unincorporated towns and villages include: Fremont, Eastwood, and Hunter.
- D. The land area of Carter County is 509 square miles of rough to hilly wooded land and open pasture. It is a rural county.
- E. Carter County is vulnerable to a number of hazards, all of which have the potential to disrupt the area, cause damage, and create casualties. The identified natural hazards include tornadoes, earthquakes, severe winter storms, and wildfire. Technological hazards include dam failure, hazardous materials incident, power failure, fires, pipeline and transportation accidents.
- F. CCHC does not have the internal capabilities to analyze air, drinking water or food for biological contamination, hazardous materials or nuclear, biological, or chemical agents.
- G State and federal agencies will begin support activities within 72 hours if capable.
- H. This plan is supported by the Carter County Emergency Operations Plan, dated January 2013, which describes the overall emergency response procedures for our community.

## **III. CONCEPT OF OPERATIONS**

- 1. This plan will normally be implemented upon receiving notification that an emergency/disaster has occurred or that the Carter County Emergency Operations Center is being activated. It may also be implemented based on analyses of epidemiological data indicating that an increase in surveillance is necessary due to a bio-terrorist or natural disease outbreak. See Appendix 1 for the Primary and Support Responsibilities Chart. See Appendix 2 for a local hazard analysis.
- 2. After normal business hours, the CCHC staff may be notified to report for work at the CCHC offices using the recall roster, see Annex A.
- 3. The CCHC has entered into a Mutual Aid Agreement (MAA) with the Shannon County Health Center, Reynolds County Health Center and Wayne County Health Center. If it is deemed necessary the Administrator of the CCHC

Administrator will contact the administrators of either health center requesting support. Reynolds County Health Center may be reached after hours at: 573-648-2513, and during normal business hours at 573-648-2498. Wayne County Health Center may be reached at 573-297-3563 after hours, and during normal business hours at 573-224-3218. Copies of the MAA's are located in Appendix 3.

4. During public health emergencies normal day-to-day operations may be suspended or curtailed to handle the increased workload. The CCHC Administrator will determine this.
5. When the Carter County EOC is activated, the CCHC Administrator will assign a staff member to represent the agency. The EOC is located in the Carter County Sheriff's Office, in the Carter County Court House, Main Street in Van Buren Missouri. An alternative site will be the Community Fire Station in Ellsinore.
6. After the recall, a review of the current situation will be given by the Administrator using the Public Health Threat Analyses, to determine priority activity for the CCHC.
7. Staffing levels will be based on the threat analysis with the assumption that the Reynolds County Health Center and the Wayne County Health Center will provide support within 24 hours.
8. Public information messages will be developed and distributed through the EOC Public Information Officer. Public information/interviews will not be given until approved by the CCHC Administrator.

**B. Operation Time Frames:** This plan addresses all phases of emergency management concerning a local public health emergency. The following operational time frames are established to accomplish various tasks within public health.

1. **Mitigation** – A period of time when public health staff will undertake activities to improve the capabilities of public health, or eliminate threats, in regards to potential local public health emergencies.
2. **Preparedness** – A period of time when public health staff will undertake activities to improve the readiness of public health in regards to local public health emergencies.
3. **Response** – A period of time when public health staff will respond to local public health emergencies.
4. **Recovery** – A period of time when public health staff will provide for the welfare of the community and agency, and restore operations to normal after local public health emergencies.



## **MITIGATION**

Active member of local emergency management planning

Assist and Support the Carter County Emergency Operation Center in its plan, assist in the preparation of any needed areas of planning, response, exercising, or revision of disaster plans, documents, or procedures.

Provide immunizations for childhood and adult diseases.

Identify which diseases are most likely to be present during disaster/emergency situations.

Prepare and provide public information, literature and presentations for both personal and environmental models of disease transmission and controlling them.

Enforce environmental regulations and conduct regular inspections that are directed toward food and water borne disease prevention.

Work with county and city officials toward developing county ordinances that protect public health.

Identify sources for vaccine (i. e. tetanus-diphtheria immune globulin).

Establish linkage between Carter County EOC and medical providers.

Develop plans with local medical providers and emergency responders for establishing First Aid Stations at the incident scene or as needed.

Locate resources/supplies for First Aid Stations as needed.

Identify and maintain on file the locations of all county public water supply districts and the contact person, and keep updated.

## **PREPAREDNESS**

- A. Actively participate with Carter County Emergency Operations Center
  - 1. Solicit and encourage participation from other agencies/organizations in emergency management planning.
  - 2. Locating and securing resources.
  - 3. Coordinate/arrange disaster/emergency training, education.

- B. Develop, exercise, and regularly update Carter County Health Department Emergency/Disaster Operating Procedures.
- C. Exercise and regularly update the Health Annex portion of the Carter County Emergency Operations Plan.
- D. Provide yearly as well as needed clinics to assure city/county first responders and emergency managers are appropriately immunized and assist in assessing immunization status.
- E. Collaborate with American Red Cross to assure public health safety in shelters.
- F. Provide staff of Carter County Health Department with adequate education/training for emergency/disaster response and continuing education in public health theory and practices.
- G. Establish methods of maintaining appropriate levels of tetanus and immune globulin to contend with the initial days of emergency/disaster...
- H. Establish methods of collecting and reporting data relating to disaster communicable diseases, food borne illness, and vital records, in the event of power outage.
- I. Develop public service announcements/packets on protecting public health in the areas of: food preparation and storage, safe water consumption, prevention of food and water borne illness, general sanitation, and alternate methods of sewage disposal.
- J. Collaborate with emergency responders to educate public in preparation before and response to an emergency/disaster.
- K. Locate possible sites across the county to utilize as mass vaccination clinics or mass prophylactic clinics.

## **RESPONSE**

- A. Activate First Aid Station as needed.
- B. Upon request by Carter County E.O.C., initiate health and medical annex of county plan.

- C. Through the Carter County E.O.C., coordinate local and state public health department activities. (sanitation, inspections, immunizations, procurement of supplies, identification of resources etc.)
- D. Upon request by Carter County E.O.C., coordinate any medical and health activities deemed necessary.
- E. Establish contact and collaborate with American Red Cross District Relief Office/Service Center to assist their service, relief, and referral efforts.
- F. Establish and maintain contact with public shelters and mobile food accommodations to institute public health measures.
- G. Provide through public information officer personal and environmental health information and precautions relevant to the situation.
- H. As event allows for diminished roles of Carter County Health Center staff, provide support to other agencies as requested/needed.
- I. Establish a system to handle increased phone calls from the public. Develop question and answer sheets for the particular problem you are addressing.

# **RECOVERY**

- A. Continuation of response activities as needed and requested by the Carter County E.O.C., Missouri Department of Health, the public and other governmental agencies.
- B. Compilation of personal and environmental health reports and Vital Records (birth and death) as required by state and local Laws.
- C. Continue inspections assuring the integrity of food and water source and supply networks.
- D. Continuation of monitoring of various phases of operational deactivation such as refuse removal and disposal (particularly in rural areas), assuring environmental damage mitigation, and that the community returns to pre-disaster levels with regards to personal and environmental health.
- E. Continuation of monitoring and surveillance of communicable disease.
- F. Continuation of Immunization Clinics.

**IV. ORGANIZATIONS AND ASSIGNMENT OF RESPONSIBILITIES**

**A. Organization**

1. Direction and Control
2. Information Technology and Communications
3. Public Information
4. Surveillance
5. Investigation
6. Prevention of Secondary Transmission
7. Isolation/Quarantine
8. Mass Prophylaxis
9. Mass Patient Care
10. Mass Fatality Management
11. Nuclear and Chemical Incidents
12. Food-borne or Waterborne Outbreaks
13. Volunteer Management
14. Recovery

**B. Assignment of Responsibilities**

1. Specific staff is assigned primary responsibility for the functions previously listed in regards to a local public health emergency. Others are assigned a support responsibility to assist those assigned primary responsibilities
2. It is the responsibility of primary and secondary assigned staff to understand their roles and responsibility in the event of a local public health emergency

**V. CONTINUITY OF CARTER COUNTY HEALTH CENTER ADMINISTRATION:**

**A. Lines of Succession :**

1. Administrator
2. RN Supervisor
3. Clerk III- Personnel, WIC Mgr.

**B. Preservation of Records**

1. The essential records for CCHC are located at 1611 Health Center Rd. in the Health Center offices.
2. The Clerical staff in each area is responsible for the day-to-day maintenance of their records and documents vital to the operation of the agency

**VI. ADMINISTRATION AND LOGISTICS**

- A. Whenever possible, procurement of necessary resources will be accomplished using normal, day-to-day channels. The CCHC Board of Trustees must approve expenditures. During an emergency the Administrator is authorized to approve purchase orders for expenditures up to \$4999.99. If an amount greater than that is required, the Board of Trustees will be called or e-mailed for their approval.
- B. Accurate records of all actions taken in a local public health emergency are essential for future mitigation activities, reimbursements, training, exercising and settling litigation issues.
- C. Disaster assistance from the state or federal government will be utilized in accordance with their provisions and statutes. Requests for federal assistance will be coordinated through the local emergency management agency.
- D. Discrimination on the grounds of race, color, religion, nationality, sex, age, physical impairment or economic status will not be allowed in the execution of local public health functions.

**VII. PLAN DEVELOPMENT AND MAINTENANCE**

- A. The plan has been developed by the Carter County Health Center information received from other participating agencies, medical facilities and voluntary agencies. The plan will be reviewed annually by CCHC and revised as necessary. Plans will be distributed to all staff and others who have a responsibility for a local public health emergency.
- B. Plan updates will be distributed to all staff and others who have a responsibility for a local public health emergency.

**VIII. AUTHORITIES AND REFERENCES**

- A. State of Missouri Emergency Operations Plan  
State of Missouri, Department of Health and Senior Services  
(Emergency Response & Terrorism Plan; Appendix-1/Annex-K)
- B. FEMA, Guide for All-Hazards Emergency Operations Planning
- C. Missouri All Hazards Emergency Planning guidance  
Environmental Standard Operations Procedures Manual
- D. Environmental Health Operational Guidelines Manual (EHOG)
- E. Communicable Disease Investigation Reference Manual (CD Manual)

**State Statute 19CSR20-20.010 to 19CSR20-20.100**

**Executive Order 13295**

**LIST OF APPENDICES**

- Appendix 1 – Primary and Support Responsibilities Chart
- Appendix 2 – Local Hazard Analysis
- Appendix 3 – Mutual Aid Agreements/Memorandum of Understandings
- Appendix 4- MOU Van Buren Youth & Community Center
- Appendix 5- MOU Van Buren R 1 School District
- Appendix 6- Region G Partners
- Appendix 7- Incident Report/ Public Health Threat Analysis Worksheet
- Appendix 8- Hazard ID & Analysis
- Appendix 9- Map of Carter County
- Appendix 10-Map of Carter County 2



**APPENDIX 1 TO THE BASIC PLAN  
PRIMARY AND SUPPORT RESPONSIBILITIES CHART**

<b>FUNCTIONAL ANNEX</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>G</b>	<b>H</b>	<b>I</b>	<b>J</b>	<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>	<b>O</b>	<b>P</b>
	<b>DIRECTION &amp; CONTROL</b>	<b>INFORMATION &amp; COMMUNICATIONS</b>	<b>PUBLIC INFORMATION</b>	<b>SURVEILLANCE</b>	<b>INVESTIGATION</b>	<b>PREVENTION OF TRANSMISSION</b>	<b>ISOLATION/QUARANTINE</b>	<b>MASSES PROPHELYS</b>	<b>MASSES PATIENT CARE</b>	<b>MASSES FATALITY MANAGEMENT</b>	<b>NUCLEAR &amp; CHEMICAL INCIDENTS</b>	<b>FOOD/WATERBORNE OUTBREAKS</b>	<b>VOLUNTEER MANAGEMENT</b>	<b>RECOVERY</b>	<b>PANDEMIC INFLUENZA</b>	<b>SHELTERS</b>
Administrator	P	S	P			S	P	S	S	S	*		S	S	S	S
CD Nurse				S	P	P		P				S			S	S
WIC RN	S	S	S	S	S	S	S	S	*	S					P	S
Assistant Administrator	S	*	S					S	S				*		S	S
Environmental		S	S	S	S	S		S			S	P			S	*
In Home Program Mgr.									*							*
Clerk-Typist II-Imm./Gen. Clerical		P		P				S	S				S		S	S
Regional Epidemiologist			S	S	S	S	S	S	S	S	S				S	S
Financial Coordinator		*		S				S	S				*		S	S
Nursing Staff			S	S	S	S	S	S	S	S					S	S
Carter County EMD		S	S				S	S	S	S	*		S	S	S	
Carter County Presiding Comm.	S	S	S				S	S	S	S	S			S		
Carter County Assessor														*		
Carter County Coroner										P				*	S	
Big Springs Med. Assoc				S			S	S	S						S	

P = PRIMARY RESPONSIBILITY S = SUPPORT RESPONSIBILITY \* = JOINT RESPONSIBILITY

## APPENDIX 2 TO THE BASIC PLAN

### CARTER COUNTY HAZARD RISK ANALYSIS

This appendix is designed to provide an overview of the hazards that could affect Carter County and its municipalities. In general, hazards can be placed into two (2) categories; natural and technological/man-made hazards.

#### NATURAL HAZARDS

##### Tornado

Since Missouri lies in the heart of the nation's "tornado alley", its residents are particularly vulnerable to tornadoes. Seventy percent (70%) of Missouri's tornadoes occur during the months of March, April, May and June, but a tornado can occur at any time of the year.

The majority of tornadoes, along with their parent thunderstorms, move from the southwest to the northeast; however, they have been observed moving in from all directions. Carter County has had 10 tornadoes, resulting in (8) deaths, during the period of 1950-2002 per the National Weather Service.

##### Winter Storms

Although excessive snowfalls with prolonged severe cold, or storm's producing blizzard conditions are rare in Missouri, they do occur. The degree of severity may be localized to a small area due to the combination of climate conditions. A large winter storm accompanied by severe cold could cause numerous secondary hazards such as power failures, fuel shortages, and transportation incidents.

##### Floods

A multitude of Creeks and the Current River are the only significant waterways in Carter County and flooding could potentially occur anywhere along these waterways. Carter County does not participate in the National Flood Insurance Program. The municipalities of Ellsinore and Van Buren do participate. The City of Grandin does not participate. The flood plain maps are kept on file with the Emergency Management Director, City Halls, as well as with the State Emergency Management Agency in Jefferson City.

##### Earthquake

Although earthquakes in the Midwest occur less frequently than on the west coast, the threat of earthquake to Missouri residents is high.

##### Other

Additional natural hazards that could affect Carter County include; drought, high winds, excessive rain, landslides, and lightening storms.

#### TECHNOLOGICAL HAZARDS

Hazardous Materials Carter County is prone to hazardous materials incidents from both

<u>Incidents</u>	fixed facilities and transportation accidents (highway, waterway, and railway and pipelines).
<u>Dam Failures</u>	Carter County is vulnerable to the effects of a levee or dam failure, since fifteen (15) dams have been identified in the county. (See Attachment A for more information.)
<u>Power Failures</u>	The loss or interruption of power can cause significant problems for the businesses and residents of Carter County. Power failure can result from another disaster (i.e., tornado, winter storm) or it can occur on its own.
<u>Transportation</u>	Carter County and its municipalities are vulnerable to the transportation incidents involving highway, rail, water, or air passenger travel. Accidents involving vehicles carrying large number of people (i.e., buses, boats, planes, etc.) can occur on the highways (Missouri Hwy's 21, 103, and US Highway 60), waterways, and in the air or near the ground.
<u>Urban Fire</u>	Fire is the primary cause of accidental death in the United States, surpassing floods, automobile accidents and other disasters. Twenty (20) times more deaths are caused by fire than by floods, hurricanes, tornadoes and earthquakes combined. Fires may be accidental or intentional and have the potential to cause major conflagrations, leading to secondary hazards, such as a hazardous materials incident.
<u>Nuclear Attack</u>	Carter County is not considered a risk area for nuclear attack.

### NATURAL SECURITY HAZARDS

<u>Terrorism</u>	<p>Much of the threat from the proliferation of nuclear and chemical weapons and delivery systems resides in the increased danger that these weapons of mass destruction will find themselves in the hands of a terrorist group or fanatic.</p> <p>Prior to September 11, 2001 the United States had never been the subject of a terrorist assault even though in 1987 there were over 800 international terrorist attacks. Recent Bombings in Oklahoma and New York have changed views on terrorism. As the attacks of September 11, 2001 made starkly evident, terrorists may try to strike at civilian targets such as high-rise buildings, transportation hubs, sporting events, and public spaces such as malls.</p>
<u>Bio-terrorism</u>	<p>In theory, biological weapons could be even more devastating than chemical or nuclear weapons. That's because some of them can spread far beyond the initial point of release through ongoing and multiplying human-to-human transmission. Terrorists might choose to spread an infectious disease by facilitating person-to-person contact, or by deploying agents that have been "weaponized." For example, an infectious disease that normally infects the</p>

skin could be turned into an aerosol or powder form that could then be sprayed over a wider area.

The U.S. Centers for Disease Control and Prevention (CDC) divides biological agents into three categories- A, B, and C- based on their ability to wreak havoc on the population at large. Category A or “high priority” agents are those that can be easily transmitted through human contact, have a high death rate and the potential for a major public health impact, may cause widespread panic and disruption, and require special public health measures. Agents in this category are in alphabetical order:

- Anthrax
- Botulism
- Plague
- Smallpox
- Tularemia (rabbit fever)
- Viral hemorrhagic fevers (such as Ebola virus)

Attachment A to Appendix 2  
To the Basic Plan

**DAM FAILURE**

## **I. DEFINITION**

Dam failure is defined as downstream flooding due to the partial or complete collapse of any impoundment.

## **II. SITUATION**

- A. Dam failure is associated with intense rainfall and prolonged flood conditions. However, dam breaks may also occur during dry periods as a result of progressive erosion or an embankment caused by seepage leaks. An earthquake can also cause dam failure.
- B. The greatest threat from dam breaks is to areas immediately downstream. The most seriously affected population would be those persons located in the potential downstream inundation area as identified by the U.S. Army Corps of Engineers or state agencies.

## **III. DAM INVENTORY**

The Missouri Department of Natural Resources; Dam and Reservoir Safety Division maintains a state-wide inventory of dams. This inventory is also given to the U.S. Army Corps of Engineers and the Federal Emergency Management Agency, who maintain a national inventory of dams. Some of the dams that are on the state list do not meet the national list's criteria, and thus, are not put on the national inventory. Addendums 1 to this attachment show dam information for Carter County that was taken from both the state and national dam inventories.

Addendum 1 to Attachment A to Appendix 2  
To the Basic Plan

**CARTER COUNTY DAM SITES**

	<b>ID</b>	<b>NAME</b>	<b>NORMAL STORAGE (ACRE-FT)</b>	<b>DAM HEIGHT (FEET)</b>	<b>HAZARD</b>
1	MO30025	Elm Springs Lake Dam	150	25	L
2	MO30052	Merrill Lake Dam	215	27	L
3	MO30104	Carnahan Lake Dam	185	21	L
4	MO30349	Neil Land Development)-North	384	32	L
5	MO30351	Neil Land Development)-South	50	30	L
6	MO30353	Lakeview Tree Farm Dam	30	20	S
7	MO31263	Wallace Lake Dam	47	25	H
8	MO31418	Lake Hogan Dam	93	24	S
9	MO31558	Pinewoods Lake	264	32	S
10	MO31715	Hill and Dale Dam West	44	25	S

**APPENDIX 3 TO THE BASIC PLAN**  
**PUBLIC HEALTH**  
**MUTUAL AID AGREEMENT BETWEEN THE**  
**FOLLOWING LOCAL PUBLIC HEALTH AGENCIES**  
**Carter County Health Center and Wayne County Health Center**

**THIS AGREEMENT**, entered into the 7<sup>th</sup> day of March, 2003 by participating parties hereto:

**WHEREAS**, each of the parties hereto desire to furnish mutual aid to each other in the event of a communicable disease outbreak, disaster, or public health emergency, with which neither party might have sufficient personnel and/or supplies to cope: and

WHEREAS, such mutual aid agreements are authorized by Missouri law, (RsMO44.415).

NOW THEREFORE, the parties do mutually agree as follows:

#### **ARTICLE I- TERM**

This agreement shall commence at 12:01 A.M. on March 7, 2003 and continue until terminated in accordance with Article V.

#### **ARTICLE II- SERVICE**

1. In the event of an emergency which requires additional aid of personnel and/or supplies beyond that which either signing party is able to provide for itself, all parties hereto agree that at the request of any party hereto, the others will loan such personnel and/or supplies as the respective officials of the lending county, in their discretion, shall determine can reasonably be spared at the time without placing their own community in jeopardy.
2. Since time is of the essence during emergencies as herein referred to the authority to dispatch personnel and/or supplies or call for aid in accordance with the terms and conditions of this Agreement shall be delegated specifically to chief official or acting chief of the parties hereto.
3. The lending county shall be responsible for the delivery of said personnel and/or supplies to the location specified by the county in need.
4. Upon arrival at said location, the officer in charge of the said personnel and/or supplies shall report to the officer in charge at the location of the disaster who shall assume full charge of all operations at a disaster or emergency location.
5. All personnel and/or supplies loaned hereunder shall be returned upon demand of the lending party or when released upon the cessation of the emergency.

#### **ARTICLE III- PAYMENT**

The purpose of the Agreement is to insure that the lending county is reimbursed for all costs pursuant hereto and assume no additional liabilities as a result of this Agreement provided the responding jurisdiction is reimbursed by same by the United States Federal Emergency Management (FEMA). The lending county shall maintain the records for personnel and/or supplies loaned to the responding jurisdiction for submittal for payment to the responding jurisdiction. Payment shall be due to the lending county within thirty (30) days from receipt of funds from the United States Federal Management Agency (FEMA) by the responding jurisdiction.

#### **ARTICLE IV- WAIVER OF CLAIMS**

Each party hereto waives all claims against the other for compensation for any loss, damage, personal injury or death occurring in consequence of performance of either party, their agents or employee hereunder.

#### **ARTICLE V- TERMINATION**

This Agreement may be terminated by either party upon at least sixty (60) days prior written notice to the other.

#### **ARTICLE VI- INTEGRATION**

This Agreement contains the entire understanding between the parties, and there are no understandings or representations not set forth or incorporated by reference herein. No subsequent modifications of the Agreement shall be of any force of effect unless in writing signed by the parties.

#### **ARTICLE VII- COMPLIANCE WITH LAWS**

In the performance of this Agreement, each party shall comply with all applicable federal, state and local laws, rules, and regulations.

/s/ Deborah S. Sandarciero  
Deborah S. Sandarciero  
Administrator, Carter County Health Center

/s/ Rae Jean Crutchfield  
Rae Jean Crutchfield  
Administrator, Wayne County Health Center

## **APPENDIX 3 TO THE BASIC PLAN MUTUAL AID/MEMORANDUM OF UNDERSTANDING**

### **MUTUAL AID AGREEMENT IN PUBLIC HEALTH EMERGENCY BETWEEN THE FOLLOWING LOCAL PUBLIC HEALTH AGENCIES Carter County Health Center and Reynolds County Health Center**

1. **PUPOSE:** This Mutual Aid Agreement (MAA) is entered into this 29<sup>th</sup> day of July, 2009, between the following Local Public Health Agencies (LPHA) Carter County Health Center and Reynolds County Health Center.
2. **AUTHORITY:** This MAA is voluntarily entered into by the agencies with the approval of the Board of Trustees.
3. **General:**



- a. SCOPE: This MAA provides guidance and documents agreements between each party to provide assistance to one another in the event of a Public Health Emergency that overwhelms the capabilities of any party. This agreement covers response to all emergency situations to include, natural disasters, technological accidents, and terrorist incidents involving weapons of mass destruction and communicable disease outbreaks.
- b. ASSUMPTIONS:
  - 1. Any major Public Health emergency will affect the parties to this agreement. Each party will prioritize its needs and the utilization of available resources. The level of assistance provided to each party will be determined by resources available and to the extent to which the supplier is affected by the disaster.
  - 2. Although the parties commit to providing maximum assistance to the other, each party's primary mission may take precedence over assistance to the other.
  - 3. When any party responds to a request for assistance, the party of whom assistance is requested may petition reimbursement for funds expended.
- c. TYPES OF AID OR SUPPORT: The following types of aid may be exchanged between parties, depending upon the conditions of need and availability, shall include but not limited to:
  - 1. Epidemiological Investigations
  - 2. Potable Water Sampling/Testing
  - 3. Vector Monitoring and Control
  - 4. Environmental Sampling
  - 5. Decontamination Assistance
  - 6. Assisting in disbursement of pharmaceuticals
  - 7. Providing emergency supplies
  - 8. Provide health care and administrative staff

4. RESPONSIBILITIES:

- a. Each party will provide assistance within existing capabilities in accordance with current guidance and directives.
- b. Parties agree to not seek indemnification from each other from any settlement, verdict, or judgment resulting from any claim or lawsuit arising out of each other's performance under this MAA.
- c. Parties will maintain records of all expenditures for reimbursement purpose in accordance with current applicable directives.

5. PROCEDURES FOR REQUESTING SUPPORT: General requesting procedures: When requesting assistance provide:

- 1. Name, Title, Agency, and Phone number of requestor
- 2. Brief assessment of the situation.
- 3. Description of the type and amount of aid needed
- 4. Name, title, location and phone number of the person from your agency that assisting personnel are to report to.
- 1. Initial request for mutual aid may be by telephone, in person, or fax but must be followed by a written request.

6. RESPONSE PROCEDURES:

- a. Response by agencies to incidents will be in accordance with the provisions of this MAA and the capabilities of the agency at that time. The affected agency will notify all parties to this agreement of the incident and request for aid. Each agency will implement their internal procedures, review their current situation, and provide assistance if they are able. The affected party will designate an on site point of contact (POC) for coordination of assistance. Personnel responding to the incident will remain under the control of their own agency.
- b. Support will continue until relieved by a competent State or Federal agency, or until the situation is resolved and the affected agency can assume normal operations.

7. ACCOUNTING AND REIMBURSEMENT:

- a. The agency responding to a request made under the provisions of this agreement will be entitled to reimbursement of expenses incurred as a result of their response.
- b. Billing:
  - 1. The responder will total all debits and expenses as a result of the requested response and submit their expenses to the requester within 15 working days of termination of the response. Periodic payments may be requested if assistance continues for an extended time period. Ensure documentation is substantiated and attached to any claims made. Any request for reimbursement shall comply with applicable laws. This mutual assistance agreement shall not be construed to be a contract for services or for reimbursement of such services.
  - 2. Each agency will keep detailed records of all expenditures incurred as a result of assistance provided.

1. SUPPORT:

- a. Plans: Each agency will make plans, resources lists and guidelines available to the other agency upon request
- b. Exercise: Each agency will notify each other of upcoming exercises and invite each other to participate, observe, and/or critique exercises of mutual interest.

2. PERIOD OF AGREEMENT: This agreement is effective upon date of signature and will remain in effect until all parties agree to amend with mutual consent.

- a. Review and revision: This agreement will be reviewed every three (3) years and revised as needed. Amendments may be submitted for consideration at any time. All changes to this agreement will be circulated among the agencies for review. Agreed changes will then be incorporated into the document and circulated for approval/implementation.
- b. Cancellation: This agreement may be rescinded by mutual consent between the parties. Any party may cancel their part of the agreement by giving at least 180 days written notice to the other parties.

/s/ Deborah S. Sandarciero  
 Deborah S. Sandarciero  
 Administrator, Carter County Health Center

s/s Kathy Zimmerman  
 Kathy Zimmerman

## **APPENDIX 3 TO THE BASIC PLAN MUTUAL AID/MEMORANDUM OF UNDERSTANDING**

### **MUTUAL AID AGREEMENT IN PUBLIC HEALTH EMERGENCY BETWEEN THE FOLLOWING LOCAL PUBLIC HEALTH AGENCIES Carter County Health Center and Shannon County Health Center**

1. **PUPPOSE:** This Mutual Aid Agreement (MAA) is entered into this 8<sup>th</sup> day of September, 2009, between the following Local Public Health Agencies (LPHA) Carter County Health Center and Reynolds County Health Center.
2. **AUTHORITY:** This MAA is voluntarily entered into by the agencies with the approval of the Board of Trustees.
3. **General:**
  - d. **SCOPE:** This MAA provides guidance and documents agreements between each party to provide assistance to one another in the event of a Public Health Emergency that overwhelms the capabilities of any party. This agreement covers response to all emergency situations to include, natural disasters, technological accidents, and terrorist incidents involving weapons of mass destruction and communicable disease outbreaks.
  - e. **ASSUMPTIONS:**

1. Any major Public Health emergency will affect the parties to this agreement. Each party will prioritize its needs and the utilization of available resources. The level of assistance provided to each party will be determined by resources available and to the extent to which the supplier is affected by the disaster.
  2. Although the parties commit to providing maximum assistance to the other, each party's primary mission may take precedence over assistance to the other.
  3. When any party responds to a request for assistance, the party of whom assistance is requested may petition reimbursement for funds expended.
  - f. TYPES OF AID OR SUPPORT: The following types of aid may be exchanged between parties, depending upon the conditions of need and availability, shall include but not limited to:
    1. Epidemiological Investigations
    2. Potable Water Sampling/Testing
    3. Vector Monitoring and Control
    4. Environmental Sampling
    5. Decontamination Assistance
    6. Assisting in disbursement of pharmaceuticals
    7. Providing emergency supplies
    8. Provide health care and administrative staff
4. RESPONSIBILITIES:
- d. Each party will provide assistance within existing capabilities in accordance with current guidance and directives.
  - e. Parties agree to not seek indemnification from each other from any settlement, verdict, or judgment resulting from any claim or lawsuit arising out of each other's performance under this MAA.
  - f. Parties will maintain records of all expenditures for reimbursement purpose in accordance with current applicable directives.
5. PROCEDURES FOR REQUESTING SUPPORT: General requesting procedures: When requesting assistance provide:
1. Name, Title, Agency, and Phone number of requestor
  2. Brief assessment of the situation.
  3. Description of the type and amount of aid needed
  4. Name, title, location and phone number of the person from your agency that assisting personnel are to report to.
  3. Initial request for mutual aid may be by telephone, in person, or fax but must be followed by a written request.
6. RESPONSE PROCEDURES:
- c. Response by agencies to incidents will be in accordance with the provisions of this MAA and the capabilities of the agency at that time. The affected agency will notify all parties to this agreement of the incident and request for aid. Each agency will implement their internal procedures, review their current situation, and provide assistance if they are able. The affected party will designate an on site point of contact (POC) for coordination of assistance. Personnel responding to the incident will remain under the control of their own agency.
  - d. Support will continue until relieved by a competent State or Federal agency, or until the situation is resolved and the affected agency can assume normal operations.

7. ACCOUNTING AND REIMBURSEMENT:

- c. The agency responding to a request made under the provisions of this agreement will be entitled to reimbursement of expenses incurred as a result of their response.
- d. Billing:
  - 1. The responder will total all debits and expenses as a result of the requested response and submit their expenses to the requester within 15 working days of termination of the response. Periodic payments may be requested if assistance continues for an extended time period. Ensure documentation is substantiated and attached to any claims made. Any request for reimbursement shall comply with applicable laws. This mutual assistance agreement shall not be construed to be a contract for services or for reimbursement of such services.
  - 2. Each agency will keep detailed records of all expenditures incurred as a result of assistance provided.
- 1. SUPPORT:
  - c. Plans: Each agency will make plans, resources lists and guidelines available to the other agency upon request
  - d. Exercise: Each agency will notify each other of upcoming exercises and invite each other to participate, observe, and/or critique exercises of mutual interest.
- 4. PERIOD OF AGREEMENT: This agreement is effective upon date of signature and will remain in effect until all parties agree to amend with mutual consent.
- c. Review and revision: This agreement will be reviewed every three (3) years and revised as needed. Amendments may be submitted for consideration at any time. All changes to this agreement will be circulated among the agencies for review. Agreed changes will then be incorporated into the document and circulated for approval/implementation.
- d. Cancellation: This agreement may be rescinded by mutual consent between the parties. Any party may cancel their part of the agreement by giving at least 180 days written notice to the other parties.

/s/ Deborah S. Sandarciero  
Deborah S. Sandarciero  
Administrator, Carter County Health Center

s/s Kandra Counts  
Kandra Counts  
Administrator, Shannon County Health Center

## **Introduction to Appendix 4 to the Basic Plan**

Carter County conducts all business at Carter County Health Center at 1611 Health Center Rd., Van Buren, MO 63965. In the event Carter County Health Center is unable to function at their normal location, the alternate site of operation will be Van Buren Youth & Community Center D Hwy, Van Buren, MO. Refer to MOU between Van Buren Youth & Community Center and Carter County Health Center (Appendix 4 to Annex A)

Appendix 4 to the Basic Plan  
**MEMORANDUM OF UNDERSTANDING**  
Between

**Van Buren Youth & Community Center**  
And  
**Carter County Health Center**

This Memorandum of Understanding (MOU) is entered between the Van Buren Youth & Community Center, and the Carter County Health Center.

**I. Purpose**

- Under a grant from the Missouri Department of Health & Senior Services, the Carter County Health Center is required to plan and prepare for a public health emergency which may result from natural or man made causes. During such an emergency, it may cause the Carter County Health Center to become inaccessible or it may cause an unsafe environment for employees to work. Therefore having an alternate work site put into place will allow the Carter County Health Center to continue operations during an emergency, until the primary facility or another permanent location is available. The Carter County Health Center has concluded that the Van Buren Youth & Community Center possesses the accommodations needed in a facility for which the Carter County Health Center can operate and perform their essential functions to the communities in an emergency. The Van Buren Youth & Community Center desires to be as helpful as possible in the event of a public health emergency and agrees to make a portion of their building available for the use of the Carter County Health Center at the time of the event.

**II. Definitions**

- **Public Health Emergency-** Refers to any event, natural or manmade, that requires immediate public health intervention.
- **Alternate Work Site-** A location where the organization can carry out essential functions when the critical facilities are inaccessible.

### **III. Activation of MOU**

- This agreement will go into effect when:
  - 1) The Administrator of the Carter County Health Center or the Carter County Health Center’s Board of Trustees declares that relocation is necessary.

### **IV. Obligations of the Carter County Health Center**

- 1) The Carter County Health Center will contact the Van Buren Youth & Community Center when an event has occurred that prohibits the normal operations at 1611 Health Center Rd.
- 2) The Carter County Health Center will supply or arrange for all equipment and personnel necessary for staffing.
- 3) The Carter County Health Center will be responsible for disposal of medical waste and disinfection at the facility following its use for the emergency.
- 4) The Carter County Health Center is responsible for the acts and negligence of its employees and its volunteers, under the state and federal law.

### **V. Obligations of the Van Buren Youth & Community Center**

- 1) The Van Buren Youth & Community Center will provide a portion of their building in an emergency which requires Carter County Health Center to relocate, for up to 30 days.
- 2) The Van Buren Youth & Community Center will provide at least one person on-site during the emergency that can provide access to the facility, and/or the security code to allow Carter County Health Center’s staff access to the building.
- 3) The Van Buren Youth & Community Center is responsible for allowing the use of the facility and all utilities (gas, electric, water, and telecommunications.)

### **VI. Term**

- This agreement becomes effective when approved by the governing body of the Van Buren Youth & Community Center and the Carter County Health Center, and shall remain in place unless otherwise agreed upon by both parties. This MOU may be terminated at any time, with thirty (30) days advanced written notification by either party.

### **VII. Liability and Risk of Loss**



- Each party shall assume full liability for its own risk associated with the activities undertaken pursuant to this MOU. The work performed pursuant to this MOU will be performed on a best efforts basis.

**VII. Payment**

- The purpose of the Agreement is to insure that the Van Buren Youth & Community Center is reimbursed for all costs pursuant hereto and assume no additional liabilities as a result of this Agreement. Van Buren Youth & Community Center shall maintain the records for personnel, supplies loaned, or additional utility costs to Carter County Health Center for submittal for payment. Payment shall be due to the Van Buren Youth & Community Center within thirty (30) days from receipt of funds from the United States Federal Management Agency (FEMA) or will be reimbursed by the Carter County Health Center if federal funding is denied

**IX. Compliance**

- Each party shall be responsible for complying with all applicable laws and regulations, including but not limited to, health, safety, and security.

**X. Amendments**

- This MOU may be amended by written agreement of both parties or by their respective designee. The MOU will be reviewed annually and updated as necessary.

**XI. Points of Contact**

**Carter County Health Center**

Deborah Sandarciero  
 Administrator Carter County Health Center  
 Office Phone: 573-323-4413  
 Cell Phone: 573-576-5532

Cathy Ball, RN  
 Carter County Health Center's RN Supervisor  
 Office Phone: 573-323-4413  
 Cell Phone: 573-944-0412

**Van Buren Youth & Community Center**

Cathy Alford  
 Executive Director  
 Office Phone: 573-323-8958

**XII. Authorization**

The persons executing this MOU on behalf of their respective entities hereby represent and warrant that they have the right, power, legal capacity, and appropriate authority to enter into this MOU on behalf of the entity for which they sign.



Appendix 5 to the Basic Plan  
**MEMORANDUM OF UNDERSTANDING**  
Between

**Van Buren R 1 School District**

And

**Carter County Health Center**

This Memorandum of Understanding (MOU) is entered between the Van Buren R 1 School District, and the Carter County Health Center for use of facilities in the event of a mass medical emergency.

**Carter County Health Center and Van Buren R 1 School District agree that:**

In the event of a mass medical emergency in Carter County, health and medical infrastructure and associated resources will be quickly committed to providing the necessary treatment and/or prophylaxis to effectively respond by request of the Emergency Management Director of Carter County. Resources from Region G, the state, federal, and private sector will be mobilized and deployed to augment local medical and health resources as soon as possible. Such an event may require a facility to support the activation of a mass prophylaxis site to dispense needed medication to the citizens of Carter County. The Mass Prophylaxis Site (MPS) will serve as a site where supportive care and medication dispensing can be provided to victims of a large-scale medical event.

**Carter County Health Center and Van Buren R 1 School District enter into this partnership as follows:**

1. Facility Space: Carter County Health Center accepts designation of Van Buren R 1 School District located at 906 Broadway St. as an MPS, in the event a need should arise.
2. Use of the Facility: Request to use facility as an MPS will occur as soon as possible by the Carter County Health Center Administrative Staff, through the local Emergency Operations Center. Designation and use of Van Buren R 1 School District will be mutually agreed upon by all parties to this agreement.
3. Modification or Suspension of Normal Facility Business Activities: Van Buren R 1 School District agrees to alter or suspend normal operations in support of the MPS as needed.

4. Use of Facility Resources: Van Buren R 1 School District agrees to authorize the use of facility equipment such as: buildings, communications equipment, computers, internet services, copying equipment, fax machines, etc. Facility resources and associated systems will only be used with facility management authorization and oversight to include appropriate orientation training as needed.
5. Contact Information: Van Buren R 1 School District will provide the Carter County Health Center the appropriate 24 hour/7day contact information and update this information as necessary.

### **Activation of MOU**

- This agreement will go into effect when:
  - 2) The Administrator of the Carter County Health Center or the Carter County Emergency Management Director declares that an MPS is necessary.

### **Obligations of the Carter County Health Center**

- 5) The Carter County Health Center will contact the Van Buren R 1 School District when a MPS is needed within Carter County and cannot be accomplished at 1611 Health Center Rd.
- 6) The Carter County Health Center will supply or arrange for all equipment and personnel necessary for staffing.
- 7) The Carter County Health Center will be responsible for disposal of medical waste and disinfection at the facility following its use for the emergency.
- 8) The Carter County Health Center is responsible for the acts and negligence of its employees and its volunteers, under the state and federal law.

### **Obligations of the Van Buren R 1 School District**

- 4) The Van Buren R 1 School District will provide a portion of the Van Buren High School building to accomplish the distribution of mass prophylaxis to the public.
- 5) The Van Buren R 1 School District will provide at least one person on-site during the emergency that can provide access to the facility, and/or a key to allow Carter County Health Center's staff access to the building.
- 6) The Van Buren R 1 School District is responsible for allowing the use of the facility and all utilities (gas, electric, water, and telecommunications.).

### **Term**

- This agreement becomes effective when approved by the governing body of the Van Buren R 1 School District and the Carter County Health Center, and shall remain in place unless otherwise agreed upon by both parties. This MOU may be terminated at any time, with thirty (30) days advanced written notification by either party.

## **Liability and Risk of Loss**

- Each party shall assume full liability for its own risk associated with the activities undertaken pursuant to this MOU. The work performed pursuant to this MOU will be performed on a best efforts basis.

## **Payment**

- The purpose of the Agreement is to insure that the Van Buren R 1 School District is reimbursed for all costs pursuant hereto and assume no additional liabilities as a result of this Agreement. Van Buren R 1 School District shall maintain the records for personnel, supplies loaned, or additional utility costs to Carter County Health Center for submittal for payment. Payment shall be due to the Van Buren R 1 School District within thirty (30) days from receipt of funds from the United States Federal Management Agency (FEMA) or will be reimbursed by the Carter County Health Center if federal funding is denied

## **Compliance**

- Each party shall be responsible for complying with all applicable laws and regulations, including but not limited to, health, safety, and security.

## **Amendments**

- This MOU may be amended by written agreement of both parties or by their respective designee. The MOU will be reviewed annually and updated as necessary.

## **Points of Contact**

### **Carter County Health Center**

Deborah Sandarciero  
Administrator Carter County Health Center  
Office Phone: 573-323-4413  
Cell Phone: 573-576-5532

Cathy Ball, RN  
Carter County Health Center's RN Supervisor  
Office Phone: 573-323-4413  
Cell Phone: 573-944-0412

### **Van Buren R 1 School District**

Sonia Kussner  
Superintendent  
Office Phone: 573-323-4281 ext. 7

## **Authorization**

- The persons executing this MOU on behalf of their respective entities hereby represent and warrant that they have the right, power, legal capacity, and appropriate authority to enter into this MOU on behalf of the entity for which they sign.

**Execution**

/s/ Sonia Kuessner                      Superintendent                      10/24/12  
Van Buren R 1 School District                      Title                      Date

/s/ Deborah Sandarciero                      Administrator                      10/24/12  
Carter County Health Center                      Title                      Date

<b>Region G Partners</b>			
Wright County Health Department	417-741-7791 ext. 1	417-259-0841 cell	Tracy Hardcastle, Admin <a href="mailto:hardct@lpha.mopublic.org">hardct@lpha.mopublic.org</a>
Douglas County Health Department	417-683-4111	417-683-4174	Valerie Reese, Admin <a href="mailto:valerier@dchd.org">valerier@dchd.org</a>
Howell County Health Department	417-256-1179	417-259-7078	Chris Gillam, Admin <a href="mailto:gillic@lpha.mopublic.org">gillic@lpha.mopublic.org</a>
Oregon County Health Department	417-778-6826	417-778-7450 870-219-5298 (cell)	Shiela Russell, Admin <a href="mailto:russes@lpha.mopublic.org">russes@lpha.mopublic.org</a>
Ozark County Health Department	417-679-3828	417-679-3334	Rhonda Suter, Admin <a href="mailto:suter@lpha.mopublic.org">suter@lpha.mopublic.org</a>
Shannon County Health Department	573-226-3240	573-226-3914	Kandra Counts, Admin <a href="mailto:countk@lpha.mopublic.org">countk@lpha.mopublic.org</a>
Texas County Health Department	417-967-5700	417-967-4131	Jackie Smith, Admin <a href="mailto:smithj3@lpha.mopublic.org">smithj3@lpha.mopublic.org</a>
Reynolds County Health Department	573-648-2510	573-648-2498	Francie Vermillion, Admin <a href="mailto:vermif@lpha.mopublic.org">vermif@lpha.mopublic.org</a>

Appendix 7 to the Basic Plan  
**INCIDENT REPORT**  
**PUBLIC HEALTH TREAT ANALYSIS WORKSHEET**

Type of Incident \_\_\_\_\_

Number of Persons Immediately affected \_\_\_\_\_

Name of Person Calling \_\_\_\_\_ Contact Phone # \_\_\_\_\_

**Areas at Risk**

\_\_\_\_\_ Van Buren                  \_\_\_\_\_ Ellsinore                  \_\_\_\_\_ Grandin

\_\_\_\_\_ Hunter                  \_\_\_\_\_ Eastwood                  \_\_\_\_\_ Fremont

**WEATHER**

Wind directions and speed \_\_\_\_\_

Temperature \_\_\_\_\_

Forecast next 12 hours \_\_\_\_\_

**PUBLIC HEALTH PRIORITY**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**STAFF AVAILABLE**

Communicable Disease \_\_\_\_\_

Nurse staff \_\_\_\_\_

Administrator \_\_\_\_\_

IO \_\_\_\_\_

Environmental Public Health Specialist \_\_\_\_\_

Appendix 8 to the Basic Plan

**NATURAL HAZARD IDENTIFICATION & ANALYSIS**

Hazards	Locations Previously Damaged	Frequency of Damage	Severity (i.e., damages relative to that	Probability (i.e., likelihood that this hazard	Ranking of Adverse Impact on Community
---------	------------------------------	---------------------	---	---	--

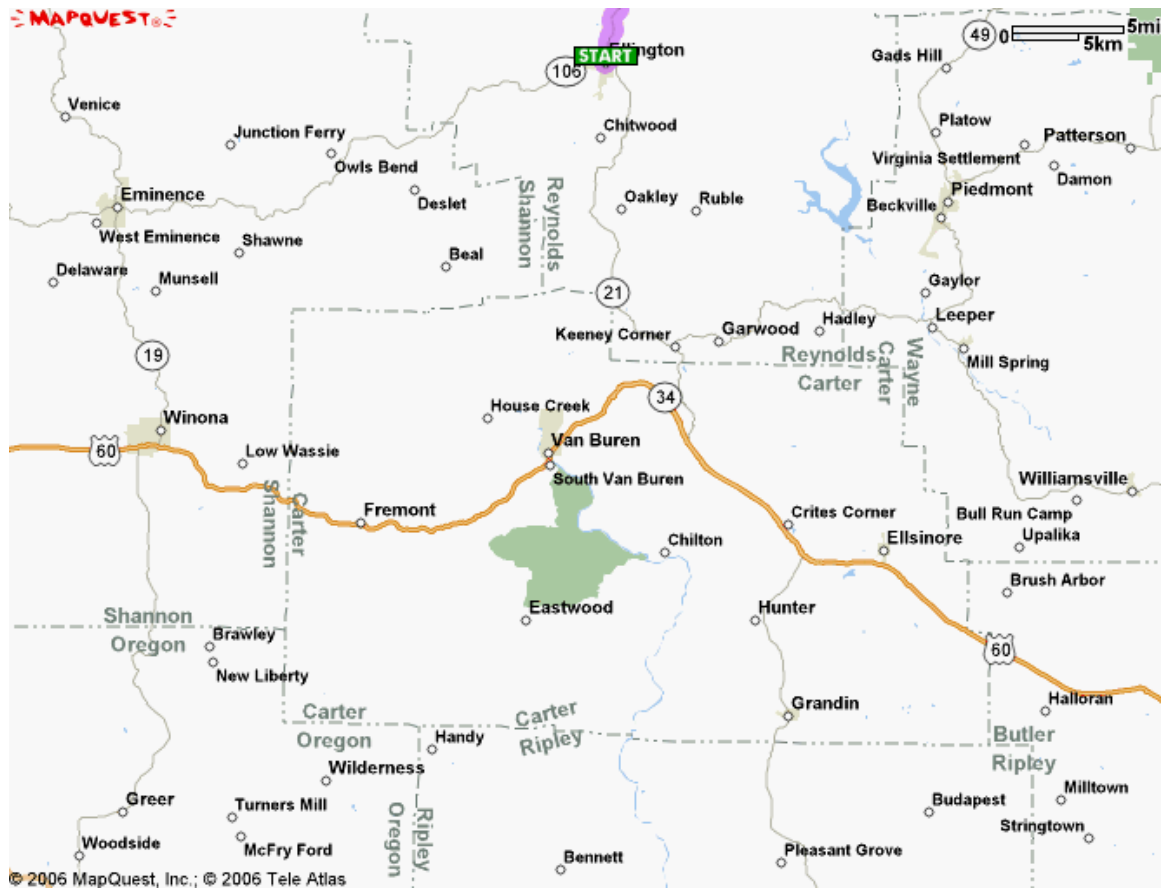


			of other hazards)	will strike community)	
<b>Tornado/Severe Thunderstorms</b> (Downbursts, Lighting, Hail, Heavy Rain, & Wind)	Entire County	Medium	High	High	Medium
<b>Floods</b> (Riverine & Flash Floods)	Highway 60 Highway 21	High	Medium	High	Medium
<b>Severe Winter Storms</b> (Snow, Ice, & Extreme Cold)	Entire County	Low	Medium	High	Low
<b>Drought</b>	Entire County	Medium	Medium	Medium	Medium
<b>Heat Wave</b>	Entire County	Low	Low	High	Low
<b>Earthquake</b>	Entire County	Low	Medium	High	High
<b>Dam Failure</b>	N/A	Low	Low	Medium	High
<b>Urban Fire/Wildfire</b>	Various	Low	Low	Medium	Low
Ozark Foothills Regional Planning Commission- Carter County Natural Hazard Mitigation Plan 2004					

Appendix 9 to the Basic Plan  
MAP OF CARTER COUNTY



**Appendix 10 to the Basic Plan**



## **ANNEX A**

### **DIRECTION AND CONTROL**

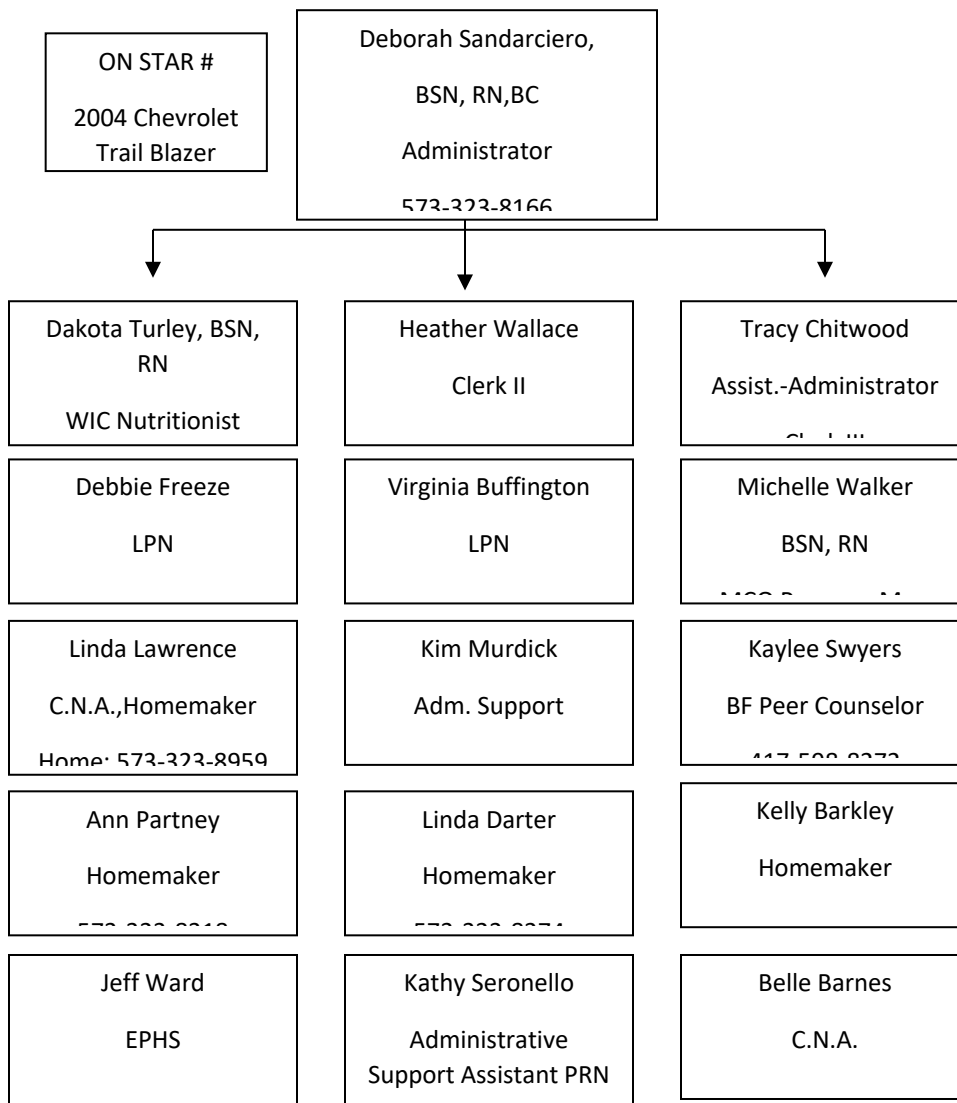
- 1. PURPOSE:** To establish a capability for the Carter County Health Center, in coordination with government officials and other outside agencies, to direct emergency operations during a local public health emergency.
- 2. ORGANIZATION AND RESPONSIBILITIES:**
  - A.** The CCHC Administrator retains control of all public health emergencies, in her absence the Assistant Administrator will assume control. If both the Administrator and the Assistant Administrator are unavailable, the Financial Coordinator will assume control.
  - B.** Appendix 1 to this annex describes actions to be taken by the CCHC, using the Homeland Security Advisory System.
  - C.** The CCHC will, when responding use the same Incident Command System as the Carter County Emergency Management Agency.
  - D.** Appendix 2 to this annex contains the call down lists.
  - E.** Operations will be conducted out of the CCHC.

### **APPENDIX 1 TO ANNEX A**

## **CCHC ACTIVITIES CORRESPONDING TO THE HOMELAND SECURITY ADVISORY SYSTEM**

LOW (Green)	Maintain routine work and staff schedules.
GUARDED (Blue)	Maintain routine work and staff schedules. Brief all employees of increase in Alert level
ELEVATED (Yellow)	Brief all employees of increased alert level Ensure HASS is initiated Review recall rosters to ensure accuracy Unless directed otherwise, maintain routine work and staff schedules If necessary institute mail screening procedures (see TAB A)
HIGH (Orange)	Complete actions from lower levels Step up HASS collection Institute mail-screening procedures Modify staff and work schedules as needed Assure key staff have made arrangements for family care/personal issues in the event of extended service Run tests on all communication systems
SEVERE (Red)	Complete actions from lower levels Activate this plan Maintain contact with EMA

### **APPENDIX 2 TO ANNEX A CCHC INTERNAL RECALL ROSTER**



REVISED 101018

This list is used for both recall emergencies, and to suspend operations due to inclement weather. The recall will be initiated by the Administrator. Each person will contact the person below them, if no answer skip that person and continue down the list. When arriving at the office give the name of the persons not contacted to the administrator.

APPENDIX 3 TO ANNEX A

CHAIN OF COMMAND FOR CARTER COUNTY HEALTH CENTER

1. **Debbie Sandarciero, Administrator**
2. **Michelle Walker, RN Supervisor**
3. **Tracy Chitwood, Clerk III Assistant Administrator**

CARTER COUNTY HEALTH CENTER EMERGENCY NUMBERS

1611 Health Center Rd.

(i) VAN BUREN, MO 65965

PHONE: 573-323-4413 or 573-323-4627

NAME	TITLE	HOME PHONE	CELL PHONE	E-MAIL
Debbie Sandarciero	Administrator	573-323-8166	573-576-5532 or 573-300-1832	<a href="mailto:dandarciero@cartercountyhealth.org">dandarciero@cartercountyhealth.org</a>
Michelle Walker	RN Supervisor		573-718-1819	<a href="mailto:mwalker@cartercountyhealth.org">mwalker@cartercountyhealth.org</a>
Tracy Chitwood	Clerk III	573-323-8446	573-351-9200	<a href="mailto:tchitwod@cartercountyhealth.org">tchitwod@cartercountyhealth.org</a>
Autumn Grim	Senior Epi Specialist	573-651-5260	573-576-3662	<a href="mailto:Autumn.Grim@health.mo.gov">Autumn.Grim@health.mo.gov</a>
<b>Missouri Department of Health and Senior Services, Center for Emergency Response and Terrorism</b> 1-800-392-0272 or 1-573-526-4768				
<b>Missouri State Public Health Laboratory</b> 1-573-751-3334 (M-F, 8 a.m. – 5 p.m.) Jefferson City, Missouri 1-417-864-1670 (M-F, 8 a.m. – 5 p.m.) Springfield, Missouri				

## APPENDIX 4 TO ANNEX A

Purpose: To identify response actions taken at various levels of a WMD (Weapons of Mass Destruction) event.

1. The event will be investigated by the Carter County EOP Director, and whom ever he delegates to.
2. When it is necessary to elevate to a higher level, the Carter County EOP Director and/or his designees will refer to the DHSS Integrated Emergency Response/Terrorism Planning Model (bull's eye), see Appendix 5 to Annex A. The DHSS phone number is 573-526-4768. Website: [www.dhss.state.mo.us](http://www.dhss.state.mo.us) and the emergency phone number which is operational 24hours a day/7days a week is 1-800-392-0272.
3. The following agencies will be notified:
  - a. Sheriff's office
  - b. CERT
  - c. All area physicians
  - d. EMS
  - e. District office

## Appendix 5 to Annex A



## PERSONNEL WITH SPEICALIZED TRAINING

The following list is a list of personnel that have received specialized training:

### **Epi training and level:**

#### **Introduction to Epidemiology Module 1-5 and Principles of Epidemiology:**

Deborah Sandarciero, BSN,RN,BC

Dakota Turley, RN

Virginia Buffington, LPN

### **Sanitation Training:**

Jeff Ward, Environmental Specialist-Contract Staff

### **Incident Command Training:**

Deborah Sandarciero, IMS-EOC Training

### **ICS 100**

Deborah Sandarciero, BSN, RN,BC-December 2005

Dakota Turley, RN-March 2009

Heather Towner, Clerk II.-March 2007

Tracy Chitwood, Clerk III- January 2007

Virginia Buffington, LPN-June 2010

Erica DeWolf, June 2010

### **IS 100 a**

Tracy Chitwood, March 2010

### **ICS 200**

Deborah Sandarciero, BSN, RN,BC-December 2005

Dakota Turley, RN -March 2009

Heather Towner, Clerk II.-March 2007

Tracy Chitwood, Clerk III- January 2007

### **ICS 300**

Deborah Sandarciero, BSN, RN,BC- October 2006

Tracy Chitwood, Assistant Administrator- June 2018

Michelle Walker- June 2018

### **ICS 400**

Deborah Sandarciero, BSN, RN, BC-January 2007

Tracy Chitwood- June 2018

Michelle Walker- June 2018

### **NIMS- 700**

Deborah Sandarciero, BSN, RN,BC- September 2005

Dakota Turley, RN-March 2009

Heather Towner, Clerk II- January 2006

Tracy Chitwood, Clerk III- December 2005

Virginia Buffington, LPN June 2010  
Erica DeWolf, June 2010

**NIMS- 800**

Deborah Sandarciero, BSN, RN,BC- September 2005  
Dakota Turley, RN-December 2005  
Heather Towner, Clerk II -January 2006  
Tracy Chitwood, Clerk III- December 2005

**IS-808**

Cathy Ball, RN July 2010  
Virginia Buffington, LPN June 2010  
Tracy Chitwood- June 2010  
Dakota Townsley, RN June 2010  
Erica DeWolf, July 2010

**IS-0022 (Are You Ready? An In-depth Guide to Citizen Preparedness)**

Deborah Sandarciero, BSN, RN,BC- February 2011  
Dakota Turley, RN- February 2011  
Virginia Buffington, LPN- February 2011  
Heather Towner, Clerk II - February 2011  
Tracy Chitwood, Clerk III- February 2011

**FEMA Independent Study-IS -00366**

(Planning for the Needs of Children in Disasters)  
Virginia Buffington, LPN -January 2012  
Tracy Chitwood-January 2012  
Erica DeWolf-January 2012  
Olivia Price-January 2012  
Deborah Sandarciero, RN-January 2012  
Kathleen Seronello-January 2012  
Heather Towner-January 2012  
Dakota Turley, RN-January 2012  
Heather Towner- February 2012  
Mary Waggoner- February 2012

**SNS Mohsaic**

Erica DeWolf April 2010, September 2012  
Heather Towner April 2010, September 2012

**FEMA-ICS 317 – Introduction to Community Emergency Response Team**

Deborah Sandarciero, BSN, RN,BC-December 2005

**SEMA Community Mass Care – West Plains February 2007**

Deborah Sandarciero, BSN, RN,BC

**SEMA Emergency Planning- Special Needs Populations-Springfield-August 2007**

Deborah Sandarciero, BSN, RN,BC

**SEMA EOC Operations and Management- Springfield April 2008**

Deborah Sandarciero, BSN, RN,BC

**SEMA Leadership and Influence/Decision Making – West Plains August 2008**

Deborah Sandarciero, BSN, RN,BC

**SEMA Exercise Design and Evaluation – Springfield September 2008**

Deborah Sandarciero, BSN, RN,BC

**SEMA Rapid Assessment Workshop – Springfield September 2009**

Deborah Sandarciero, BSN, RN,BC

**FEMA Emergency Planning IS-235- April 2010**

Deborah Sandarciero, BSN, RN,BC

**FEMA Multi-Hazard Emergency Planning for Schools IS 362- April 2010**

Deborah Sandarciero, BSN, RN,BC

**FEMA Principles of Emergency Management- August 2009**

Deborah Sandarciero, BSN, RN,BC

**FEMA Effective Communication IS 242- April 2010**

Deborah Sandarciero, BSN, RN,BC

**FEMA Anticipating Hazardous Weather & Community Risk IS 271- April 2010**

Deborah Sandarciero, BSN, RN,BC

**FEMA Developing & Managing Volunteers July 2009**

Deborah Sandarciero, BSN, RN,BC

**SEMA WEM: Recovery from Disaster:  
The Local Government Role- Rolla March 2009**

Deborah Sandarciero, BSN, RN,BC

**SEMA Decision-making & Problem Solving- West Plains April 2008**

Deborah Sandarciero, BSN, RN,BC

**SEMA ICS/EOC Interface- April 2010 Springfield, MO**

Deborah Sandarciero, BSN, RN,BC

**SEMA Mitigation Planning- Jefferson City May 11-12, 2010**

Deborah Sandarciero, BSN, RN,BC

**SEMA EOC Management & Operations- April 2008 Springfield, MO**

Deborah Sandarciero, BSN, RN,BC

**FEMA Emergency Management Institute- Professional Development Series**

Deborah Sandarciero, BSN, RN,BC –April 2010

**FEMA Emergency Management Institute- Advanced Professional Series**

Deborah Sandarciero, BSN, RN,BC –April 2011

**MOHSIS**

Heather Towner, Clerk II

**Hazardous Materials:**

Deborah Sandarciero- Public Health Food Incident, Chemical and Radiological Testing

**MOSAIC**

Heather Towner, Clerk II

**Vital Records:**

Heather Towner, Clerk II

Tracy Chitwood, Clerk III

**Nursing:**

Deborah Sandarciero, BSN, RN,BC

Dakota Turley, RN

Michelle Walker, RN

Virginia Buffington, LPN

Debbie Freeze, LPN

Belle Barnes, C.N.A.

**CPR**

Deborah Sandarciero, BSN, RN,BC

Dakota Turley, RN

Heather Towner, Clerk II

Erica DeWolf, Clerk II

Tracy Chitwood, Clerk III

Virginia Buffinton, LPN

Linda Darter, Homemaker

Linda Lawrence, Homemaker

Belle Barnes, Homemaker

**CERT: Basic Class**

Deborah Sandarciero, BSN, RN,BC

Dakota Turley, RN

Heather Towner, Clerk II

Tracy Chitwood, Clerk III

**Risk Communication- Basic**

Deborah Sandarciero, BSN, RN,BC

**Risk Communication- Advanced**

Deborah Sandarciero, BSN, RN,BC

**HAN Training** -Deborah Sandarciero- February 2012

**IS-042 Social Media in Emergency Management**

Deborah Sandarciero- April 2013

Tracy Chitwood- April 2013

Virginia Buffington- April 2013

Erica DeWolf- May 2013

**IS-520 Introduction to Continuity of Operations Planning for Pandemic Influenzas**

Deborah Sandarciero- December 2013

Virginia Buffington-January 2014

Tracy Chitwood-December 2013

Erica DeWolf- January 2014

Heather Towner-April 2014

Michelle Walker-December 2013

**Web EOC Operations Training**

Deborah Sandarciero- August 2014

**IS-368 Including People with Disabilities & Others with Access & Functional Needs in Disaster Operations**

Deborah Sandarciero- January 2015

Virginia Buffington-February 2015

Tracy Chitwood-February 2015

Erica DeWolf-February 2015

Dakota Turley-January 2015

Michelle Walker-February 2015

**IS- 394.a Protecting Your Home or Small Business from Disaster**

Virginia Buffington- August 2017

Tracy Chitwood- July 2017

Debbie Freeze- July 2017

Deborah Sandarciero- March 2018

Kathleen Seronello-August 2017

Dakota Turley- August 2017

Heather Wallace-March 2018

**Disaster Preparedness for Hospitals and Healthcare Organization Within the Community Infrastructure**

Tracy Chitwood- September 2018

Michelle Walker-September 2018

**IS- 909 Community Preparedness Implementing Simple Activities for Everyone December 2017**

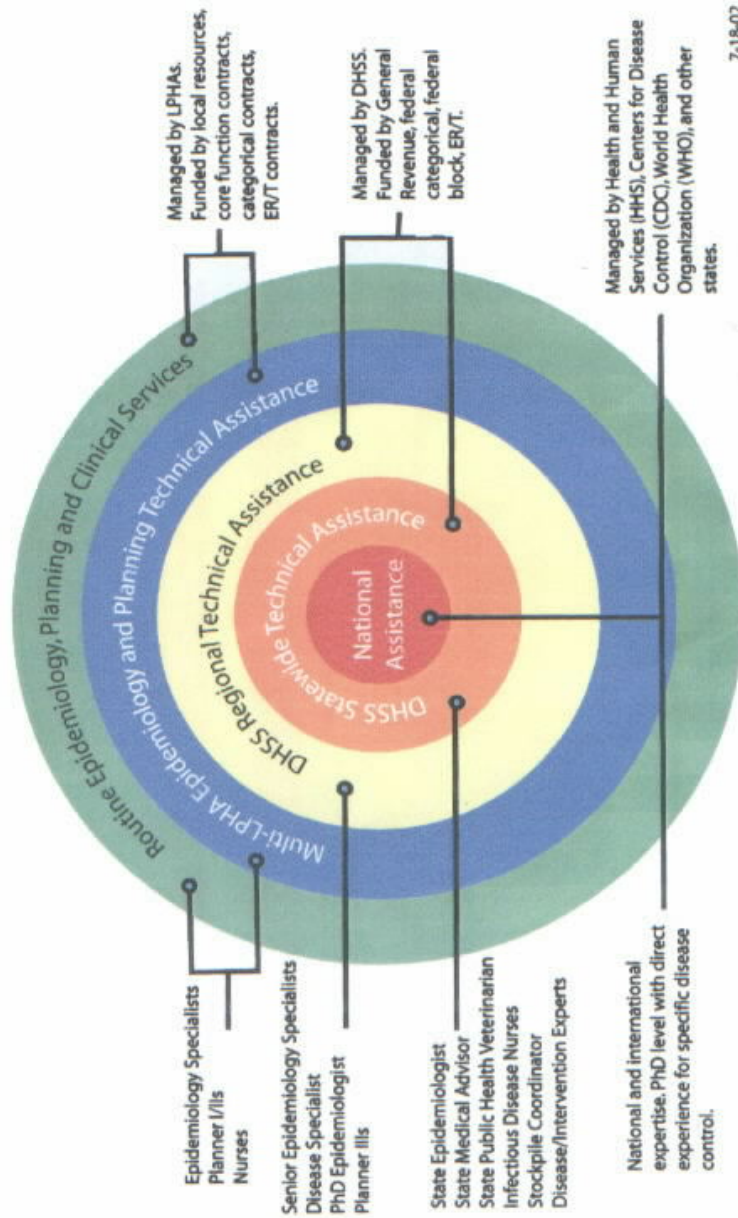
Tracy Chitwood- December 2017

Debbie Freeze-January 2018  
Deborah Sandarciero-March 2018  
Dakota Turley- December 2017  
Heather Wallace-January 2018

**WEBEOC Operator Training**  
Tracy Chitwood- September 2018

# Appendix 6 To Annex A

## Integrated Emergency Response/Terrorism Planning Model



7-18-02  
 Prepared by: DHSS Center for Emergency Response and Terrorism  
 Phone: 573-526-4768 Website: www.dhss.state.mo.us  
 For emergencies: 800-392-0272 (24 hours a day/7 days a week)

Missouri Department of Health and Senior Services  
 Emergency Response and Terrorism Plan - Page K.1.2(17)

## ANNEX B

## **INFORMATION TECHNOLOGY AND COMMUNICATIONS**

**PURPOSE:** To provide information technology and communications resources to public health staff and others during a local public health emergency.

### **ORGANIZATION AND RESPONSIBILITIES:**

- A.** CCHC will communicate during an emergency using existing phones, fax, and e-mail devices.
- B.** During a public health emergency, information for the CCHC staff will be disseminated through normal channels.
- C.** During a public health emergency, it may be necessary to increase our communications capability. If all other means of communication are exhausted contact the Carter County Emergency Management agency, 573-323-4510 (through the Carter County Sheriff's Office) and request for communications support.
- D.** See Appendix 1 to this annex for important phone and contact numbers.

## **APPENDIX 1 TO ANNEX B NURSING HOME AND RESIDENTIAL CARE FACILITIES**



<b>NAME</b>	<b>PHONE</b>	<b>ADDRESS</b>	<b>NO. BEDS</b>	<b>OCCUPIED BEDS</b>
Riverways Manor Nursing Home	573-323-4282 F:573-323-	403 Watercress Rd. Van Buren, MO	60	
Fremont Residential Care	573-251-3555 F: 573-251-2589	Hwy. 60 E Fremont, MO	45	

### PHYSICIANS

<b>NAME</b>	<b>PHONE</b>	<b>ADDRESS</b>	<b>TYPE</b>
Dr. Tammy Lindsay	573-323-4253	402 Main Street	General Practice
Dr. Michael Moore	573-323-4253	402 Main Street	General Practice
Dr. Pryor	573-323-4287 F: 573-3238120	511 West Elsie	Dentistry

### PHARMACIES

<b>PHARMACY</b>	<b>PHONE</b>	<b>ADDRESS</b>
Van Buren Drug	573-323-8159	406 Main St.

### LOCAL CONTACTS

<b>AGENCY</b>	<b>PHONE</b>
Van Buren Fire Department	573-323-4567
Van Buren Police Department	573-323-4394
Ellsinore Police Department	573-323-4510
Carter County Sheriff's Office (Rick Stephens)	573-323-4510
Van Buren Ambulance Service	573-323-8323
Ellsinore/Hunter Ambulance Service	573-322-5555
MO State Highway Patrol	1-800-525-5555
Environmental Protection Agency	(913) 551-7221
Missouri Dept of Natural Resources	(573) 634-2436
Ozark National Scenic Riverways	573-323-4236
Carter County Family Service Office	573-323-4201
Carter County Road Dept (Ellsinore)	573-322-5350
Carter County Road Dept (Van Buren)	573-323-4519
Carter County Emergency Director –Justin Eudaley	573-429-3550
Carter County Coroner (Eric McSpadden)	573-323-4545
Larry Johnson, Superintendent Ozark Nat. Sci. Riv.	573-323-4236
Dawn Rector, Carter County Family Service Office	573-300-6726 (cell)
Conservation Agent: David Baldrige	573-323-
Van Buren R 1 Superintendent-Jeff Davis	573-783-9579
Ellsinore R 2 Superintendent- Dr. Richard Sullivan	573-322-5653

## 24-HOUR CONTACTS

<b>AGENCY</b>	<b>WEB ADDRESS</b>	<b>24 HOUR NUMBER</b>
MO Dept of Health and Senior Services	<a href="http://www.dhss.state.mo.us">www.dhss.state.mo.us</a>	800-392-0272
MO Center for Emergency Response and Terrorism	<a href="http://www.dhss.state.mo.us">www.dhss.state.mo.us</a>	573-526-4768
State Public Health Lab	<a href="http://www.dhss.state.mo.us">www.dhss.state.mo.us</a>	573-751-3334
State Emergency Management Agency	<a href="http://www.sema.state.mo.us">www.sema.state.mo.us</a>	573-751-2748
Department of Natural Resources	<a href="http://www.dnr.state.mo.us">www.dnr.state.mo.us</a>	573-634-2436
Troop A Highway Patrol	<a href="http://www.mshp.state.mo.us">www.mshp.state.mo.us</a>	816-524-1407
Centers for Disease Control	<a href="http://www.cdc.gov">www.cdc.gov</a>	404-639-2888
Federal Emergency Management Agency	<a href="http://www.fema.gov">www.fema.gov</a>	816-283-7060
Environmental Protection Agency	<a href="http://www.epa.gov">www.epa.gov</a>	913-281-0991
Food and Drug Administration	<a href="http://www.fda.gov">www.fda.gov</a>	913-752-2100
FBI	<a href="http://www.fbi.gov">www.fbi.gov</a>	816-512-8200
Nuclear Regulatory Commission	<a href="http://www.nrc.gov">www.nrc.gov</a>	301-415-5385
USA Medical Research Institute of Infectious Diseases (USAMRIID)	<a href="http://www.usamriid.army.mil">www.usamriid.army.mil</a>	888-872-7443

### Appendix 2 to Annex B

At the present time Carter County Health Center is equipped with:

- Incoming phone lines: 573-323-4413, 573-323-4271, 573-323-4627 and 1-800-869-4086

- Cell Phone: 573-300-1832
- Fax Machines: 573-323-8489 and 573-323-8703
- Internet Access: Century Tel (DSL)
- Intranet Access: DHSS
- Computer Stations: 9
- Lap Top Computers: 8
- Handheld radios: 4
- Other equipment or lines: Proxima Projector
- Emergency Scanner/Emergency Weather Radio

### **Appendix 3 to Annex B**

#### **AMATEUR RADIO OPERATORS LIST**

Carter County has an amateur radio club in the county, Current River Amateur Radio Group. The group meets monthly at the Winona Fire House on the second Friday of the month. Current

Officers are: President- Dave Hannigan, Vice-President- rob Cassie, Secretary/Treasurer- Bob Foard. The purpose of the club is to promote amateur radio service and strive for radio communication excellence.

NAME	CALL SIGN	STATUS	CONTACT INFORMATION	EMAIL ADDRESS
Ray Brookover	ABOJW	Extra X VE	Rt. 11, Box 705 Poplar Bluff, MO 63901 573 785-9244	<a href="mailto:brookover@imsinternet.net">brookover@imsinternet.net</a>
Sam Christy	WIKSU	Extra X VE	2012 Snider Rd., Poplar Bluff, MO 63901 573-686-5700	<a href="mailto:schristy@semo.net">schristy@semo.net</a>
Michael Duncan	KOMED	Extra X VE	PO Box 1114 Van Buren, Mo 63965 573-323-4647	None
Clark Garcia	WOMEX	Extra X VE	294 Cty. Rd. 464 Poplar Bluff, MO 63901 573-686-3894	<a href="mailto:cgracia@semo.net">cgracia@semo.net</a>
Dave Hannigan	KNOD	Extra X VE	PO Box 133 Eminence, MO 65466	<a href="mailto:davedbee@semo.net">davedbee@semo.net</a>
Mark Henry	WAOWIK	Extra X VE		
Carl Hert	NOKUQ	Extra	RR 2, Box 2885 Piedmont, MO 63957 573-223-2388	None
Michael Spacek	ABOTT	Extra X VE	1425 Hwy 17 Summersville, MO 65571 573-932-5330	<a href="mailto:abe@fidnet.com">abe@fidnet.com</a>
Jack Triplett	KGOMI	Extra X VE	RR 1, Box 116 Birch Tree, MO 65438 573-292-3150	<a href="mailto:tripanna@semo.net">tripanna@semo.net</a>
Larry Wilson	KORWL	Extra X VE	8479 Private Rd 6895 West Plains, MO 417-257-1417	<a href="mailto:korwl@townsq.com">korwl@townsq.com</a>
Ralph Case	NOIBV	General VE	Rt. 1, Box 92 Van Buren, MO 63965 573-323-8595	<a href="mailto:rcase@simple.net">rcase@simple.net</a>
Gene Caulk	KCOSHG	General X	650 County Rd. 425 Poplar Bluff, MO 63901	None
Carol Cureton	WOOYL	General X VE	2876 Windwood Dr. Poplar Bluff, MO 63901 573-718-2296	<a href="mailto:ccureton@semo.net">ccureton@semo.net</a>
Bob Foard	N5Wnf	General X VE	PO Box 69 Van Buren, MO 63965 573-323-4827	<a href="mailto:bobanoe@aol.net">bobanoe@aol.net</a>
Dick Hern	N6IUK	General X	Rt. 2, Box 2681 Ellsinore, MO 63937 573-322-5516	<a href="mailto:N6iuk@semo.net">N6iuk@semo.net</a>
Jean Hern	KCOQFA	Novice	Rt. 2, Box 2681 Ellsinore, MO 63937 573-322-5516	<a href="mailto:N6iuk@semo.net">N6iuk@semo.net</a>
Dale Robinson	KCOQNS	General	Vine St. Poplar Bluff, MO 63901 573-776-6767	Poplarbluffcounseling.com

Duane Thomas		General	RR 1, Box 53A Koshkonong, MO 65692 417-867-3721	<a href="mailto:ddranch@wpcs.net">ddranch@wpcs.net</a>
Royce Bishop	KCOQFA	Tech.	PO Box 247 Eminence, MO 65466	None
Richard Bloom	KCOSZZ	Tech.	Redford, MO 573-300-9614	<a href="mailto:Richard@simple.net">Richard@simple.net</a>
Chris Carroll	KCOSEH	Tech.	Rt. 1, Box 92 Van Buren, MO 63965 573-323-8867	None
William Cassie	KCOSQT	Tech.	PO Box 614 Eminence, MO 65466 573-226-3695	<a href="mailto:robassie@yahoo.com">robassie@yahoo.com</a>
Linda Caulk	KCOSHF	Tech. X	650 Cty. Rd. 425 Poplar Bluff, MO 63901	None
Bobby Frank	KOSEG	Tech.	Rt. 1, Box 1900 Winona, MO 65588	None
Patrick Green	KCORPG	Tech.	Rt. 2, Box 2624 Ellsinore, MO 63937 573-322-5242	<a href="mailto:pieman@semo.net">pieman@semo.net</a>
Jim Slaton	KCOQNR	Tech.	HCR 2, Box 7 Eminence, MO 65466	<a href="mailto:Slaton6@centurytel.net">Slaton6@centurytel.net</a>
Clifton Smith	KCOSQU	Tech.	614 Plum Eminence, MO 65466 573-226-3695	None
Larry Spurlock	KOLEZ	Tech.	Eastwood, MO	None
Gary Sullivan	KCOLXX	Tech.	HCR 67, Box 86 Fremont, MO 63941 573-251-3647	<a href="mailto:crowbuster@semo.net">crowbuster@semo.net</a>
Royce Keebler	KCOTRA	Tech.	Rt. 1, Box 92 Van Buren, MO 63965 573-323-4858	None

### RADIO FREQUENCIES AND CALL SIGNS

**Sheriff State Wide Network, Point to Point Freq. 155.370 and Mutual Aid Freq. 155.475**

**155.7 is State Wide Sheriff's Network**

**FREQ.        155.73**  
**County of Oregon**  
**County of Howell**

**CALL SIGN**  
**KAI 688**  
**KAI 669**

County of Iron	KGL 585
County of Reynolds	KQO 319
County of Ripley	KSL 987
County of Carter	KSN 236
City of Birch Tree	KEG 335
City of Winona	KJD 421

**COUNTY OF CARTER**

Freq. 154.025 (Private Channel)	WPFJ 640
Freq. 155.970	WNWQ 933
Freq. 154.755	WQGC 900
Freq. 156.195	WQGC 900

**COUNTY OF SHANNON**

Freq. 158.745	WPKP 416
Freq. 151.280	
Freq. 153.935	
Freq. 155.790	

**COUNTY OF OREGON**

Freq. 155.370	KAI 688
Freq. 155.625	
Freq. 158.925	

**COUNTY OF RIPLEY**

Freq. 155.370	KSL 987
Freq. 153.740	Freq. 154.055
Freq. 155.475	Freq. 155.775
Freq. 156.150	

**COUNTY OF REYNOLDS**

Freq. 155.370	KQO 319
Freq. 155.250	

**MISSOURI STATE HIGHWAY PATROL**

Freq. 42.06	42.12	42.38	42.58	42.92	42.94
Freq. 154.92	155.37	155.475	456.525	460.425	
WILLOW SPRINGS	KA A 522				
POPLAR BLUFF	KA A 270				

**MO DEPARTMENT OF TRANSPORTATION**

**Highway 9 Willow Springs**

<b>Freq.</b>	<b>151.07</b>	<b>KN5 291</b>	<b>156.015</b>	<b>WDC 27</b>
<b>Freq.</b>	<b>156.045</b>	<b>KLA 46</b>	<b>156.135</b>	<b>KLA 46</b>

**MO DEPARTMENT OF TRANSPORTATION**

**Highway 10 Sikeston**

<b>Freq.</b>	<b>151.13</b>	<b>KJI 572</b>
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**Highway 8 Springfield**

<b>Freq.</b>	<b>151.04</b>	<b>KJI 568</b>
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**CONSERVATION DEPARTMENT**

<b>Freq.</b>	<b>151.19</b>	
<b>Freq.</b>	<b>151.265</b>	
<b>Freq.</b>	<b>151.325</b>	<b>KHF 79</b>

**NATIONAL PARK SERVICE**

<b>Freq.</b>	<b>171.625</b>
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**OZARK BORDER ELECTRIC COOPERATIVE**

<b>Freq.</b>	<b>154.47</b>	<b>KAA 336</b>
<b>Freq.</b>	<b>158.22</b>	

**CITY OF VAN BUREN**

<b>Freq.</b>	<b>158.805</b>	<b>WNSU 864</b>
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**WEST CARTER COUNTY AMBULANCE**

<b>Freq.</b>	<b>155.085</b>
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**OZARKS MEDICAL CENTER**

<b>Call Sign WQR 263</b>					
<b>Freq.</b>	<b>154.385</b>	<b>155.28</b>	<b>155.34</b>	<b>155.4</b>	<b>458.75</b>
<b>Call Sign WPJT 485</b>					
<b>Freq.</b>	<b>464.325</b>	<b>469.325</b>			

**AIR EVAC LIFETEAM**

<b>Freq.</b>	<b>151.505</b>	<b>158.4</b>	<b>WPYR 891 West Plains</b>
<b>Freq.</b>	<b>159.7125</b>		<b>WPYF 285 Cape Girardeau</b>
<b>Freq.</b>	<b>160.02</b>	<b>159.87</b>	<b>WPYQ 285 Blytheville, AR</b>
<b>Freq.</b>	<b>153.215</b>		<b>WQCD 342 Kirksville, MO</b>
<b>Freq.</b>	<b>152.9975</b>		<b>WPRL 740 Cuba, MO</b>

**ST JOHNS REGIONAL HEALTH CENTER**

<b>Freq.</b>	<b>151.115</b>	<b>154.625</b>	<b>155.235</b>	<b>155.34</b>	<b>WZX 647</b>
<b>Freq.</b>	<b>155.805</b>	<b>155.82</b>	<b>156</b>	<b>159.12</b>	

**Annex C**

**PUBLIC INFORMATION AND EMERGENCY RISK COMMUNICATION**

**I. Purpose**

Instill and maintain public confidence in the public health system and its ability to respond to a public health emergency by providing timely, accurate, consistent and comprehensive information on health, wellness, prevention, safety, survival and recovery, in order to protect public health, to calm fears, dispel rumors and misinformation and maintain a sense of order. The Carter County Health Center will coordinate and deliver risk communication and public health information support before, during and after an emergency/bio-terrorism event. These support operations will be accomplished in close coordination with the Carter County Emergency Management Agency's Public Information Officer, the Missouri Department of Health and Senior Services and other lead



public information officers in accordance with state and federal emergency plans, as well as with appropriate regional public health agencies.

## **II. Situations and Assumptions**

### **A. Situation**

1. Carter County could be affected by several types of public health emergencies that would require the dissemination of information and guidance to various audiences.
2. While the predominant language in Carter County is English, steps should be taken to ensure the language barrier is effectively addressed for those residents whose primary language is something other than English.

### **B. Assumptions**

1. A suspected disease outbreak or public health emergency will generate immediate, intense and sustained public, health care provider, media and policymaker concern, interest and demand for information.
2. Accurate, consistent and comprehensive information must be available immediately to reduce public fear and minimize the spread of rumors, inaccuracies and misinformation.
3. Effective communication requires preparing and disseminating messages and materials in advance of an event to increase public, health care professional, policymaker, media and key partner knowledge and understanding.
4. Communication activities must address the needs of the local public health department, local health care providers, key partner and stakeholder organizations, media and the public.
5. Informational materials and resources should be developed and approved in advance of an event whenever possible.
6. An effective public information program will empower individuals to take appropriate actions to help reduce casualties and slow and stop the spread of disease.
7. Web sites should be used as a central component to manage the influx of information requests and provide updated information to a large audience.
8. Communication efforts with local, regional, state and federal partners should be coordinated whenever possible to provide accurate, timely, consistent and easily accessible information.
9. The media serving Carter County will cooperate with local officials in the dissemination of information to the public
10. A public health emergency may result in national and international media coverage by media who are not familiar with Carter County or their media relations policies.
11. State and federal officials may be on site to offer assistance and guidance. The Carter County Health Center lead Health Public Information Officer (PIO) will maintain jurisdictional control concerning local PIO activities.
12. When more than one agency PIO becomes involved in the response, a Joint Information Center (JIC) will be established to coordinate the release of public information and risk communication.

### III. Concept of Operations

#### A. General

1. This plan will be implemented whenever deemed necessary by the Carter County Health Center's (CCHC) Administrator.
2. The CCHC Health Educator and/or Administrator will operate as Lead Health PIO.
3. The Lead Health PIO will work with Lead PIOs from local public health agencies in Region G, The Missouri Department of Health and Senior Services (DHSS), local agencies and neighboring jurisdictions.
4. In order for the Carter County jurisdiction to speak with one voice, keep messages consistent, control dissemination of information and appear unified before the public, all health public information or emergency risk communication will originate from or be approved by the CCHC Administrator, in accordance with CCHC Agency policy and Annex C of the Local Public Health Emergency Plan (LPHEP).
5. Only approved information will be considered official, and the media will be so informed.
6. Any person, department or agency releasing information to the public of their own volition will bear the responsibility for any legal or moral ramifications and repercussion resulting from that release.
7. Public information and emergency risk communication will be managed out of a Joint Information Center (JIC), where PIOs from various agencies will work together to collect, assemble and disseminate information to the media, the general public and other audiences.
8. Staff at the JIC will coordinate with the Lead Health PIO, who will brief the Administrator.
9. Information will be disseminated via the media, the internet, public access television, Emergency Alert System (EAS), telephone hotlines and other means as necessary. In the case of power outages, information may be disseminated by distributing fliers or push cards to various populated areas of the community. Mass printing may be done at the CCHC, or using local printing companies. **A list of local news sources and contact information is included in Appendix 1 to Annex C. A list of facilities willing to display fliers is included in Appendix 2 to Annex C.**

### IV. Organization and Responsibilities

#### A. Administrator

1. Serves as primary spokesperson before media.
2. Gives final approval to release of all information.
3. Designates a location for media briefings and JIC.
4. Approves implementation of any special provisions for media convergence.
5. Briefs peers and Emergency Operation Center (EOC) staff.

B. Public Health Information Designee (Lead Health PIO)

1. Manages all aspects of public information and emergency risk communication on behalf of Administrator.
2. Assumes public health information and emergency risk communication functions delegated by Administrator.
3. Ensures timely preparation of public information and emergency risk communication and its dissemination.
4. Ensures that the public is able to obtain additional information and provide feedback.
5. Ensures gathering of necessary information and timely preparation of news releases.
6. Knows incident-specific policy, science and situation.
7. Works with subject matters experts to ensure accuracy of information.
8. Ensures that public information and emergency risk communication principles are employed in all contact with media, public and partner information release efforts.
9. Coordinates with other PIOs to gather, assemble and dispense materials and messages for public education, warning, emergency risk communication and recovery.
10. Provides updates to the Administrator, EOC, Local Public Health Agency (LPHA) PIOs and others as deemed appropriate.
11. Advises the Administrator regarding information to be released, based on the organization's role in the response.
12. Briefs public affairs officers traveling to the incident site.
13. On request, arranges for tours of the event site for visiting dignitaries, politicians, and officials.
14. Assesses media needs and organizes mechanisms to fill those needs.
15. Schedules news conferences, interviews and other media access.
16. Represents the CCHC in the JIC.
17. Assigns print and broadcast monitors to review all media reports for accuracy.
18. Coordinates rumor control activities.
19. Maintains a chronological record of disaster events.
20. Works with County Emergency Management Director to store and release messages via the EAS.
21. Works with foreign language translators and special needs groups liaisons to ensure messages are understandable and culturally appropriate for the intended audience.
22. Cooperates in public education and emergency risk communication efforts.
23. Provides leadership to the CCHC risk communication team.
24. Ensures communication with CCHC staff, area PIOs and other key partners.
25. Acts as liaison between CCHC and partners such as Health Care Providers, Nursing Homes, Schools, etc..

**Responsibilities of the Lead Health PIO**

## Mitigation (Pre-Event) / Education

1. Identify and increase public, health care professional, policymaker, media and key partner knowledge, understanding and beliefs related to public health emergencies.
2. Identify bioterrorist agents and public health threats and develop messages and materials that address the public's needs, knowledge gaps and interests related to these agents and threats.
3. Coordinate with PIOs from other agencies to gather, assemble and dispense materials and messages for public education, warning, emergency risk communication and recovery.
4. Identify the principal means by which public information and emergency risk communication will be disseminated during a public health emergency.

### a. Emergency Alert System

The Emergency Alert System was established by the Federal Communications Commission (FCC) in 1994. It provides the President, national, state, regional and local authorities the ability to quickly disseminate emergency messages to the public via broadcast stations, cable and wireless cable systems. Participation in national EAS alerts is mandatory for these providers, however participation in state, regional, and local EAS alerts is voluntary.

### b. Health Alert Network (HAN)

The Health Alert Network (HAN) allows health information to be quickly disseminated simultaneously to a large group or groups of contacts via fax or email.

### c. Media Coverage

- i. Identify areas of media coverage in order to ensure entire community has ability to receive media messages.

### d. Community networking for special needs individuals and isolated groups through liaisons.

- i. Specific messages for non-English speaking groups
- ii. Specific messages for the home-bound, elderly, visually impaired, deaf or hard-of-hearing, disabled, illiterate or other special needs individuals
- iii. Specific messages for tourists and transients
- iv. Specific messages for isolated populations

### e. Back-up message dissemination procedures

- i. Depending on the public health emergency, public information and risk communication efforts may be hampered due to loss of phone lines, loss of electricity, blocked streets or destruction of buildings. In such an event, backup emergency risk communication dissemination procedures will be utilized, including ham radio, door-to-door flyer distribution and other means as available. **A list of facilities willing to display fliers is included**

**in Appendix 2 to Annex C.**

5. Describe the audience to which information will be disseminated during a public health emergency.
  - a. Public at risk (those directly affected by the emergency)
  - b. Carter County Health Department employees
  - c. Health care partners
  - d. Policymakers
  - e. Key partners and stakeholders
  - f. Media
  - g. General public
  - h. Special needs groups
    - i. Non-English speaking
    - ii. Illiterate
    - iii. Visually impaired
    - iv. Deaf or hard-of hearing
    - v. Home-bound or disabled
    - vi. Elderly
    - vii. Isolated Populations
    - viii. Residents of medical care facilities
    - ix. Caretakers in schools or day-care centers
    - x. Tourists
    - xi. Transients
6. Identify the level of public preparedness preceding a public health emergency.
  - a. Hold community forums on bioterrorism preparedness in order the public's level of understanding and preparedness preceding a bioterrorist event or other public health emergency and to provide information and literature to better inform and prepare them.
  - b. Create fact sheets on bioterrorist agents and other public health threats that can be used in preparing news releases and broadcast public service announcements. **See Appendix 3 to Annex C.**
  - c. Develop materials to inform families on preparations they need to make, as well as what local public health authorities are doing to prepare the community for a bioterrorist event or other public health emergency. Make materials available at the health department and on the department's website. Distribute materials to community organizations, groups, and individuals.
  - d. Publicize locations for Point of Dispensing (POD) sites in case mass prophylaxis is necessary. Determine times and location for media briefings outside dispensing site area.
7. Help prepare and establish appropriate public, health care professional, policymaker, media and key partner responses to a bioterrorist event or other public health emergency.
  - a. Identify how the public health system will respond.
  - b. Describe the roles and responsibilities of the different sectors involved.

- c. Develop reasonable expectations regarding the scope and effects of public health actions.
  - d. Create key messages and talking points.
  - e. Emphasize the importance of message accuracy, timeliness and consistency.
8. Establish protocols to communicate specific data that would need to be reported daily or more frequently after a confirmed bioterrorist event or other public health emergency.
  9. Develop and maintain ties to media in and around Douglas County and keep a current list of names and contact numbers.
  10. Develop relationships with key partners and become familiar with their policies and emergency plans. Keep a current list of contact information.

#### Preparedness (Immediately Pre-Event) / Warning

1. Verify information with appropriate official.
2. Use the EAS to notify the public of impending event or danger.
  - a. Create warning messages.
  - b. Contact the Douglas County Emergency Management Director.
3. Issue information to physicians, stakeholders and partners via the Health Alert Network (HAN) or Broadcast fax.
4. Notify the public of a change in the community health status via EAS, area media, websites, and methods as described in LPHEP, Annex C.
5. Coordinate with key partners to determine status of plans and timing of actions.
6. Review incident-specific policy, science and situation.
7. Issue specific, follow-up information via the HAN or other routes of communication.
  - a. Describe hazard.
  - b. Identify estimated risk area and time of impact.
  - c. List health, property and animal protection measures.
  - d. Describe shelter-in-place or evacuation instructions if appropriate.
  - e. Describe how additional information will be relayed to the public.
  - f. Provide telephone numbers, web site addresses and other resources for specific inquiries.
8. Issue press releases and statements to media as necessary.
9. Triage media inquiries and ensure they are addressed appropriately.
10. Monitor media messages.

#### Response (Event) / Risk Communication

1. Activate full-scale communication activities initially focused on the dissemination of emergency risk communication to stakeholders.
  - a. Press releases / media briefings should provide the known facts of the incident, actions being taken by the health depart-

- ment and public guidance and resources.
  - b. Prepare for media convergence. Implement media accountability and credentialing system.
  - c. Implement call-in of support staff.
  - d. Provide timely, accurate and comprehensive information as the incident progresses to dissuade the public from overloading a jurisdiction's communication network, transportation and staff in their quest for additional, updated information
2. Deploy PIO staff to the incident site and the EOC.
  3. Activate the JIC or provide a liaison to serve as a member.
  4. Prepare and support spokesperson(s).
  5. Log all media interviews and review for misinformation.
  6. Contact key local, state and federal government agency partners.
    - a. Provide them with information and materials that will enable them to respond to public, health care professional, policy-maker, media and key partner inquiries.
    - b. Implement briefings with frequency based on situation.
  7. Issue informational updates as quickly as possible to dispel rumors and correct misinformation or misperceptions.
  8. Respond to requests and inquiries from legislators and special interest groups.
  9. Work with County Emergency Management Agency to establish phone bank. Provide scripted information and approved messages to phone bank and collect call log from them in order to address rumors.
  10. Expand emergency risk communication outside the risk area to the general public who are seeking information or expressing a desire to help.
  11. Implement daily routines for informing and responding to health care providers, policymakers and key partner inquiries.
  12. Schedule press conferences daily or as frequently as needed to respond to media and public inquiries and provide the latest information.
    - a. Local media should place the community's need for information ahead of the need for news coverage, at least in the initial warning and emergency risk communication stages.
    - b. External media will likely be more interested in human interest and spectacle stories of universal appeal and quick impact. These media may place heavy demands on PIO time and resources and may require expansion of the PIO organization to facilitate their needs.
  13. Monitor media messages and correct misinformation quickly.
  14. Maintain chronology of events.

#### Recovery (Post-Event) / Reassurance

1. Provide timely, accurate and comprehensive information including facts on the current situation, what the health department is doing and guidance and resources for the public.

2. Issue informational updates as needed to the public to dispel rumors and correct misinformation or misperceptions.
3. Implement routines for informing and responding to health care provider, policymaker and key partner inquiries.
4. Schedule press conferences as appropriate to respond to media and public inquiries and provide the latest information.
5. Facilitate site tours and media opportunities for visiting politicians, dignitaries and other VIPs as requested.

**V. Direction and Control**

A. PIO

1. Administrator will act as the Lead Health PIO.
2. If the Administrator is unable to perform the duties of the Lead Health PIO, the Assistant Administrator will assume that role.
3. If the Assistant Administrator is unable to perform the duties of the Lead Health PIO, the RN Supervisor will assume that role.

B. Spokesperson

1. The Administrator will act as the primary spokesperson.
2. In the absence of the Administrator the Assistant Administrator will assume the role of primary spokesperson.
3. In the absence of the Assistant Administrator RN Supervisor will assume the role of primary spokesperson.

**VII. Administration and Logistics**

A. Administration

1. The Lead Health PIO will maintain a log and a chronological file of all press releases sent during the public health emergency
2. The Lead Health PIO will maintain a chronological log of all events during the public health emergency
3. The Lead Health PIO will maintain a log of all media requests, interviews, and coverage during the public health emergency

**VIII. Plan Development and Maintenance**

The Lead Health PIO will be responsible for maintaining this plan in its entirety. The PIO will revise the plan as necessary, but no less than once a year.



**APPENDIX 1 TO ANNEX C  
LOCAL NEWS SOURCES**

<b>NAME</b>	<b>TYPE</b>	<b>PHONE</b>
Poplar Bluff DAR	Paper	573-785-1414
The Current Local	Paper	573-323-4515
KWOC/KKLR( Poplar Bluff)	Radio	573-785-0881
KJEZ (Poplar Bluff)	Radio	573-626-2403
KAPE/KGMO (Cape Girardeau)	Radio	573-335-8291
KFVS-TV Channel 12 (Cape Girardeau)	Television	573-335-1212
KAIT-TV Channel 8 (Jonesboro, Ark.)	Television	501-256-3666
WPSD-TV Channel 6 (Paducah, Kentucky)	Television	502-442-8214

**APPENDIX 2 TO ANNEX C  
FLIER DISTRIBUTION SOURCES**

<b>NAME</b>	<b>TYPE</b>	<b>PHONE</b>
Carter County Court House	court house	573-323-4344
The Current Local	Paper	573-323-4515
Van Buren U.S. Post Office	post office	573-323-4703
Big Springs Medical Clinic	medical clinic	573-323-4253
Van Buren Medical	medical clinic	573-323-4812
Pryor Family Dental	dental clinic	573-323-4287
G & W Foods	supermarket	573-323-4244
Main Street Market	supermarket	573-323-4755
Crafton Equipment & Farm	hardware	573-323-4432
Carter County Abstract Office	abstract office	573-323-4343
Division of Family Services Office	DFS	573-323-4201
University Extension Office	extension	573-323-4418
Van Buren Drugs	pharmacy	573-323-8159
Big Springs Sheltered Workshop	workshop	573-323-8507
Big Springs Video	video store	573-323-8368
Carter County Senior Center	senior center	573-323-8377
Grassham Lumber Company	hardware	573-323-8458
Godsey Farm Supply	farm supply	573-323-4517
Ozark Border Electric Cooperative	electric	573-323-4317
Van Buren Youth & Community Center	community ctr.	573-323-8958
Simmons Grocery & Hardware	hardware	573-322-5758
Stray Dog BBQ	restaurant	573-323-5428
The Pin Cushion	fabric shop	573-323-8154
The Store	food/gas	573-322-5452
Van Buren Propane	propane office	573-323-4732
Van Dykes Store	grocery	573-322-5313

## SURVEILLANCE

1. **PURPOSE:** To maintain a high alert surveillance system for the early detection of a suspected intentional release of a biological weapon.
  
2. **ORGANIZATION AND RESPONSIBILITIES:**
  - A. For the CCHC the Clerk II-Imm/Gen. Clerical will conduct the High Alert Surveillance System (HASS). The backup will be the CCHC Administrator, CD Nurse, and WIC RN. Other support staff include Regional Epi.
  
  - B. HASS surveillance sites will collect data daily and transmit the data to CCHC. CCHC will compile and transmit the data to the DHSS on Monday, Wednesday and Friday.
  
  - C. The Senior Epidemiologist Specialist for Region G is Autumn Grim at the District Office in Cape Girardeau. Work number is 573-290-5783, home number-573-651-5260, and cell number is-573-576-3662.
  
  - D. See Appendix 1 of this annex for surveillance sites.
  
  - E. See Appendix 2 of this annex for HASS reporting instructions.
  
  - F. HASS reports will be made to DHSS/Bio-Terrorism Surveillance, phone: 573-522-8367, Fax: 573-751-6417
  
  - G. If unusual activity is noticed immediately contact the above or contact the Center for Emergency Response and Terrorism at 800-392-0272.

**APPENDIX 1 TO ANNEX D  
CCHC SURVEILLANCE SITES**

Van Buren Headstart, Winston Dr. Van Buren, Missouri 63965 at 573-323-8905.

East Carter Head Start: 63 N. Herren Ave. Ellsinore Missouri.63937 Phone 573-322-0099.

Van Buren R-I: Stacy Keeney, RN, Hwy. Business 60, Van Buren, Missouri 63965, Phone 573-323-4266. Reports for Van Buren R I School District.

East Carter RII School District, Ladena Crowley,RN, Hwy. A, Ellsinore, Mo 63937, Phone 573-322-5325 ext. 7. Reports for East Carter R-II School District.

Big Springs Medical Clinic, Hwy. Business 60, Van Buren, MO 63965. Phone 573-323-4253.

Van Buren Medical Clinic, 1009 Business Hwy. 60, Van Buren, MO 63965. Phone 573-323-4812.

Riverways Manor Nursing Home, Paula Norris, 403 Watercress Road, Van Buren, Missouri 63965. Phone 573-323-4282

**APPENDIX 2 TO ANNEX D  
HASS FORM 1 INSTRUCTIONS**

**GENERAL INSTRUCTIONS FOR  
HIGH ALERT SURVEILLANCE SYSTEM (HASS)**

## (ii) REPORTING

**If there is an emergency public health threat or you suspect a bio-terrorism event, IMMEDIATELY call the Center for Emergency Response Terrorism (CERT) at 1-800-392-0272 (24 hours a day / 7 days a week), Carter County Health Center at 827-1130**  
(see Addendum to Appendix 2 to Annex D)

**NOTE FOR MEDICAL CARE PROVIDERS:** Submitting the HASS Form 1 does not relieve you of your legal obligation for reporting diseases and conditions under 19 CSR 20-20.020.

- Collect surveillance data and complete a Form 1 daily.
- All HASS data must be submitted on the HASS Form 1.
- **All information on the Form 1 must be completely legible or it cannot be entered.**
- Remember to use a separate form for **each** day. **A Form 1 that contains data from multiple days cannot be used in the HASS system.**
- Submit the Form 1s to your LPHA via email or fax at least three times each week.
- Notify your LPHA and /or the DHSS, Office of Surveillance of any changes in the following information for your agency:
  - Email address
  - Telephone number
  - Street address
  - Contact person
- **Chemical Exposures:** When reporting chemical exposures, list the chemical the patient was exposed to if known (if not known state “chemical unknown”) in the field “Other Information, Suspected Outbreaks, Unusual or Nonspecific Cases” at the bottom of the Form 1.
- **To decrease the number of telephone calls you receive from the DHSS, Office of Surveillance (OoS) for clarification of elevated rates:** Write brief reason/ explanations at the bottom of the Form 1, in the field “Other Information, Suspected Outbreaks, Unusual or Nonspecific Cases.”

### **Some examples of reasons or explanations:**

#### ER Visits:

- ◆ Holiday weekend. Doctors’ office’s closed
- ◆ Moving vehicle accident
- ◆ Nothing unusual – busy day

#### Deaths:

- ◆ Heart attach, cancer and old age

#### Neurologic:

- ◆ Headache – no pattern

Absenteeism:

- ◆ Deer season
- ◆ Vacation

**Article II. COMPLETING THE FORM 1**

**(a) Site Information**

**PLEASE BE SURE ALL INFORMATION ON THE FORM 1 IS LEGIBLE.**

- **Reporting Site Name and Address:** The name and mailing address of your agency.
- **Site Contact:** The first and last name of the person completing the Form 1.
  - **Date Of Incident:** The date the patient(s) presented to your agency.

**Remember, “ONE DAY, ONE FORM”**

- **Date Submitted:** The date the Form 1 is submitted to the LPHA or the DHSS.
- **Phone Number:** The telephone number of the HASS contact at your agency.

**Syndromic Information**

**Refer to the HASS “Cheat Sheet” for the Do’s and Don’ts of HASS Reporting.**

- **Syndromic categories:** For each syndromic category, under the “Total” column, record the number of patients seen with the symptoms or syndromes.
- **Fever Illness:** Remember a fever is a “Body temperature of 37.8 degrees C or > 100 degrees F **orally**, or 38.2 degrees C or 100.8 degrees **rectally**.”

**(b) Non-Syndromic Information**

**PLEASE BE SURE ALL INFORMATION ON THE FORM 1 IS LEGIBLE.**

**Complete only the sections that pertain to your agency (i.e. schools, day care centers and nursing homes would not complete hospital or emergency room visit information.)**

- **School/ Workplace Absenteeism:** The number of students or employees absent due to illness. **SCHOOLS ONLY NEED TO REPORT DATA ON STUDENT ABSENTEEISM.**
- **Total ER Visits:** The total number of emergency room visits during the 24-hour reporting period.

- **Total Urgent Care or Clinic Visits:** The total number of visits to the urgent care center or clinic/s for that day.
- **Total Hospital Admissions:** The number of persons admitted to the hospital during the 24-hour reporting period.
- **Deaths:** The number of deaths during the 24-hour reporting period.
- **Other Information, Suspected Outbreaks, Unusual or Nonspecific Cases:**  
*(This information often answers questions that would normally demand a follow up phone call.)*

Any other relevant or descriptive information regarding reported data.

This may include but is not limited to:

- ◆ Chemical agent involved in chemical exposures.
- ◆ Descriptive name of suspected outbreak(s) and unusual or nonspecific cases and the count of individuals involved.
- ◆ Unusual or nonspecific cases that do not fit any of our predefined categories.
- **Date Received:**
  - ◆ By LPHA: enter date received by LPHA (for use by LPHA only).
  - ◆ By DHSS: for use by DHSS only.

For questions regarding the Form 1 or the HASS program, please call your LPHA or the Department of Health and Senior Services, Office of Surveillance, at 1-800-392-0272.

**\*Remember - If there is an emergency public health threat or you suspect a bio-terrorism event, IMMEDIATELY call the Center for Emergency Response Terrorism (CERT) at 1-800-392-0272 (24 hours a day / 7 days a week), or CARTER County Health Center at 827-1130.**

Addendum to Appendix 2 to Annex D



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
OFFICE OF SURVEILLANCE  
**HIGH ALERT SURVEILLANCE SYSTEM (HASS FORM 1)**

REPORTING SITE NAME:		CONTACT (IF DATA COLLECTION)		DATE OF COLLECTION	
ADDRESS:		CITY:	COUNTY:	ZIP CODE:	PHONE:
<b>SIGNS AND SYMPTOMS OF DISEASES OR CONDITIONS</b>					
					Totals*
I. Gastrointestinal illness with or without fever (such as: diarrhea, vomiting, abdominal symptoms, etc)					
II. Hemorrhagic Disease (such as bleeding from skin or mucus membrane surfaces or reddish or purplish spots or discolorations on skin or mucus membrane surfaces (petechiae, purpura)					
III. Respiratory illness with or without fever (such as pneumonia, cough, sore throat, influenza, trouble breathing)					
IV. Neurologic illness (such as headache, sensitivity to light, confusion, stroke, coma, convulsions, double/blurred vision, drooping eyelid, muscle twitching, difficulty talking/swallowing, weakness or paralysis)					
V. Rash illness with or without fever (including chicken pox, exanthem, dermatitis, erythema)					
VI. Fever illness of unknown origin (such as acute febrile illness, viral syndrome, sepsis, suspect infection)					
VII. Chemical Exposure with sudden onset (< 60 minutes) of illness (such as: difficulty breathing, diarrhea, vomiting, profuse watery saliva, small pupils, and slow heart rate.)					
List Suspected Outbreaks, unusual or nonspecific cases					
A.					
B.					
C.					
School/Workplace Absenteeism / Normal Census					
Total ER Visits					
Total Urgent Care or Clinic Visits					
Total ICU beds used / Empty available ICU beds					
Total Hospital Admissions					
Hospital Census / Empty available hospital beds					
Deaths					
<b>Other Information:</b>					
Hospitals - Note here the source of syndromic data: <input type="checkbox"/> Admissions <input type="checkbox"/> ER Visits <input type="checkbox"/> Urgent Care/Clinic Visits					

MO 580 2485E (11/01)

Contact: (800) 392-0272 (voice)

(573) 751-6417 (fax)

Missouri Department of Health and Senior Services  
Emergency Response and Terrorism Plan - Page K.1.3(8)

**Chemical:**

1. Do **NOT** report:  
Drug overdoses  
Household chemical exposures



Voluntary chemical ingestions

**2. DO report: ALWAYS LIST THE CHEMICAL (IF KNOWN) INVOLVED FOR EVERY CHEMICAL EXPOSURE REPORTED**

Occupational or work related chemical exposures

For example: Industrial, agricultural or commercial chemical spill or exposure.

Community acquired chemical exposures

For example: A truck transporting chemicals is involved in an accident.

For example: A manufacturing facility has a chemical spill or release that affects the people in the surrounding community.

When a patient presents with an obvious chemical exposure, but the chemical agent and/or exposure is unknown.

**Hemorrhagic:**

**1. Do NOT report:**

Hemorrhoids, Nosebleeds, STD's (e.g. HSV), Miscarriages,

Vaginal/rectal bleeding, Bruises or bleeding resulting from falls or physical trauma

**2. DO report:**

Unexplained bleeding from the orifices (e.g. eyes, ears, etc.)

Unexplained reddish or purplish spots/lesions on the skin or mucous membrane surfaces

**Neurological:**

**1. Do NOT report when:**

Symptoms are heat or cold weather related (e.g. heat exhaustion, hypothermia)

Source or cause of neurological symptoms is known

Chronic illness (e.g. migraines, Alzheimer's)

Psychiatric or mental illness (e.g. Bipolar disorder, Depression, Schizophrenia)

**2. DO report when:**

The cause of symptoms is unknown

A particular disease is suspected, **especially if there is a known outbreak occurring** (e.g. West Nile Virus, Encephalitis, etc.)

Seeing an elevation in the number of people presenting with similar neurological symptoms

ANY and ALL unusual or nonspecific cases

**Rash:**

1. Do **NOT** report:

Heat rash

Scabies

STDs

Sun poisoning

Poison ivy or oak

2. **DO** report:

Chicken pox

Any unusual or nonspecific cases

Pustules

Small pox

Measles

**APPENDIX 3 TO ANNEX D**

Department of Health and Senior Services  
Communicable Disease Investigation Unit  
Southeast Region Office  
2875 James Blvd.  
Poplar Bluff, MO 63901

NAME	TITLE	HOME ADDRESS	TELEPHONE
Autumn Grim	Senior Epidemiology Specialist	338 Broadway, Suite 200 Cape Girardeau, MO 63701	(W) 573-290-5783 (F) 573-290-5195 (C) 573-576-3662 (H) 573-651-5260
Amy Bradshaw	Community Health Nurse IV	338 Broadway, Suite 200 Cape Girardeau, MO 63701	((W) 573-290-5783 (F) 573-290-5195
Kurry Barton	Health Program Rep. II	HC 7, Box 5 Doniphan, MO 63935	(W) 573-840-9118 or 1-800-554-2076 (H) 573-996-5720 (M) 573-450-5522

Fax for Communicable Disease Investigation Unit: (573) 840-9119

## ANNEX E

### INVESTIGATION

1. **PURPOSE:** To assure the investigation of confirmed or suspected cases and contacts associated with an accidental or deliberate local public health emergency.
2. **ORGANIZATION AND RESPONSIBILITIES:**

- A. The Bio Epidemiologist is responsible for conducting all suspected biological agents releases. The CD nurse is responsible for investigating all non-bioweapons communicable disease outbreaks with support from the epidemiologist.
- B. A suspected or confirmed bioweapons outbreak would quickly overwhelm our local investigators. Support could be requested from the Reynolds County Health Department or the Wayne County Health Department.
- C. The DHSS could also dispatch investigators from the Section of Environmental Health, Office of Epidemiology. Regional Assessment Teams will provide immediate local response to emergency situations and provide feedback to DHSS and CCHC. The teams consists of members from the area LPHA and the state regional office. Our RAT (Regional Assessment Team) will be directed out of the southeast region and can be reached at 573-840-9720.
- D. Appendix 1 to this annex gives specific investigation procedures for all suspected or confirmed smallpox investigations.
- E. Appendix 2 to this annex gives specific investigation procedures for all other communicable diseases.
- F. Per Carter County EOP dated January 2015, Carter County does not have the resources to neutralize the effects of a serious hazardous substance release and must turn to outside government and private agencies for assistance. The county has the capability to provide some logistical support for these outside agencies and to coordinate off-site protective actions. Carter County has the capability to make a first response to a hazardous materials release with local response agencies with personnel who are trained at the awareness level. This response will be defensive and is to assess the severity of the incident, classify the emergency and start the notification chain and/or response chain.
- G. Chemical or Nuclear Incident Investigation:
  - 1. In a chemical event, DHSS has a supporting role (lead response will be by the Department of Natural Resources and local hazmat teams). The Department's role will be to coordinate with the Department of Natural Resources, State Emergency Management Agency (SEMA), and local HAZMAT teams.
  - 2. In a nuclear event, the director of EHCDP activates staff within the division to provide analysis of air, water, soil, and plants for radiological contamination.
  - 3. The director of SEPH will immediately consult the OoE for technical and analytical advice. The OoE will assist as needed in the design and implementation of biological, chemical or nuclear incident investigations. The OoE shall be the lead contact with the CDC.

## **APPENDIX 1 TO ANNEX E SMALLPOX INVESTIGATION**

- 1. PURPOSE:** To establish procedures used during an investigation involving suspected or confirmed smallpox release. **INDIVIDUALS PARTICIPATING IN A SMALLPOX INVESTIGATION MUST BE VACCINATED.**
  
- 2. ORGANIZATION AND RESPONSIBILITIES:**
  - A.** Smallpox investigations and vaccination of contacts will follow procedures established by the DHSS Center for Emergency Response and Terrorism Annex K.1.4 of the State Emergency Response Plan and Guide A to CDC Smallpox Response Plan and Guidelines.
  
  - B.** Two to three people in the CCHC will be vaccinated during pre-event vaccination. This will be the Bio Terrorism Epidemiological Investigator, Administrator and Nursing Supervisor.
  
  - C.** Investigations will be initiated based upon information obtained from local physician's office. The below listed gives smallpox case definitions:
    - 1.** Suspected: A case that meets the clinical case definition but is not laboratory confirmed and does not have an epidemiological link to a confirmed or probable case of smallpox. OR a case that has an atypical presentation that is not laboratory confirmed but has an epidemiological link to a confirmed or probable case of smallpox. Atypical presentations of smallpox include a) hemorrhagic lesions OR b) flat, velvety lesions not appearing as typical vesicles nor progressing to pustules.
  
    - 2.** Probable: A case that meets the clinical case definition that is not laboratory confirmed but has an epidemiological link to another confirmed or probable case.
  
    - 3.** Confirmed: A case of smallpox that is laboratory confirmed.
  
    - 4.** Definition of a Contact: A person who has had a contact with a suspected, probable or confirmed case of smallpox. A close contact is defined as any face-to-face contact (less than 6 feet) with a smallpox case.
  
  - D.** Even one confirmed case of smallpox requires urgent detailed investigation. The purpose of the case investigations are:
    - 1.** To establish the diagnosis and case classification.
    - 2.** To identify contacts for tracing, vaccination and surveillance.
  
    - 3.** To impose isolation of confirmed, probable and suspected cases.
  
    - 4.** To identify the most likely source of initial exposure for the case.

5. To monitor clinical course and outcome of cases.
  6. To monitor the epidemiology of the outbreak for analysis and communications purposes.
- E.** In order to facilitate case investigation and contact tracing, a detailed case investigation form (see Tab A to Appendix 1 to this Annex) has been prepared to use in the initial case investigations. Once person-to-person transmission is ongoing and identifying location of exposure to identify a population at risk is not needed, short case surveillance forms (see Tab B to Appendix 1 to this Annex) that will record key demographic, clinical and outcome information could be used along with the contact identification.
- F.** See Appendix 2 to this Annex for Guidance on Case investigation and Follow-up.

**INSERT FORMS 3 A-C FROM CDC RESPONSE GUIDELINES  
TAB C TO APPENDIX 2 TO ANNEX E  
GUIDANCE FOR CASE INVESTIGATION AND FOLLOW-UP**

**The process to be followed in case investigation and follow-up is outlined below:**

**1. Obtain notification of suspected case**

**2. Are there other associated cases, extent of illness?**

\_\_\_\_\_ Yes, the case is similar to other previously or currently reported cases - expand investigation, look for associations between cases.

\_\_\_\_\_ No, the case is ***not*** similar to any other previously or currently reported cases – focus investigation around single case.

**3. Is agent transmissible from person to person?**

\_\_\_\_\_ Yes

\_\_\_\_\_ Investigate area of exposure (if known) to determine/identify others that may have been exposed when the identified person was exposed.

\_\_\_\_\_ Determine when the case was infectious.

\_\_\_\_\_ Identify contacts for possible secondary transmission.

\_\_\_\_\_ If person is currently infectious, then recommend practices to prevent further transmission of the illness.

\_\_\_\_\_ If person is no longer infectious, then focus on previous contacts that may now be incubating or onsetting with disease.

\_\_\_\_\_ No

\_\_\_\_\_ Target area of exposure (if known) to determine/identify others that may have been exposed when identified person was exposed.

**4. Conduct investigation.**

For all ill cases identified, obtain appropriate information:

\_\_\_\_\_ Complete survey tool on all persons at the affected site.

\_\_\_\_\_ Complete disease specific investigation form for all suspect cases.

\_\_\_\_\_ Collect clinical specimens.

\_\_\_\_\_ Conduct environmental assessment and collect specimens.  
Select comparison group (not ill persons) and obtain appropriate information for a risk assessment.

## **5. Formulate a case definition**

Combine clinical characteristics, laboratory tests, and epidemiological information into criteria for the categorization of cases:

\_\_\_\_\_ Ill, but does not meet case definition – watch for development of signs and symptoms characteristic of agent and, if observed, refer to health care provider for testing and possible treatment.

\_\_\_\_\_ Well, but had appropriate exposure – implement control measure which could include vaccination or quarantine.

\_\_\_\_\_ Well, but did not have appropriate exposure – educate individuals on agent and alert them to visit their health care provider if they become ill.

\_\_\_\_\_ Confirmed case – Implement control measure that could include vaccination/quarantine of exposed contacts.

\_\_\_\_\_ Suspect Case – Implement control measures that include testing, treatment/quarantine, and vaccination of exposed contacts.

\_\_\_\_\_ Presumptive Case – Implement control measures that could include testing, treatment/quarantine and vaccination of exposed contacts.

## **6. Identify Cases for Analysis:**

\_\_\_\_\_ Prepare a line list of relevant case information that has been gathered.

\_\_\_\_\_ Categorize the cases according to the definition (see 5 above).

\_\_\_\_\_ Select the categories to be analyzed for risk factors and or associations using EpiInfo 2002.

## **7. Analyze the Cases and Characterize the Cases by Time, Place, and Person:**

\_\_\_\_\_ Prepare a frequency distribution of cases by location and by personal characteristics, obtain denominator data to calculate attack rates and distributions for each – identify associations/risk factors

\_\_\_\_\_ Create and Epi curve using EpiInfo 2002 (which reflects onset time and incubation period for the agent).

## **8. Formulate hypotheses of the attack:**

Interpret available data to determine:



\_\_\_\_\_ Likely area of attack.

\_\_\_\_\_ Likely mode or means by which the agent was released.

\_\_\_\_\_ Likely number of people affected

**9. Implement control measures.**

**10. Evaluate the control measures:**

Determine if solution specified in control plan are being achieved

\_\_\_\_\_ Yes – consider solution have been achieved if additional cases are prevented.

\_\_\_\_\_ No – identify problems, develop new solution, implement and evaluate.

**11. Prepare report investigation.**

**12. Distribute report to all contributors and users.**

**TAB C TO APPENDIX 1 TO ANNEX E**  
**SMALLPOX CONTACT IDENTIFICATION, TRACING AND RING VACCINATION**

1. **PURPOSE:** To establish procedures to be used when conducting a smallpox investigation. CDC and DHSS policy is to use contact tracing and ring vaccination. To the extent this is possible CCHC will also use this guidance.
2. **IDENTIFICATION OF CONTACTS:**
  - A. Using forms 3A – 3D, interview each suspected, probable, or confirmed case to get detailed name and contact information for *all persons with case had face-to-face contact*. Names of household and non-household contacts should be listed on the appropriate forms. The interviewer should obtain as much locating information as possible, for *every person* with whom the case had a known face-to-face contact following the onset of fever. The case should be questioned as to what they did and who they saw *each day*.
  - B. Detailed information is sought on places visited since fever onset to determine sites where unknown persons are likely to be exposed to an infectious case. These also include in-town and out of town travel history since the onset of fever.
  - C. If time/personnel constraints permit or if the patient is unable to answer questions because of illness, interview the patient's family, close friends, and work associates to verify cases travel and contact history since onset of fever.
  - D. Once all contacts are listed, they should be allocated to priority categories for vaccination based on duration of exposure according to the following guidelines:
    1. **Highest priority:** Household contacts, immediate family members and persons who work full time in the household.
    2. **Second Priority:** Named contacts who spent time in cases home but who do not live there (close friends who visited, any person who spent the night).
    3. **Third Priority:** Named non-household contacts with 1 to 3 hours of exposure.
    4. **Fourth Priority:** Named non-household contacts with less than 1 hour of exposure.
    5. **Last Priority:** Non-household contacts with less than 1 hour of exposure at a designated location.

**3. Tracing and Interviewing of Contacts**

Personnel assigned to trace contacts will receive names and any known address, telephone number(s), or other locating information for these contacts from case investigation personnel. The number of contacts for each case may require a very large number of personnel be identified, trained and available for contact tracing and follow-up activities.

- A. Contact tracing personnel should:

1. Find locating or contact information for each contact of a smallpox case. Use work and school contact numbers, telephone directories, voting lists, neighborhood interviews, site visits, hangouts, etc. to trace contacts when contact information is unknown or incomplete. If contacts cannot be found through these mechanisms, other sources for notification of potential contacts, such as media announcements, may have to be considered.
2. Locate each contact.
3. Interview each contact to confirm contact with the suspected, probable, or confirmed smallpox case, the presence or absence of symptoms in the contact (fever and/or rash) and to identify additional contacts that may not have been listed by the case. Record this information on Form 8.
4. Make arrangements for immediate vaccination of the contact and his/her household contacts and if this is not conducted at the household by the contact tracer, provide a form that documents names and identifying information of all persons in the household who are referred for vaccination on Form 9.
5. If the contact is symptomatic with fever or rash, the contact should be immediately transported to a Type C facility or other designated evaluation site for medical evaluation to rule out smallpox. The patient should be interviewed as a suspected case using the Smallpox Case Investigation Form and his/her contacts should be identified, interviewed, and vaccinated while the evaluation for smallpox is being undertaken.
6. If the contact does not have fever or rash, place the contact under surveillance, so that if they develop fever or rash they are immediately isolated and evaluated and do not expose other persons (see below).
7. Identify household contacts (including regular household visitors and persons who work in the home) of the contact of the smallpox case. Record their names, ages, relationship to the case, and other information on Form 8 (secondary contact person worksheet)
8. If household members cannot be vaccinated because of contraindications, they should avoid contact with the contact until the end of the contact's quarantine period, or until all vaccinated persons in the household are noninfectious for vaccinia virus (after the scab at the vaccine site has separated, 14 to 21 days after vaccination).
9. Notify the person responsible for reporting out-of-state contacts to the CDC Coordination Group if it is learned that a contact has left the state.

## **B. Surveillance (monitoring) of health status and vaccine "take" of contacts**

Contacts who do not have fever or rash at the time of interview must remain under active surveillance for 18 days after their last contact with the smallpox case, or 14 days following

successful vaccination. The contact tracer will establish methods for daily reporting with the contact including methods for daily tracking if the contact does not have access to a home telephone.

1. Contacts must monitor and record their temperature in the morning and early evening each day.
2. Each day before 8 p.m. they must call or be called by a designated person (or staff at a designated phone number) to report their daily temperatures, health status and any severe adverse vaccine reaction in themselves or household members following vaccination.
3. During the surveillance period they may continue their usual daily activities, going to work or attending school, as long as no temperatures  $\geq 101^{\circ}\text{F}$  ( $38^{\circ}\text{C}$ ) are measured. They should not, however, travel away from their city of residence.
4. If they have a temperature  $\geq 101^{\circ}\text{F}$  ( $38^{\circ}\text{C}$ ), they must remain in their own home. If they have two successive temperature readings of  $\geq 101^{\circ}\text{F}$ , they must contact health department personnel immediately, and remain at home, having contact only with vaccinated household members, until further evaluated by health department personnel.
5. On day 7 following vaccination, depending on local arrangements and staff availability, contacts must visit or report to the health department the status of their vaccine site (does the area of their arm where they were vaccinated look like the picture they were given when they were vaccinated?) and the vaccine sites of their household members.

**C.** Personnel assigned to monitor the health status of contacts will answer questions of contacts who are under surveillance, record daily temperature readings and health status, record information on vaccine “take” and severe adverse vaccine reactions among contacts and their household members, and refer for in-home follow-up any contacts who fail to report in and cannot be contacted by telephone. If resources permit, they will visit the household on day 7 following vaccination to record vaccine “take”.

1. These personnel will maintain Form 11 for each contact. Record information on the date and type of follow up (in person or by telephone), recorded temperature, other symptoms of illness, and on day 7 after vaccination, vaccine site reaction.
2. These personnel will obtain information on the vaccine “take” of other persons in the household and record it on the same form.
3. In addition, a daily tracking form should be used to record on a master sheet summary information from all contacts monitored (Form 11).

**D.** If personnel are limited, state and Federal health authorities may institute a passive system to monitor health status of contacts. In this approach, contacts under monitoring are only required to call health department personnel if:

1. They have two consecutive temperatures  $\geq 101^{\circ}$  F ( $38^{\circ}$ C) or develop a rash;
2. They have no reaction at the vaccine site on day 7;
3. They have a severe adverse vaccine reaction; or
4. They have completed the period of monitoring (18 days from last contact with the case or 14 days following successful vaccination) and are reporting in to be officially released from monitoring.

This change should only be implemented by the State Epidemiologist after consultation with Federal health authorities and only if limited personnel resources and the size of the outbreak do not permit effective institution of the standard procedure.

**E. For Coordination of Contact tracing with Vaccination, Personnel Should:**

Make a list of names and social security numbers (or drivers license numbers) of contact and household members who will be referred for vaccination and provide this list to the fixed vaccination clinic site where the contacts/household members will be sent (Duplicate of Form 8).

## APPENDIX 2 TO ANNEX E

### Communicable Diseases (Ebola)

The information in this appendix is specific to Ebola virus disease (EVD), unless noted, with the understanding that many of the recommendations and processes will be similar for other highly infectious or communicable diseases, and that the user will verify with CDC and MoDHSS precautions specific to any communicable disease encountered.

This appendix does not consider the risk of an airborne virus. In the event that a highly infectious disease is airborne, additional precautions and recommendations will be necessary.

EVD is a rare and deadly viral illness that is reportable to the National Notifiable Disease Surveillance System in all U.S. states and territories. The likelihood of contracting EVD in the U.S. is extremely low unless a person has direct contact with the blood or body fluids of someone infected with EVD and showing symptoms. However, because early EVD symptoms are similar to those seen with other febrile illnesses, providers should consider and assess patients for the possibility of EVD.

The key to safely caring for patients with EVD or persons under investigation for EVD is to **detect** possible cases, **protect** workers and other people, and **respond** appropriately.

### Health Care System Preparedness

Health care providers at all levels should focus on four primary areas:

- Assessment and triage of patients
- Patient transport and placement
- Visitor management
- Worker safety (PPE)

#### Assessment and Triage

Early recognition of EVD is critical for infection control. The process begins with front line triage/intake staff at health care facilities and 9-1-1 dispatchers. When a patient presents at a clinic, urgent care center, or emergency room, health-care providers should be alert and evaluate patients for EVD using the algorithm at <http://www.cdc.gov/vhf/ebola/pdf/ed-algorithm-management-patients-possible-ebola.pdf>. If EVD is suspected, the patient should immediately be isolated and the local public health department (LPHA) contacted. The LPHA will consult with CDC in order to determine whether the patient should be considered a person under investigation and whether testing is indicated. If warranted, the LPHA will also begin identifying contacts.

Emergency dispatch centers, including 9-1-1 should screen callers for signs and symptoms of EVD and ensure the correct type of resource is dispatched. Details are provided in the algorithm at <http://www.cdc.gov/vhf/ebola/pdf/ems-911-patients-with-possible-ebola.pdf>. Detailed guidance can also be found at <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>.

If possible, dedicated ambulances should be used to transport persons suspected to have EVD. Seats and other surfaces should be covered with plastic or other cleanable material. The ambulance crew should be trained in PPE donning, doffing and use, and should have appropriate PPE on board.

### First Responders

Medical first responders in rural communities should follow the same protocol as the ambulance crew as described below. First Responders should be trained in PPE donning, doffing and use, and should have appropriate PPE on hand. Agencies should document the names of all first responders who run a medical call for a person with EVD or suspected EVD. First responders should limit physical contact with the patient, environmental surfaces, and items to only what is necessary for patient care. When ambulance crews arrive to transport the patient, first responders should perform observed doffing of PPE, dispose of it safely in biohazard bags, and practice hand hygiene. Any equipment that was used (stethoscope, blood pressure cuff, etc.) should be cleaned following CDC guidance at <http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/hospitals.html>.

### EMS Assessment

When EMS providers arrive at the scene, to minimize potential exposure, only one EMS provider should approach the patient and perform the initial screening from at least 3 feet away from the patient. Based on the initial screening, if the EMS provider suspects the patient could have EVD, PPE should be put on before coming into close contact with the patient.

If the patient is not exhibiting obvious bleeding, vomiting, or diarrhea and there is no concern for bleeding, vomiting, or diarrhea, EMS personnel should at a minimum wear a face shield, a surgical face mask, a disposable fluid-resistant gown and two pairs of exam gloves where the outer gloves have extended cuffs.

If the patient exhibits obvious bleeding, vomiting, copious diarrhea or a clinical condition that warrants invasive or aerosol-generating procedures (such as intubation, suctioning, active resuscitation), then ambulance workers should use PPE designated for the care of hospitalized patients. See <http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html> for details.

### Transport

Ebola patients should not receive EMS care at home. If the patient is able to walk unassisted, he should be asked to climb into the ambulance on his own, without touching the exterior. Patients

and caregivers should be transported only in the back of the ambulance. The front cab should remain a “clean” zone.

The patient’s personal items should be stored in the back of the ambulance. The patients should be given a clean disposable gown to wear in the ambulance, but no other PPE. He should be given a water bottle containing safe drinking water and oral rehydration solution. The patient should be instructed to vomit into a bucket that contains a small amount of strong (0.5%) chlorine solution and has a tight fitting lid. Needles or other sharps should not be used when the ambulance is moving.

A caregiver may accompany a child, if necessary for the child’s well-being. Caregivers will need to be provided with a face mask, gown, single pair of gloves, and shoe covers and given help with donning and doffing.

The ambulance team should notify the receiving Ebola care facility by phone or radio prior to arrival so that staff is ready to help the patient. Upon arrival at the hospital, workers properly fitted with PPE should collect the patient as soon as possible and escort him into the facility. Ambulance workers should remain with the ambulance.

#### Decontamination

After the patient is transferred, ambulance staff should perform supervised doffing of PPE, shower, and change into clean clothing.

The ambulance should be moved to an isolation zone where waste and water can be collected and disposed of as it is cleaned. A designated cleaning team should clean and decontaminate the outside surfaces and inside the back of the ambulance, including stretchers, railings, any medical equipment control panels, floors, walls, and work surfaces.

#### Patient Placement

Transmission of Ebola can be prevented by using appropriate infection control measures. Facilities should promptly apply standard, contact, and droplet precautions for any suspected or confirmed EVD patients before they are transported and received at a facility.

The patient should be placed in a single patient room with a private bathroom. The door should be kept closed. The facility should maintain a log of every person who enters the patient’s room.

#### Visitor Management

Visitors should not be allowed in the patient’s room unless their presence is absolutely necessary for the well-being of the patient. If they are allowed in the room, they should be instructed in PPE use, hand hygiene, and limiting surfaces touched. Visitors should not remain in the room during any procedures.



Visitors who have already been in contact with the patient are a possible source of Ebola for other patients, visitors, and staff. Their movement in the facility should be limited to the patient's room and an immediately adjacent private waiting room.

Visitors should properly don and doff PPE under supervision by a trained health care professional and should practice frequent hand hygiene, especially before and after entering the patient's room.

### Worker Safety

Healthcare personnel can be exposed to Ebola virus by touching a patient's body fluids, including but not limited to: urine, feces, saliva, sweat, urine, vomit, breast milk, semen, and vaginal fluids; or by coming in contact with contaminated bedding, clothes, needles, medical supplies, equipment, or contaminated surfaces.

Splashes to unprotected eyes, nose or mouth are particularly hazardous. Aerosol-generating procedures such as intubation, open suction of airways, bronchoscopy and others should not be used unless absolutely necessary. If these or other aerosol-generating procedures must be performed, they should be done in a private patient room (ideally an airborne infection isolation room) with only critical staff present. Doors should be closed during the procedure. Staff should use a combination of measures to reduce exposure, including wearing recommended personal protective equipment (PPE) and disposable filtering face piece respirators. After the procedure, environmental surface cleaning should be done.

Needles and other sharps should be used only when absolutely necessary, and phlebotomy, procedures, and laboratory testing should be limited to the minimum necessary for essential diagnostic evaluation and medical care. Any injection equipment or medication container (other than oral medication) that enters the patient treatment area should be dedicated to that patient and disposed of at the point of use. Needles and sharps should be handled with extreme care and disposed of in puncture-proof, sealed containers.

Health care providers should wash their hands frequently with soap and water, if visibly soiled, or with alcohol-based hand rubs. Hands should be cleaned before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.

### Exposure

Health care workers who have eyes, nose, mouth, or skin exposure to the patient's blood or body fluids should stop working and immediately wash the affected skin surfaces with soap and water. Exposed eyes should be flushed with large amounts of water or eye wash solution. The worker should report the exposure immediately to a supervisor for assessment and access to post-exposure management services.

Health care workers who develop a sudden onset of fever, fatigue, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage should not report to work or should immediately stop working. They should notify their supervisor and their local health department, and should seek prompt medical attention. Workers may not return to work until they are determined to no longer be infectious.

Workers who were exposed, but are not symptomatic should receive medical evaluation and follow-up care including fever monitoring twice daily for 21 days after the last known exposure.

#### Fatalities

Workers should avoid direct, unprotected contact with the bodies of people who have died with EVD. Only personnel trained in handling infected human remains and wearing recommended PPE should touch or move any remains that contain Ebola virus. Remains should be handled following CDC guidelines as described in <http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html>.

Morticians and funeral home directors should follow the Guidance for Safe Handling of Human Remains of Ebola Patients at U.S. Hospitals and Mortuaries located at <http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html>.

#### Equipment

Dedicated, disposable medical equipment should be used when providing care to patients. If equipment cannot be disposable or dedicated, it must be cleaned and disinfected according to the manufacturer's instructions.

### **Emergency Public Information and Warning**

The Agency will provide credible, timely, accurate public information to the general public about the risks of Ebola, signs and symptoms, how the virus spreads, and how they can protect themselves and their families.

The Agency's public information officer (PIO) will identify communication objectives and outcome measurements specific to the event. The PIO will utilize approved messages and talking points from the CDC, found at <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/qa.html>. The PIO may also use approved messages from MoDHSS, and local messages approved by the Agency Administrator. Messages will be updated throughout the response.

The PIO will monitor media outlets and social media and address rumors and misinformation. The PIO will utilize various means to disseminate information in accordance with the Emergency Public Information and Warning section of this EOP.

## **Information Sharing**

The Agency Administrator will ensure appropriate staff are enrolled to receive CDC Health Alert Network (HAN) notifications, NPHIC updates, and MoDHSS HAN notifications. The epidemiologist/CD nurse will maintain situational awareness by regularly visiting the CDC Ebola website at <http://www.cdc.gov/vhf/ebola/index.html> for the latest information, guidance documents, current case counts, maps of affected areas, and other CDC resources. The epidemiologist/CD nurse will disseminate information to state and local response partners, including hospitals, health care providers, pharmacies, school nurses, county OEM, and other partners as relevant based on the incident (Appendix \_\_\_ - Stakeholder Contact List).

## **Non-Pharmaceutical Interventions**

The Administrator and epidemiologist/CD nurse will ensure staff and partners with a need to know are aware of the most current recommendations for travelers. The epidemiologist will provide updates to staff and partners as information changes.

The epidemiologist/CD nurse will regularly review CDC's Interim Guidance for Monitoring and Movement of Persons with EVD Exposure at <http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html>.

The epidemiologist/CD nurse will offer information to community residents who are planning to travel to affected countries or are returning from affected countries. The epidemiologist/CD nurse will ensure travelers have access to the CDC Travelers' Health website at <http://wwwnc.cdc.gov/travel/diseases/ebola> and will work with travelers to implement public health interventions and travel restrictions as appropriate.

## **Public Health Laboratory Testing**

When a case or person under investigation presents in the county, the Agency will consult with MoDHSS and CDC to determine whether laboratory testing is indicated.

Presumptive testing for Ebola virus is available at over 50 LRN laboratories located throughout the United States. Any presumptive positive Ebola test result must be confirmed at the CDC to inform public health decisions. Guidance on collecting, transporting and submitting specimens can be found at <http://www.cdc.gov/vhf/ebola/healthcare-us/laboratories/specimens.html>.

## **Surveillance and Epidemiological Investigations**

The Agency's epidemiologist/CD nurse will consider risk factors when evaluating a person for EVD, classifying contacts, or considering public health actions such as monitoring and isolation

based on exposure. Risk factors are described in detail at <http://www.cdc.gov/vhf/ebola/exposure/risk-factors-when-evaluating-person-for-exposure.html>.

The case definition for a person under investigation is as follows:

a person who has both consistent signs or symptoms and risk factors as follows:

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

**AND**

- An epidemiologic risk factor as described at <http://www.cdc.gov/vhf/ebola/exposure/risk-factors-when-evaluating-person-for-exposure.html>, within the 21 days before the onset of symptoms.

A confirmed case will have laboratory-confirmed diagnostic evidence of Ebola virus infection.

When a case or person under investigation enters the Agency's jurisdiction, the epidemiologist/CD nurse will work with MoDHSS and CDC following guidance in CDC's Interim Guidance for Monitoring and Movement of Persons with Ebola Virus Disease Exposure at <http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html>.

As warranted, the epidemiologist/CD nurse will conduct contact tracing to find everyone who has come in direct contact with a sick Ebola patient. The Agency's epidemiologist/CD nurse and trained public health nurses will monitor contacts for 21 days from the day they came in contact with the Ebola patient. They will watch for a fever or other Ebola symptoms to develop. If a contact becomes symptomatic they will be immediately isolated in an approved Ebola care facility. The epidemiologist/CD nurse will then start the contact tracing process all over again, searching for all the contacts of this new patient. Even one missed contact can allow the outbreak to continue.

### **Responder Health and Safety**

Using the appropriate PPE is one vital component in protecting health care providers from the volunteer First Responder to the hospital specialist. The Agency's Administrator will ensure local stockpiles of PPE are adequate and that all responders are offered training on PPE use, donning and doffing.

The epidemiologist/CD nurse will regularly review the CDC's guidance on PPE use when responding to an Ebola case or suspected Ebola case, and will share updates with health care providers and community partners. Guidance can be found in two documents at <http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html> and <http://www.cdc.gov/vhf/ebola/healthcare-us/emergency-services/ems-systems.html>.

Additional details are provided in earlier sections of this appendix and in the Responder Health and Safety section of this EOP.

### **Special Considerations**

Close contact is defined as being within approximately 3 feet of a person symptomatic with Ebola for a prolonged period of time while not using appropriate PPE.

Ebola virus can be detected in semen for months after recovery from the disease. Unprotected contact with the semen of a person who has recently recovered from Ebola may constitute a potential risk for exposure. The period of risk is not yet defined.

Very few tests have been done to determine how long the Ebola virus can remain viable on surfaces, but one test indicates that under the right conditions, it may remain viable for up to 6 hours.

Rooms in the home where a person with Ebola or suspected Ebola only had a fever with no diarrhea, vomiting or bleeding can be cleaned and laundered as normal. Rooms in the home where a person with Ebola had a fever AND diarrhea, vomiting, or bleeding should only be cleaned by a professional, under the supervision of the local public health agency. Family members and other non-professionals should not handle contaminated materials or waste, or try to clean up any body fluids, soiled surfaces, clothing, bedding or materials.

## **Appendices**

Stakeholder Contact List

## **References**

CDC

<http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/infection-control.html>

<http://www.cdc.gov/vhf/ebola/healthcare-us/preparing/checklists.html>

<http://www.cdc.gov/vhf/ebola/outbreaks/preparedness/planning-tips-top10.html>

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

<http://www.cdc.gov/vhf/ebola/hcp/patient-management-us-hospitals.html>

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

<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>

## ANNEX F

### PREVENTION OF SECONDARY TRANSMISSION

**1. PURPOSE:** To prevent the secondary transmission of communicable diseases as a result of a public health emergency.

**2. ORGANIZATION AND RESPONSIBILITIES:**

- A.** The CCHC in coordination with the DHSS, Southeast District Office, and the Carter County Emergency Management Agency will use this annex and Annex K.1.4 of the DHSS plan. This plan will be implemented if a life-threatening communicable disease emerges.
- B.** The CD Nurse will be for implementing procedures to prevent secondary transmissions during a public health emergency. The Administrator, the RN Supervisor will serve as support and backup
- C.** The CCHC, experiencing a deadly communicable disease, will disseminate information, manage resources (meds/vaccines), and provide technical assistance in accordance with Annex K.1.7 (mass prophylaxis), Annex K.1.8 (mass care) and Annex K.1.9 (mass fatality).
- D.** Inoculation/treatment of medical and emergency personnel and volunteers will be accomplished prior to or immediately after a deadly communicable disease is identified. The Division of Environmental Health and Communicable Disease Prevention maintains the Standard Operating Procedure.
- E.** Hospitals, long term care facilities, and other health care providers, as well as managers of sites providing mass care while experiencing a deadly communicable disease will track the occurrences of secondary transmission and report infection rates daily. See Appendix 1 to this annex for a listing of long-term care facilities and Appendix 2 to this annex for physicians offices.
- F.** The HASS system will be used to report collected data daily to the DHSS. The DHSS will use the Emergency Response Data Collection System to provide CCHC managers with daily information about trends in the communicable disease.
- G.** If the event occurs in an area bordering or close to Carter County, we will increase our use of the HASS system. All health care providers in the area will be asked to collect and report data 7 days a week.
- H.** The DHSS will have primary responsibility for coordination of a response to secondary transmissions of an infectious agent when the affected area extends beyond the area of Carter County.

- I. Once the agent has been identified and it's treatment determined, the DHSS will coordinate delivery of medications/vaccines for emergency workers and potential contacts. Request for support of the CDC's 12 hour Push Package is described in Annex H.
- J. If necessary a patient who is affected by the agent will be isolated or quarantined. Once the agent has been identified, isolation or quarantine procedures will be given final determination. See Annex G for Isolation and Quarantine procedures.
- K. Medical waste will be disposed of in accordance with applicable guidance. Contact Danner Medical Services at 1-573-785-0471.
- L. During the event either Big Springs Medical Clinic or the CCHC will provide monitoring the health status of health care workers. If the capability of monitoring is beyond our capability, the DHSS will establish a monitoring program.
- M. CCHC will work with local veterinarians and local conservation staff for all zoonotic disease. Refer to Annex B- Appendix 1 for contact information.

## ANNEX G

### ISOLATION/QUARANTINE

**1. PURPOSE:** To establish a capability to isolate or quarantine in the event of a local public health emergency. Smallpox and Plague are the most likely biological agents requiring isolation or



quarantine. This annex will deal with smallpox procedures. All other infectious diseases that may require isolation or quarantine will follow similar actions, but will normally be less severe.

**Quarantine** – is defined as a period of detention for persons that may have been exposed to a reportable disease. The period of time will not be longer than the longest period of communicability of the disease. Smallpox is contagious from around day 4 until the last scab falls off. The purpose of quarantine is to prevent effective contact with the general public. The DHSS in coordination with the CCHC Administrator may establish either a complete or a modified quarantine.

A complete quarantine is a limitation of freedom of movement of persons or animals exposed to a reportable disease, for a period of time not longer than the longest period of communicability of the disease.

A modified quarantine is defined as a selective, partial limitation of freedom of movement of persons determined on the basis of differences in susceptibility or danger of disease transmission. Modified quarantine is designed to meet particular situations and includes, but is not limited to, the exclusion of children from school, the closures of schools and places of public and private assembly and the prohibition or restriction of those exposed to a communicable disease from engaging in a particular occupation. 19 CSR 20-20.010(31).

**Isolation** – is defined as the separation for the period of communicability of infected individuals from other individuals, in places and under conditions as will prevent the direct or indirect transmission of the infectious agent from infected individuals to other individuals who are susceptible or who may spread the agents to others. 19 CSR 20-20.010(22)

**2. ISOLATION MEASURES TO A SMALLPOX EMERGENCY:** The following describes the type of facilities that will be utilized for housing selected groups of individuals during a smallpox emergency. **Although isolation of a limited number of smallpox cases may be initially accomplished at local area facilities (Three Rivers Health Care in Poplar Bluff and Advanced Health Care in Ellington, we must be prepared to activate facilities for a larger population of potential smallpox contacts. Until that time, should a suspect case of smallpox be identified in a hospital, strict standard, airborne, and isolation precautions will be followed. These procedures are similar to those used in dealing with varicella cases.**

**A. TYPE C = Contagious Facility:** This facility will house cases of smallpox to minimize the exposure of susceptible individuals to contagious individuals. Contacts who develop a fever and rash during their surveillance period should also be housed in this type of facility (if vaccinated prior to facility admission) while the diagnosis of smallpox is being confirmed or ruled-out in order to minimize the chance of exposure to susceptible persons. **ALL persons entering or admitted to a Type C facility must be vaccinated. Including those who are considered to be smallpox cases.**

**B. TYPE X = Uncertain diagnosis, vaccinated febrile contacts without rash – (two successive temperatures greater than 101 F:** This facility will house a febrile contact during the observation period for further development of symptoms of smallpox (rash). If the number of vaccinated febrile contacts is small, they will be housed in the Type C

facility. It is expected that there will be a number of individuals who will experience fever during this interval. Some will be experiencing the prodrome of smallpox, while most will probably be experiencing fever associated with vaccination or from some other cause. A Type X facility should meet the same isolation and general supply requirements as a Type C. However, a Type X facility need to supply only basic medical care functions such as monitoring vital signs.

**C. TYPE R = Asymptomatic Contacts (not infectious):** A Type R facility may be the person’s home. Asymptomatic contacts must be placed under surveillance for 18 days after their last exposure or until 14 days following successful vaccination (whichever comes first). Asymptomatic contacts may continue routine activities but must remain within 20 miles of their city of residence and must monitor their temperatures twice daily. In addition, they must maintain daily telephone contact with designated health department personnel. If resources permit, closer monitoring is desirable, such as daily visits by the CCHC.

If an asymptomatic contact under fever surveillance develops two successive fevers greater than 101F, they should notify CCHC and **REMAIN** in their home until transportation to a Type X or Type C facility for further evaluation.

**D.** Carter County will the use the following areas for Type C, X and R facilities within the county.

- **Type C:** none within the county
- **Type X:** Carter County will utilize local schools, churches, and the Baptist Assembly Camp facilities.
- **Type R:** Individuals will be confined within their homes.

**E.** Local law enforcement from the Carter County Sheriff’s office or local city marshals will be contacted in the event suspected cases fail to comply with requests by the health department to be quarantined.

Appendix 1 to Annex G

## Isolation and Quarantine Requirements for Smallpox cases and Contacts

### Types of facilities for use during a Smallpox Emergency

<p style="text-align: center;"><b>(iii) Type C Facility</b></p> <p>Type C (=Contagious) Facilities house known or presumed infectious individuals:</p> <ol style="list-style-type: none"> <li>a) Persons with a compatible illness and laboratory confirmation of smallpox (<u>confirmed case</u>)</li> <li>b) Persons with a compatible illness following suspected/known exposure with pending laboratory confirmation (<u>probable case</u>)</li> <li>c) Persons referred by a consultant as <u>suspected cases</u> of smallpox but who do not have a typical clinical presentation</li> <li>d) Can also house <u>febrile contacts without rash</u> (i.e., vaccinated contacts under surveillance who become febrile with oral temperatures of 101°F [38°C] or higher on two successive readings but do not have a rash)</li> </ol> <p>The purpose of a Type C Facility is to house <u>smallpox cases</u> and thus minimizes the exposure of susceptible individuals to contagious individuals. <u>Contacts who develop a fever and rash</u> during their surveillance period should also be housed in this type of facility (if vaccinated prior to facility admission) while the diagnosis of smallpox is being confirmed or ruled-out in order to minimize the chance of exposure to susceptible persons.</p> <p>In addition, if the number of <u>contacts who develop a fever but no rash</u> is small, they may be housed in a Type C Facility with smallpox cases. (If the number is large, additional facilities must be utilized [Type X Facility] to house these individuals.)</p> <p>All persons entering or admitted to a Type C Facility must be vaccinated, including those who are considered to be smallpox cases, because errors in diagnosis are possible. Prior to admitting a patient to a Type C group facility, it is reasonable to consider laboratory testing to rule-out varicella disease in patients without a previous</p>	<p style="text-align: center;"><b>(ii) Type X Facility</b></p> <p>Type X (=Uncertain Diagnosis) Facilities house <u>febrile contacts without rash</u>, i.e., vaccinated contacts under surveillance who become febrile with oral temperatures of 101°F [38°C] or higher on two successive readings (but do not have a rash).</p> <p>The purpose of a Type X Facility is to house a febrile contact during the observation period for further development of symptoms of smallpox (rash). It is expected that there will be a number of contacts who will experience fever during the surveillance period. Some will be experiencing the prodrome of smallpox while most will probably be experiencing fever associated with vaccination or from some other cause. All such individuals should be treated as potentially contagious.</p> <p>A Type X Facility should meet the same isolation and general supply requirements as a Type C Facility. However, Type X Facilities need to supply only basic</p>	<p style="text-align: center;"><b>(i) Type R Facility</b></p> <p>Type R (=Residential) Facilities house <u>asymptomatic (Afebrile) Contacts</u>:</p> <ol style="list-style-type: none"> <li>a) Afebrile vaccinated contacts</li> <li>b) Afebrile vaccinated individuals who were with a smallpox patient 10-18 days before the onset of the patient’s rash (possible common exposure)</li> <li>c) Contacts who refuse vaccination</li> </ol> <p>In a Type R Facility, asymptomatic contacts are placed under fever surveillance for 18 days after their last exposure or until 14 days following successful vaccination (whichever comes first).</p> <p>A Type R Facility may be the person’s own home. Alternatively, because of logistical problems or societal unacceptance of home monitoring, a specific Type F Facility may be established to cohort and monitor asymptomatic contacts during their</p>
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## 2) Rationale for Isolation & Quarantine Guidelines

Prevention of the spread of the smallpox virus from patients to others is a critical part of a control strategy. Smallpox patients usually transmit infection by expelled droplets to close contacts (those within 6 to 7 feet). Although smallpox patients generally are infectious from the time of the first development of rash, the earliest stages of the rash be difficult to recognize. However, preceding the development of rash, the patient will run a high fever for 2-3 days. Isolation of a possible case from the time of the onset of fever will provide a sufficient time to assure appropriate infection control measures are in place at the onset of his/her infectious period (rash). Timely implementation of appropriate infection control precautions in combination with vaccination of all of the close contacts to the case should sharply limit the spread of smallpox.

### 3) Smallpox clinical case definition

An illness with acute onset of fever with 101°F [38°C] followed by a rash characterized by firm, deep seated vesicles or pustules in the same stage of development without other apparent cause.

Laboratory criteria for confirmation\*

Polymerase chain reaction (PCR) identification of variola DNA is a clinical specimen, OR

Isolation of smallpox (variola) virus from a clinical specimen (Level D laboratory only) with variola PCR confirmation.

**Note:** Orthopox PCR and negative stain electron microscopy (EM) identification of a pox virus in a clinical specimen suggest an orthopox virus infection but are not diagnostic for smallpox. Additional variola-specific laboratory tests, such as antigen capture and DFA tests are under development and may be available in the future.

from cases with an unclear presentation but who are suspected cases.

*\*Laboratory diagnostic testing for variola virus is conducted in Level C or D laboratories only. Level D laboratories include the CDC and USAMRIID. Initial confirmation of a smallpox outbreak requires testing in a Level D laboratory. Level C laboratories will assist with testing of clinical specimens following initial confirmation of an outbreak by CDC.*

### a) Smallpox case classification

**Confirmed case:** A case of smallpox that is laboratory confirmed, or a case that meets the clinical case definition that is epidemiologically linked to a laboratory confirmed case.

**Probable case:** A case that meets the clinical case definition, or a case that does not meet the clinical case definition but is clinically consistent with smallpox and has an epidemiological link to a confirmed case of smallpox. Examples of clinical presentations of smallpox that would not meet the clinical case definition are: a) hemorrhagic type, b) flat type, and c) variola sine eruptione.

**Suspect case:** A case with a febrile rash illness with fever preceding development of rash by 1-4 days.

**Contact:** A person who has been exposed to the risk of infection.

**Primary contact:** person with contact with a confirmed, probable, or suspected case of smallpox during the infectious period. Primary contacts include both household and non-household contacts. Risk of smallpox transmission is increased with increased duration of close, face-to-face (<6 ft) contact. Priority categories for contacts, from highest priority to lowest, are as follows:

- a. Case household family members and others spending 3 or more hours in the household since the case's onset of fever.

### i) Isolation

**Isolation:** The separation of a person or group of persons from other people to prevent the spread of infection.

**Quarantine:** The restriction of activities or limitation of freedom or movement of those presumed exposed to a communicable disease in

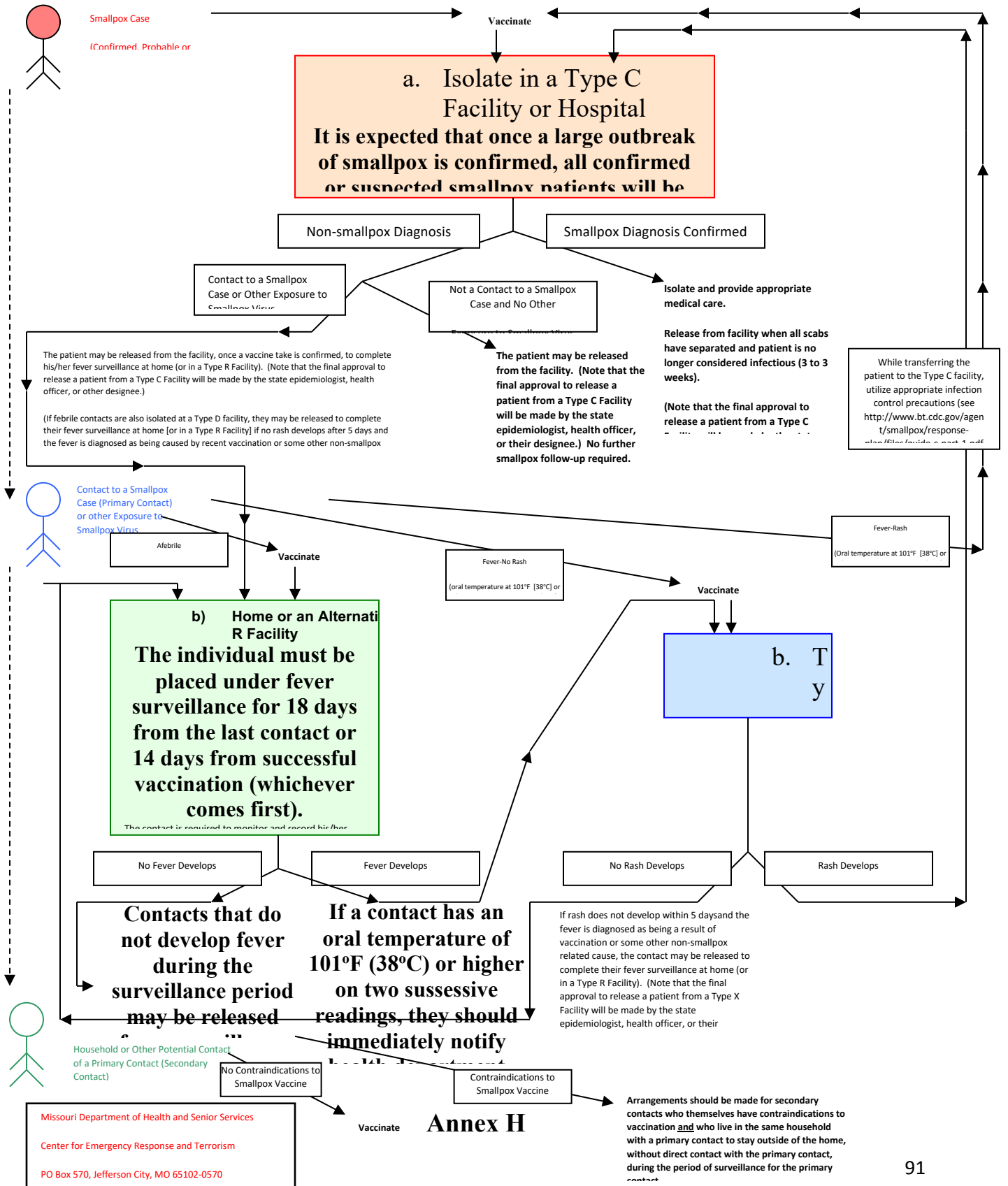
Quarantine has had a legal basis in Missouri (and in other states) for many years. According to 192.020 RSMo, the Department of Health and Senior Services (DHSS) has the "general duty and responsibility" to safeguard the health of the people in the state and all its subdivisions. The department "shall designate those diseases which are infectious, contagious, communicable or dangerous in their nature and shall make and enforce adequate orders, findings, rules and regulations to prevent the spread of such diseases."

According to 19 CSR 20-20.040, when a report of a communicable disease is received, one of the duties of the Local health authority, the director of DHSS, or the director's designated representative will be to "establish and maintain quarantine, isolation or other measures as required," and to "establish appropriate control measure which may include isolation, quarantine, disinfection, immunization, closure of establishment and other measures considered appropriate by medical experts for the protection of public health."

Missouri Department of Health and Senior Services  
Center for Emergency Response and Terrorism  
PO Box 570

**Regarding situations where a suspected (but not yet definitively diagnosed) communicable disease is**

Appendix 2 to Annex G  
**Isolation and Quarantine Requirements for Smallpox Cases and Contacts**  
**Types of Facilities for Use During a Smallpox Emergency**



## MASS PROPHYLAXIS

### **I. PURPOSE:**

To establish procedures for providing life-saving pharmaceuticals and medical supplies with or without the activation of the Strategic National Stockpile (SNS) in a local public health emergency. In the event of a public health emergency, including those resulting from a terrorist attack or other natural disaster, Carter County residents, surrounding community residents and visitors to the community may require medicines, antidotes, medical supplies and medical equipment to counter the effects of biological pathogens, chemical and nerve agents. These guidelines establish a framework to distribute needed pharmaceuticals throughout the community in a coordinated and efficient manner.

Distribution of prophylaxis materials will be accomplished by establishing distribution sites strategically located throughout the community. Distribution sites may be a public distribution site for the general population of the affected area or a private distribution site for a specific target population such as first responders within the affected area. The goals of all distribution sites will be:

1. Provide preventive medications or vaccinations as deemed appropriate
2. Provide the pharmaceuticals in an orderly and efficient manner
3. Provide basic educational information
4. Divert asymptomatic persons away from area hospitals
5. Direct symptomatic patients to area health care facilities
6. Secure the pharmaceuticals within the distribution sites
7. Provide secure transportation of the pharmaceuticals from the community distribution node to the distribution site
8. Provide a timely, essential service throughout the community

Public distribution sites are selected based on their location, size, facility assets, being a well known facility within the community, traffic flow options externally as well as internally and normal use of the facility.

If a terrorist attacks or a major natural disaster or a technological accident occurs that requires the deployment of the SNS, CCHC will be responsible for deploying its resources for retrieving the SNS from the RSS/ADS.

### **II. ORGANIZATION AND RESPONSIBILITIES:**

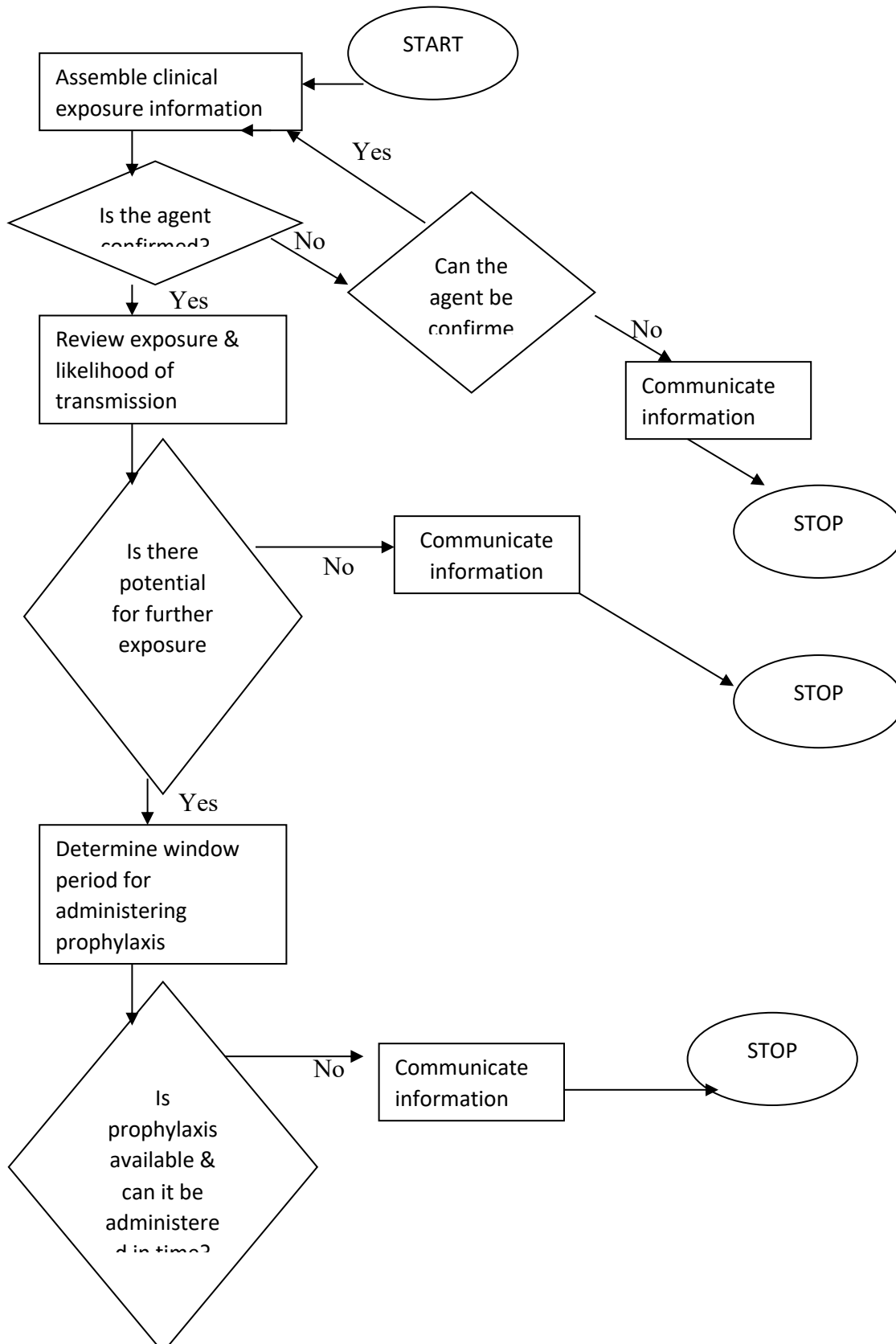
A. Before an emergency, our mission is to:

1. Educate public and private health care providers about the
  - Contents of the packages of medical material and equipment included in the SNS.
  - Method and justification for requesting the SNS.
  - Arrival of the SNS after a federal decision to deploy.
2. Assist hospitals in planning for dispensing the SNS to treat patients as well as employees and their families.

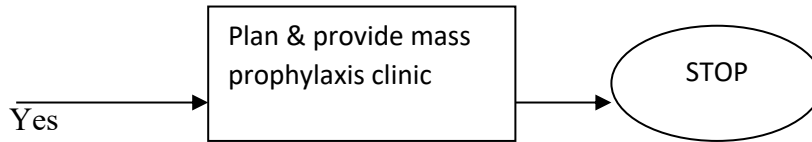
3. Plan and train for management of the SNS at the dispensing sites to provide prophylactic medicines to others.
  4. Establish and maintain methods for distribution of the SNS quickly to hospitals and distribution sites located throughout the county.
- B. During and emergency, our mission is to:
1. Distribute drugs, vaccines, medical supplies, and medical equipment to the dispensing sites, hospitals and other emergency medical providers within 6 hours after the SNS is received into Carter County, and continue to deliver material to these entities, for as long as it is needed.
- C. The Carter County Health Center (CCHC) Administrator is responsible for activating the procedures for providing pharmaceuticals/vaccines and medical supplies in a local public health emergency. The Administrator must exhaust all local pharmaceutical resources before requesting the SNS. Pharmaceutical resources can be found in the Resources Guide, see Pharmacies. In the absence of the Administrator, the responsibility for activation would rest with the Assistant Administrator then the Director of Nursing. Follow the Line of Succession outlined in the Chain of Command in the Basic Plan.
- D. Justification for providing mass prophylaxis may include but not limited to; overt release of a chemical or biological agent, a claim of release from intelligence or law enforcement, and clinical or epidemiological indications. See Appendix 1 for the Decision Process for Mass Prophylaxis.
- E. A first responder vaccination/medication plan may be implemented to treat certain key staff, first responders, volunteers and perhaps their families. Dispensing Sites will be utilized to medicate/vaccinate the first responders/staff prior to opening the Dispensing Site to the general public. The number of individuals to receive needed medications will be determined by the CCHC's Administrator in coordination with the EMA. See Resource Guide for First Responders.
- F. A ring vaccination plan may be implemented to treat the symptomatic ill and their contacts. Plans for deploying the SNS should happen simultaneously with implementation of the ring vaccination plans. The ring vaccination plan is designed to slow and perhaps stop the spread of an infectious disease in a relatively small group of symptomatic ill individuals.
- G. Mass prophylaxis requires collaboration and communication among several entities to provide rapid, effective intervention. The CCHC will collaborate between the Centers for Disease Control (CDC), the Missouri Department of Health and Senior Services (DHSS), and local community partners to administer the dispensing of mass antibiotics and/or vaccinations.
- H. The CCHC Medical Director or Standing Order Physician is responsible for providing official written orders allowing CCHC employees, whether full-time, part-time or volunteer, to administer or distribute lifesaving medications; this includes all pharmaceuticals in the SNS. These official pre-signed documents can be found in the CCHC Command Center and the nursing department. See Resource Guide for Standing Orders and MOU's.

- I. The SNS will be deployed only after all local pharmaceuticals/antibiotics/vaccines are exhausted and the need for additional supplies is required. In the event of an emergency, local pharmacies will be asked to assist by providing pharmaceuticals to the CCHC. Local pharmacies are NOT obligated to supply drugs and there are no guarantees for replenishment. See Pharmacies in Resource Guide.
- J. If identification of the biological or chemical agent is obtained. The CCHC in collaboration with DHSS may request a portion of the SNS called the Vendor Managed Inventory (VMI).
- K. Communications between CCHC and **ALL** sentinel sites, hospitals, veterinarians and pharmacies will be established and maintained to determine the number of symptomatic ill and casualties. If necessary, increase surveillance to at least daily. A list of all the above agencies can be found in the Resource Guide under the general heading of each category.
- L. The CCHC will contact the representative for the Carter County EMA to request the assignment of Volunteers. These Volunteers will be deployed to their predesignated or upon reporting an immediately assigned site/post to assist in the distribution of pharmaceuticals/vaccines.
- M. \*(1, 2, or 3)\* locations in Carter County have been chosen and identified as Vaccination/Dispensing Sites (DS). These DS's will be used to dispense the proper medications or vaccinate against the suspected disease/agent. For location and contact information concerning Distribution Sites, See Distribution Sites in the Resource Guide. For additional information concerning Dispensing Sites see Appendix 2 to Annex H, Part II Standard Operating Guidelines.
- N. CCHC Administrator and the Director of Nursing may need to address the needs of those individuals identified as high risk in a fixed population area. Mobile medical/vaccination teams, consisting of CCHC nurses and CERT volunteers may be deployed to high-risk/fixed population areas to administer emergency medications/vaccinations. This process will not begin until the general population has been treated. As staff members are released from their duties at the Dispensing Sites, they will be utilized to form mobile Dispensing teams. The CCHC Director of Nursing will be in charge and the Administrator will oversee the entire process. See Resource Guide for list of High-Risk/Fixed population areas, especially the Home Bound and those confined to Nursing Homes.
- O. Nursing homes and other fixed population facilities may prearrange with CCHC to pick up certain medications from the DS. Narcotics will not be released to these facilities but medications for Anthrax, Tularemia, Plague may be picked up prior to the DS opening for the general public. These facilities must have qualified individuals to dispense medications.
- P. Security of the SNS will be provided by the Carter County Sheriff's Office and the host city Police Department. These law enforcement agencies will provide total security (24/7) of the SNS while it is in the possession of the CCHC.
- Q. For Missouri Department of Health and Senior Services (DHSS) response to mass prophylaxis, see State of Missouri Post-Event Smallpox Mass Prophylaxis Plan Annex K.1.7.

Appendix 1 to Annex H  
**DECISION PROCESS FOR MASS PROPHYLAXIS**







Appendix 2 to Annex H  
PART I  
**MASS PROPHALAXIS**  
**SNS INTRODUCTION**

**PART I**

**SNS INTRODUCTION**

The SNS is a federal repository of medicines, antidotes, medical supplies and medical equipment (life-support medications, IV administration and airway maintenance supplies). The SNS Program is designed to supplement and re-supply state and local public health agencies in the event of a biological, chemical or nerve agent terrorism incident anywhere, at anytime, within the United States.

The SNS is organized into two types of delivery packages. **12-Hour Push Packages** that are caches of pharmaceuticals, antidotes, and medical supplies designed to address a variety of biological, chemical or nerve agents. The Push Packages are approximately 3% of the SNS assets. The second delivery type is the **Vendor Managed Inventory (VMI)**. VMI supplies are specific materials that can be deployed in larger amounts than the supplies in the Push Packages. The SNS is also capable of obtaining additional materials from the manufacturers or vendors of the materials in a rapid procurement system.

Push Packages are positioned in secure regional warehouses ready for immediate deployment to the airfield closest to the affected area following a federal decision to release SNS. The Push Package should arrive at any location within 12 hours of deployment orders. The Push Package may also be trucked into a community if the SNS warehouse is near the desired destination. The CDC is responsible for delivery of the SNS or VMI to the designated Receipt, Storage, and Staging (RSS) facility within the requesting community.

If an incident requires additional pharmaceuticals and/or medical supplies, follow-up Vendor Managed Inventory (VMI) supplies will be shipped to the affected area. The VMI packages can be tailored to provide pharmaceuticals, supplies and/or products specific to the suspected or confirmed agent or combination of agents.

The CDC may opt to not deploy a complete Push Package in some incidents but instead send VMI materials that are sufficient for the specific incident or agent.

On March 1, 2003 the Strategic National Stockpile (SNS) program (formerly the National Pharmaceutical Stockpile [NPS] Program) was transferred from the Centers for Disease Control and

Prevention, to the U.S. Department of Homeland Security. The SNS Program provides states with quantities of medical materiel and equipment to utilize during a terrorist event.

The Missouri SNS Program is located in the Department of Health and Senior Services (DHSS), Center for Emergency Response and Terrorism (CERT) and is a component of Missouri's public health system to respond to a terrorist or natural event. The CERT exists to not only protect Missouri residents and guests from a terrorist event, but to also assist other state agencies, organizations, hospitals, Local Public Health Agencies (LPHAs), and communities to respond to the medical consequences of terrorist attacks, natural disasters, and technological accidents.

**If a terrorist attacks or a major natural disaster or a technological accident occurs, state and local jurisdictions probably will deplete the supplies of pharmaceuticals and other medical items rapidly. Anticipating this situation, congress established a massive stockpile of pharmaceuticals, vaccines, medical supplies, equipment, and other items to augment local supplies of critical medical items. That stockpile, managed by the U.S. Department of Homeland Security, in coordination with the Centers for Disease Control Prevention (CDC), is known as the Strategic National Stockpile (SNS).**

The Missouri Department of Health and Senior Services (DHSS) has a plan to request, receive, and distribute the SNS to Local Public Health Agencies (LPHAs), hospitals, and EMS providers. The State will distribute the contents of the stockpile at six state distribution sites (number of distribution sites open will depend on the location and size of the event). Due to security reasons, the location of these sites will **NOT** be made known to the LPHAs, hospitals, and EMS providers until the time of the event. Additional state distribution sites will be added in the future.

While the receipt and distribution of the stockpile is a monumental task, this is a small part of what needs to be done in order to get necessary medicines and medical supplies to the residents and guests of Missouri. The dispensing process is the most challenging and labor intensive function of the SNS management. Carter CCOUNTY HEALTH CENTER must be prepared to receive their portion of the stockpile should a biological emergency arise. The Carter CCOUNTY HEALTH CENTER must plan for mass pharmaceutical dispensing, as well as mass vaccination. Hospitals must plan for the treatment of staff, their families, as well as patients. Hospitals must also address how their facility will handle a surge capacity of large numbers of individuals presenting for treatment as a result of a terrorist event.

## **ABBREVIATIONS/DEFINITIONS**

SNS Strategic National Stockpile. Stockpile of drugs and other medical material that CDC will deliver to a state.

CDC Centers for Disease Control and Prevention.

RSS Receiving, Staging, and Storage Site for SNS (state responsibility).

ADS Area Distribution Site for the SNS (state responsibility).

Distribution. The process of providing the SNS from a RSS or ADS to Local Public Health Agencies, treatment centers, community health centers, emergency medical system providers, or private physicians (state responsibility).

Dispensing Sites. The community locations where the public receives prophylactic medicines (local responsibility).

Prophylactic Drugs. The drugs that protect against biological threats, such as anthrax.

TARU. The SHS Program's Technical Advisory Response Unit of skilled individuals who arrive with the first shipment of the SNS to assist state and local officials.

Treatment Centers. The locations in a community where the sick receive treatment. These include hospitals, clinics, and other sites that treat the sick and injured.

Material. Contents of the 12-hour Push Package or the Vendor Managed Inventory.

#### **a. CARTER COUNTY SNS PARTICIPANTS**

The CCHC will be assisted in any emergency response effort by many other agencies including but not limited to the following:

- The Local Emergency Planning Committees (LEPCs) and their members
- Other local Health Centers
- The American Red Cross
- Local police, fire and medical first responders
- Local hospitals and health care workers
- Local volunteers
- Local public schools and other designated dispensing sites
- Local media
- The Missouri Department of Health and Senior Services
- The State Emergency Management Association (SEMA)
- The Missouri State Highway Patrol
- The National Guard
- The Federal Emergency Management Association (FEMA)
- The US Centers for Disease Control and Prevention (CDC)
- The Federal Bureau of Investigation (FBI)

If a terrorist attacks or a major natural disaster or a technological accident occurs that requires the deployment of the SNS it is likely that one of the effected counties will be Carter County.

One Carter CHC employee and one pharmacist (if needed) will be contacted and required to report to the Carter CHC Command Center. These two individuals will accompany the delivery vehicle to the state RSS/ADS site. The Carter CHC employee will sign release forms to receive all of the SNS except the narcotics. The pharmacist will sign different release forms to acquire into their possession the narcotics portion of the SNS. A list of five (5) Carter CHC employees available to sign the release forms and a list of available pharmacists is as follows: Michelle Walker, RN,

Dakota Turley, RN, Tracy Chitwood, Heather Towner, and Debbie Sandarciero. See Pharmacists in the Resource Guide.

The CCHC's Administrator or their designee will contact the Health Centers of Region G, Butler, Ripley and Wayne Counties to prepare to implement their emergency plans.

The Carter CHC will contact the local EMD to begin the contact process for the SNS Team Leaders. The Team Leaders will be briefed and updated on the possibility of deploying the SNS. This team will then begin the contact process for the entire SNS Team.

The SNS Team Leaders consist of:

Health Center Administrator  
Carter County Commissioners  
Carter County Emergency Management Director  
Stockpile Liaison  
Incident Commander

**Health Center Administrator** (Will remain on duty or on call)

- A. Maintains contact with the DHSS SNS Program Manager through the Department Situation Room (DSR) and updates the plan when needed.
- B. Answers and oversees all leadership questions for the entire event.
  - C. The Administrator must choose one of five predestinated employees available to sign the release forms required by the state to acquire Carter County's portion of the SNS. The person chosen by the Administrator (one of the five) must accompany the delivery truck(s) to the RSS/ADS and sign the appropriate SNS release forms.
- D. Maintains constant contact with the EMA and Planner.
- E. Has full responsibility of the SNS while it is in Carter County.
- F. Must convene with the Carter County Commissioners Office prior to deployment of SNS.
  - The Health Center Administrator will be assigned to the Carter CHC Command Center. (2<sup>nd</sup> choice- the Carter County EOC).

**RN Supervisor** (Will remain on duty or on call)

- A. Assist the CCHC Administrator with planning decisions in all aspects of the SNS deployment.
- B. If chosen by the Administrator, must accompany the delivery vehicle(s) to the RSS/ADS and sign the appropriate SNS release forms.
- C. Assist with the communications between Administrator, DHSS, EMA, the Distributions Sites and all other agencies involved.

**Epidemiology Specialist** (Will remain on duty or on call)

- A. Is responsible for investigation of suspected released agent and providing information to the Administrator for decision making purposes. Type of agent released, when and where released, and what can be done to prevent spread of disease.
- B. Remains in contact with the DHSS Epidemiologist and CCHC Administrator.
- C. If chosen by the Administrator, must accompany the delivery vehicle(s) to the RSS/ADS and sign the appropriate SNS release forms.

- The Epidemiology Specialist will be assigned to the CCHC Command Center.

**CARTER County Commissioners** (Will remain on duty or on call)

- A. Commissioners' duties are outlined in the Carter County Emergency Operations Plan, but will be available as a resource and to answer any questions concerning the logistics and financial state of the county.
  - B. Based on information from the Carter CCHC and Carter County EMD, the final decision to deploy the SNS rest with the Commissioners.
  - C. Will remain available for immediate contact by the Carter CCHC Administrator and the Carter County Emergency Management Director.
- The Carter County Commissioners will be assigned to the Carter County EOC.

**Carter County Emergency Management Director** (Will remain on duty or on call)

- A. Is responsible for beginning the "call down list" to alert EOC staff and coordinators of possible deployment.
  - B. Is responsible for contacting the appropriate SEMA representatives and other agencies.
  - C. Remains in continuous contact with the CCHC Administrator and Planner at the Command Center.
- The Carter County Emergency Management Director will be assigned to the Carter County EOC.

**Stockpile Liaison** (1 per shift).

- A. Will work in cooperation with the CCHC Administrator to answers leadership questions and oversee the entire SNS once it is deployed.
  - B. Clarifies leadership information and provides guidance to the SNS Team Leaders.
  - C. Maintains contact with the CCHC Administrator and updates the plan when needed.
  - D. Works with CCHC administrator, DHSS, CDC and all other participants to properly deliver, distribute and dispense the SNS.
  - E. If chosen by the Administrator, must accompany the delivery vehicle(s) to the RSS/ADS and sign the appropriate SNS release forms.
- The Supply (Stockpile) Manager will be assigned to the CCHC Command Center. (2<sup>nd</sup> choice- the Carter County EOC).

**Dispensing Site Incident Commander** (one per incident)

- B. Will be involved with overall strategic planning with SNS Team Leaders.
- C. Will be assigned by the CCHC Administrator and/or County Commissioners for planning and operations of one dispensing site or all dispensing sites in Carter County.
- D. Will review the SNS planning documents and make adjustments to meet the current situation.
- E. Notify the EOC of the medical and non-medical personnel needed to handle the dispensing site(s)
- F. Will keep the EOC informed of plans, status, and other information so the Carter County situation can be assessed and other decisions can be made...

## PART II

### STANDARD OPERATING GUIDELINES

#### I. PURPOSE:

To establish Standard Operating Procedures and resolve operational issues of dispensing and administrating medications. In order to provide medication to large numbers of population efficiently and quickly, Standard Operating Procedures (SOP) must be uniform for each Dispensing Site (DS).

#### II. ORGANIZATION AND RESPONSIBILITIES:

CCHC will be responsible for receiving, storing and dispensing the SNS to the residents of Carter County. See Appendix 2 to Annex H for MOU between Health Center of Region G and the responsibilities of said counties. Wright County will work to secure adequate transportation that meets DHSS approval to transport resources allocated for said counties from SNS RSS/ADS site. Carter CHC will only be responsible for deploying a vehicle to retrieve the proper amount of pharmaceuticals for Carter County to distribute to their residents at the site specified in Appendix 2 to Annex H.

1. Security must be provided from the time the delivery trucks leave Carter County until the SNS is returned back to the CDC. The Carter County Sheriff will provide security.
  - a. Carter County Sheriffs Office (SO) will have the lead role for providing security while the SNS is being transported. The SO in cooperation with the Missouri State Highway Patrol and perhaps the Missouri National Guard will provide enough armed officers required to escort the delivery vehicles from Carter County to the pick-up site and to the designated/assigned DS located in Carter County. Carter County SO will remain with the trucks until they reach their destinations. Carter CHC and Carter CSO will determine the proper number of officers prior to departure of the delivery truck(s). It is suggested that two patrol vehicles will accompany the delivery truck(s).
  - b. All SNS products delivered to Carter County **must** remain under security 24 hours a day 7 days a week. The Carter County SO may find it necessary to request state assistance for law enforcement and security.
- B. Definition of Roles and Responsibilities for Dispensing Site Staff and Volunteers. The DS will be managed using ICS. The size of the organization will depend on tasks at hand, time constraints, and available facilities.
  1. **Incident Commander**-The Incident Commander will be responsible for incident activities and implementing strategic decisions and approving and releasing

resources. Oversees all Dispensing Site functions/problem solving, planning and continuity of DS. IC is responsible to the LPHA and/or county commissioners.

2. **Deputy Incident Commander**-The Deputy Incident Commander will assist the Incident Commander in duties as assigned.
3. **Operation Section Chief**-The Operation Section Chief is a member of the general staff and will be located in the incident command post and will oversee the non-medical and medical operation of the dispensing activity and assist with the problem solving and planning, staffing and supply needs. The Operation Chief will supervise Medical Branch Director and Administrative Support Branch Director report to the Incident Commander.
4. **Medical Branch Director**-One (1) Medical Branch Coordinator (medical personnel) will supervise the vaccination stations or dispensing stations and all medical aspects of the DS and assist all medical staff members with their duties. The Medical Branch Director will coordinate very closely with the Administrative Support Branch Director in the management of the site. They will report to the Operation Chief.
5. **Registered Nursing Staff**-(5-10) registered nurses will be utilized in many areas throughout the DS. Nurses will review recipient's medical history for those with contraindications and answer questions for informed consent, if required. Highlight contraindications and record comments on back of the Screening and Consent Signature Form. Check all forms for completeness and collect all required forms. Dispense medications correctly based on information collected from each individual. Confirm that each dosage of medication is correct. Verify that the recipient is to be medicated/treated. Administer medication/treatment and teach medication procedures to recipients. Assist recipients with completing the required forms and direct them to the next area of DS. Actual numbers may vary from site to site. Algorithms and other associated medical paperwork will be provided to each nurse. RN's will report to the Medical Branch Director. See attached individual Site Map for exact location of nurses.
6. **Pharmacist**-(1) pharmacist or pharmacy technician that has been trained in preparation of medications will be located in the Dispensing Area of the DS. The Pharmacist will ensure that all medication is stored and handled according to specific manufacturer's instructions. Prepare medication to supply to distributions tables. Maintain adequate supply of medication. Keep medication supply locked and limit access to storage area to authorized personnel. Track medication supply by lot numbers, distribution, and wastage. The pharmacist will confirm each pharmaceutical dosage based on the information collected and recorded on forms. The pharmacist along with the medications will be located in a secure area inside the distribution area. If not available, these tasks will be assigned to the Medical Branch Director. See attached individual Site Map for exact location of pharmacist and medications. (Establish relationships with local Pharmacists.)
7. **Pharmacist Helper**-(1-2) Pharmacist Helper will be assigned to assist the Pharmacist with their duties. The helper will report directly to the Pharmacist.

8. **Triage Staff**-Medical volunteers (Nurse, EMT or Paramedic). (1-2) Triage Staff members will be located outside the DS to examine and redirect ill or symptomatic recipients to other evaluation facilities or locations within the DS. Symptomatic individuals with the disease of the released agent must not be allowed to enter the DS. Triage forms will be provided to Triage Staff. Actual numbers may vary from site to site.
9. **Administrative Support Branch Director**-One (1) Administrative Support Branch Director (non-medical) will supervise the non-medical support functions (forms, greeting, printing, etc.) of the dispensing operation in support of the medical staff. They will coordinate very close with the Medical Branch Director and Operation Chief.
10. **Greeters/Internal Flow Staff** (internal)-Greeters will be non-medical volunteers that will help maintain traffic flow through DS, assist with forms, quality assurance, rotate through DS to answer questions, and talk with recipients to assure them, as needed. Scripts will be provided to those staff members to properly orient the public. (5) Greeters will be located throughout the DS. Actual numbers may vary from site to site. Greeters may also be used in other areas that do not require prior medical knowledge. See attached individual Site Map for exact locations for Greeters.
11. **Forms Distributors Staff**-(4) non-medical Forms Distributors will be located near the beginning of each DS. Forms Distributors will put together recipient forms packets and distribute packets with information sheets, registration and consent forms and all other required forms along with clipboards and pencils. Forms Distributors will also assist Internal Flow Staff by directing recipients to the next area of the DS.  
Forms will be provided to each DS. Carter CCOUNTY HEALTH CENTER Administrator will be responsible for determining the number and type forms needed. The Forms Leader will report to Administrative Support Branch Director. Actual number of staff may vary from site to site. See attached individual Site Map for exact location of Traffic Flow Staff.
12. **Float Team Leader and Staff/Runners**-(2) Float Staff team members comprised of both medical and non-medical volunteers will be located throughout the DS to answer telephones, collect forms, assist with handicapped and elderly and assist other staff members as needed. Float Staff volunteers will standby to assist in all areas of the DS. Float Staff leader will report to the Administrative Support Branch Director. Actual numbers may vary from site to site. See attached individual Site Map for exact location of Float Staff.
13. **Video Orientation Leader or Health Educator**-(3) non-medical volunteer to operate video equipment, advising recipients on clinic procedures and perhaps paperwork and indications and contraindications to medications. Videos will be shown simultaneously on several monitors located throughout the DS or a large viewing room may be utilized. The Leader or Health Educator will report to the



Administrative Branch Director. See attached individual Site Map for exact location of video equipment and rooms.

14. **Printing Leader and Staff**- This may be a very big task depending on the agent, materials received with the SNS, and size of dispensing site. This staff member will have at least one and probably two computers and printers available to print labels, forms, educational sheets and other materials needed by the staff of the DS. They will report to the Administrative Support Branch Director but working very close with the Medical Branch personnel. *Computers, printers and electrical supply cords will be furnished by the host agency supplying the building for the DS or placed at the DS by the LPHA or provided by Logistics.*
15. **Planning Section Chief** – Planning Section Chief is a member of the general staff and responsible for collection, evaluating, dissemination and status of resources. They also supervise preparation of the Incident Action Plan, provide for check in procedures, coordinate information reporting requirements and supervise the planning section. They are located at the incident command post.
16. **Resource Unit Leader**-The Resource Unit Leader is responsible for establishing check-in procedures, preparation of resources status changes, preparing and maintaining lists, charts, and maps that reflect resource status, location, and maintain a master check-in list if assigned. Resource Unit Leader reports to the Planning Section Chief.
17. **Stockpile Liaison**-One person will be assigned to be the liaison between the Health Administrator, EOC, DHSS and the Incident Commander with issues dealing with the SNS while it is in Carter County. They will assist in coordination of all supply, tracking medication, supply/lot numbers, distribution, wastes associated with the DS. The Stockpile Liaison will be located in the EOC.
18. **Volunteer Manager**-One (1) non-medical Volunteer Manager will report to the Plans Chief to assist in assigning all non-medical and medical volunteers in the proper places to best serve the recipients. The Manager will maintain open communications with the Volunteer Coordinator at the EOC. Through the EOC and the Emergency Management Agency the Volunteer Manager should maintain a small team of extra volunteers at the DS and have additional volunteers available off site. The Volunteer Manager will be located in the incident command post and keep in contact will functions using volunteers.
19. **Physician Evaluator**-At least (1) medical physician will be in attendance at the DS if possible. (If a physician is not personally present then arrangements must be made to contact one by phone). The physician will evaluate/examine triaged ill persons and provide backup counseling for those with contraindications and answer questions for informed consent. Evaluate any immediate medical problems throughout the DS. The Physician will be assigned to the Planning Section and work with all other sections as a technical specialist.

20. **Translator**-One (1) Translator will be available at each site to translate for recipients who do not speak English and are not accompanied by someone who can translate for them. The Translator should be stationed near the front entrance of the DS. The Translator will report to the Administrative Support Branch Director.
21. **Emergency Medical Services**-An EMS team will be provided to the DS by the county emergency medical services department and will be staged at the incident command post. The EMS team will provide enough proper equipment to handle any medical emergency that might arise. The EMS team will not leave the DS for any reason. If transportation of a victim is required an additional EMS team will be called to the scene. The EMS team will provide first aid for recipients and DS staff within the scope of licensure. Maintain a record of emergency care given. EMS will report to the Plans Chief. They may be used to provide triage at times.
22. **Logistics Section Chief** – Logistics Section Chief is a member of the general staff and responsible for providing facilities, services and material to support the incident. They will assist in the overall planning and supervises those units in the logistics section. They are located at the incident command post.
23. **Supply Team Unit Leader and Staff**-(5) volunteers will be assigned as the Supply Unit. This Unit will assist all functions with securing and storing needed supplies to carry out their assigned responsibilities at the DS. They will assist with movement of the medications from one station or location to another within the DS. This team will deliver and move all materials, tables, computers, printers, chairs and other equipment. The Supply Unit Leader will report directly to the Logistic Section Chief.
24. **Security Manger and Security Staff**-will be provided by both the Carter County Sheriffs Office (SO) and the host city Police Department. SO will provide (1-2) officers to each DS and will be stationed primarily outside the building to provide external security and assist with parking issues. The host city will provide minimum of (X) officers and primarily will be stationed inside the DS to provide security and safety of staff and recipients. Officers will maintain security of DS supply storage site, maintain security within DS and maintain perimeter security outside DS. Security will maintain crowd control inside and outside of DS, assist with clinic and traffic control, and other security matters. All officers will survey all individuals for suspicious activity and take all precautions to maintain peace and safety of others. The actual number of officers may vary depending on needs and from site to site. The on-site Security Manager will be the host city Police Chief or their designee. The Security Manager will be located in the on-site. See attached individual Site Map for exact locations for security officers.
25. **Ground Support Leader and Parking Staff** (external)-The Ground Support Leader and Parking Staff will maintain traffic flow and order in parking areas. This group will work together to direct recipients to the proper parking areas and assist them to the DS. They will survey all recipients for suspicious activity and report their findings to security immediately. The actual number needed will vary from site to site.

Ground Support Leader will report to and take direction from the Logistics Chief located in the on-site incident command post. See attached individual Site Map for exact locations for parking and traffic flow patterns.

**26. Facilities Unit Leader and Staff-** Facilities Unit Leader is responsible for general layout and activation of the incident facilities and incident command post. This will include setting up all work stations, sanitation, lighting, waste and clean up. They will report to the Logistics Section Chief.

**26. Finance Section Chief** – Finance Section Chief is a member of the general staff and responsible for all financial and cost analysis aspects of this incident. This includes timekeeping, procurement, claims and composition injury. They are located at the incident command post.

#### **D. Legal/Policy Issues**

1. **Priority Prophylaxis:** To mitigate potential absenteeism, and because of the concern for first responders, prophylaxis medications may be available to affected first responders prior to, or simultaneously to, the arrival of the SNS. Priority prophylaxis may be provided to these groups in the following order:

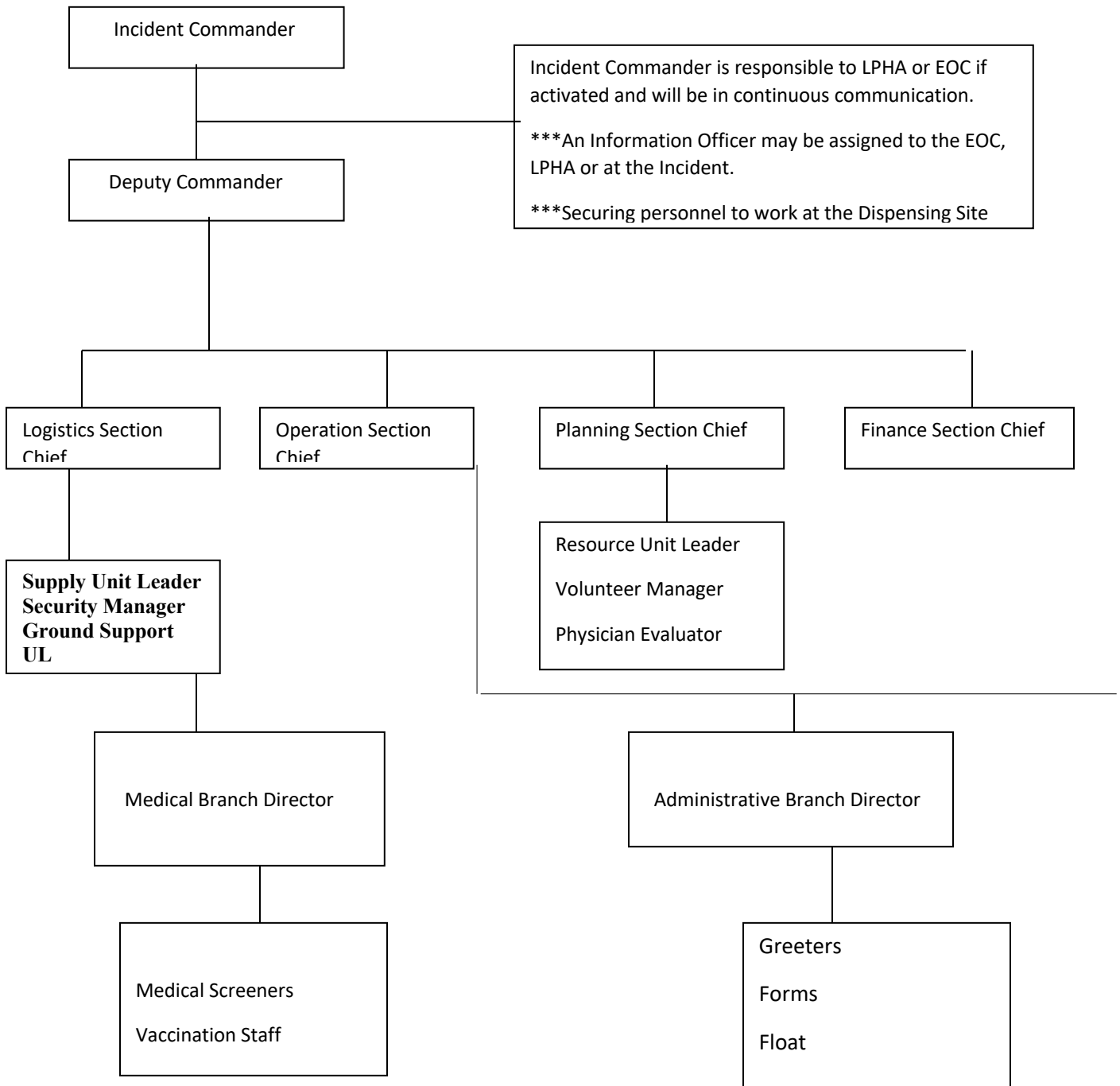
- a. Emergency health and medical staff
- b. Health Center clinic volunteers
- c. Emergency Medical Services Personnel
- d. Fire Department Personnel
- e. Law Enforcement
- f. Other critical infrastructure staff
- g. General Public

2. **Multiple Regimen Pick Up Policy:** A multiple regimen policy allows a person to pick up medicines for up to fifteen (15) people, including him or her self who are not present at the POD. The person requesting multiple regimens will be required to complete patient information for each regimen they pick up. If a person is requesting regimens for a child, the person receiving the regimens must provide an estimate of the child's weight. If pediatric dilutions are not available, the person receiving the medications will be provided with an adult regimen and the pediatric dosing instructions.

3. **Unaccompanied minors:** In a situation where an adult member of the family is unable to go to a POD to pick up medicines, unaccompanied minors may pick up medicines for their family. The minor should be able to fill out the patient information sheet for the requested regimes as noted in the Multiple Regimen Pick Up Policy section of this plan.

4. **Minimum Identification Requirements:** There are no minimum identification requirements to obtain medicines at the PODs. Requiring identification would exclude certain members of the population from obtaining needed medicines. Every person who picks up medicine at a POD will be required to provide patient information for each regimen he or she receives.

5. Use of force guidelines for Law Enforcement: Justifiable use of force guidelines are defined in Missouri Revised Statutes Chapter 563, Defense of Justification. Force will be used in accordance with state statute and each law enforcement department's standard operating procedure.
6. Medical Practitioners Authorized to Issue Standing Orders and Protocols for Dispensing Sites: CCHC has entered in to a collaborative practice agreement between Donna Harper, DO of the Missouri Ozarks Community Health and licensed to practice in the state of Missouri, and registered professional nurses employed by or serving as volunteers for CCHC, for practices limited to administration and dispensing medications during a mass prophylaxis event.
7. Personnel Authorized to Dispense Medications during a State of Emergency: Any registered professional nurse working in a POD operated by CCHC may dispense as directed by the Missouri Department of Health and Senior Services, provided that a medical professional who is authorized to prescribe or dispense medications is present. Medical professionals who are authorized to prescribe or dispense medications include: pharmacists, physicians, physician assistants, advanced registered nurse practitioners, and other medical providers registered as "dispensing practitioners" (dentists, podiatrists, etc.). These medical professionals will supervise all dispensing operations. If a medical practitioner is not personally available at the POD, arrangements must be made to contact one by phone.
8. Liability Protection and Workers Compensation: Workers' compensation and liability coverage is provided under CCHC specific plans regarding a work-related illness or injury for CCHC employees and volunteers working this SNS plan.
9. Staff compensation: Staff will be compensated for hours worked per CCHC policy, whether regular work hours or overtime hours.
10. In the event of an emergency which requires evacuation, Agency policy will be followed. See Policy Manual emergency evacuation procedure, page 4.4.



**APPENDIX 1 TO ANNEX H**

**MASS PROPHYLAXIS  
STANDARD OPERATING GUIDELINES**

**Standards for Antibiotic Treatment**

**1. Local Supplies of antibiotic (see TAB A)**

- A. The list on Tab A gives estimated amounts of certain antibiotics and number of doses along with days the regimen can continue.
- B. Standing orders must be written prior to giving antibiotics to potentially exposed persons. Standing orders will be given by Doctor Tammy Lindsay.

**2. High Risk Populations:**

- A. Individuals who are exposed to the agent will take priority on receiving mass prophylaxis. These individuals can include Law Enforcement, Fire Department, Emergency Medical Services, Hospital workers and CCHC employees. This group also includes family members of each person. Persons who were in the attack area will be given mass prophylaxis.
- B. Once it has been determined that an attack has taken place an epidemiological investigation will attempt to identify those individuals who were directly exposed to the agent.
- C. If the attack took place outside of our area, treatment can be given to those individuals utilizing our available assets.
- D. Special needs persons may have the prophylaxis delivered to their residency. The CCHC is in the process of developing a list of special needs persons. Using this list, CCHC and volunteers from the community may be required to provide screening and delivery of antibiotics.
- E. Nursing home residents may have antibiotics delivered or may have staff who have overall medication authority dispatched to pick up needed medications.
- F. The local confinement facility will be responsible for providing a list of jailed individuals. Jail Officials will be responsible for maintaining antibiotics for each individual.

**Packaging and dispensing of antibiotics for post-exposure prophylaxis:**

To establish procedures for providing life-saving pharmaceuticals and medial supplies with or without the activation of the National Pharmaceutical Stockpile (NPS) in a local public health emergency.

- A. Local supplies of needed antibiotics will be dispensed and labeled for a 3-day regimen. Dependent upon the agent dispensed antibiotics may include doxycycline or

ciprofloxacin. If and individual cannot take either doxycycline or cipro then they will be evaluated for amoxicillin. Dosage amounts will be determined by the agent used.

**1. Anthrax:** See Tab B for patient information. Inhalational anthrax will be treated with either doxycycline or cipro. Dosages will be specified at time of issue.

**2. Pneumonic Plague:** See Tab B for patient information.

**APPENDIX 2 TO ANNEX  
Memorandum of Understanding**

**Introduction**

This document is a memorandum of understanding between the Wright County Health Department and the Carter, Douglas, Howell, Oregon, Ozark, Reynolds, Shannon and Texas County Health Departments. The memorandum is intended to establish responsibilities for said parties. It reflects an arrangement that currently is satisfactory to the parties.

**Common Objective**

The Wright County Health Department and Carter, Douglas, Howell, Oregon, Ozark, Reynolds, Shannon and Texas County Health Departments have the following common objective;  
To assure resources from the Strategic National Stockpile or Vendor Managed Inventory is safely and securely received into Region G; counties of Carter, Douglas, Howell, Oregon, Ozark, Reynolds, Shannon, Texas, and Wright counties, in a timely manner to respond to a public health emergency.

**Wright County Health Department Responsibilities**

The Wright County Health Department will work to secure adequate transportation that meets DHSS approval to transport resources allocated for said counties from SNS RSS/ADS site to the following locations in Region G

- Hwy 60/Mansfield (Ozark and Douglas County pick up)
- Wright County Health Department Mountain Grove Location (Wright and Texas County Pick up)
- Howell County Health Department (Howell, Oregon, Reynolds, Shannon, and Carter County pick-up)

Should a dock be required other locations will be secured by the county where drop off takes place. Wright County Health Department will arrange for security during the transportation of SNS or VMI resources from SNS RSS/ADS site to the Mountain Grove drop off site.


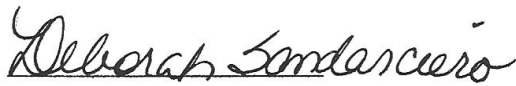
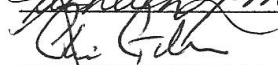
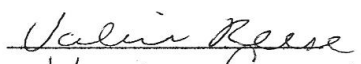
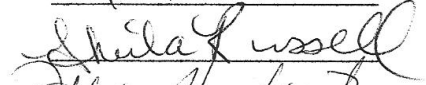
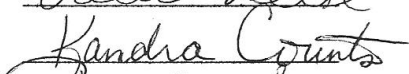
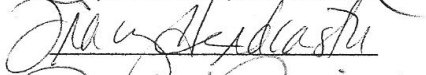
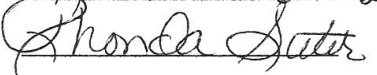

**Carter, Douglas, Howell, Oregon, Ozark, Shannon and Texas County Responsibilities**

Carter, Douglas, Howell, Oregon, Ozark, Reynolds, Shannon and Texas County agree to support Wright County by provide staff if needed to assist with the transportation of SNS or VMI resources.

Carter, Douglas, Howell, Oregon, Ozark, Reynolds, Shannon and Texas County agree to share the costs of transporting the resources from the SNS RSS/ADS site to all drop off sites in Region G.

Carter, Douglas, Howell, Oregon, Ozark, Reynolds, Shannon and Texas County agree to secure their own security in transporting these resources in their respective counties.

DATE 9-11-2013

 _____ Kelly Zimmerman	 _____ Deborah Sordascio
 _____ Chie Gilman	 _____ Valerie Reese
 _____ Shilal Russell	 _____ Kandria Counts
 _____ Mary Anastasi	 _____ Rhonda Suter
 _____ Jacob Smith	



## **JOB ACTION SHEETS**

### **Position Title: Clinic Flow Staff**

**Position Summary:** Responsible for continuously monitoring and directing patient's activity throughout the clinic. Responsible for providing early alert information regarding congestion to Area Coordinator and/or security so that they may assist with alleviating the congestion and prevent a potentially dangerous situation.

**Skills Needed:** Must be able to calmly manage and assist patients who may be anxious and unable to follow directions.

#### **Duties/Tasks:**

1. Be familiar with the outlay and flow of the clinic area.
2. Direct patients and groups from one station to the next, assist stragglers.
3. Offer assistance, guidance to patients in line and provide general support and reassurance to patients as needed.
4. Monitor the flow of patients
5. Escort symptomatic patient to triage area.
6. Alert Area Coordinator for appropriate area if congestion occurs in an area
7. Communicate as necessary with security.

#### **Supervision Exercised:**

None

#### **Supervision Received:**

Clinic Manager

#### **Equipment:**

None

#### **Outer Wear:**

CCHC tee shirt and/or colored vest

### **Position Title: Clinic Manager**

**Position Summary:** Oversees the clinic and its operations

**Skills Needed:** Good organizational skills. Has previous management experience. Ability to take leadership and make decisions. Good communications skills.

#### **Duties/Tasks:**

1. Maintain contact with Administrator or designated employee to update on clinic progress.
2. Work with area Coordinators to identify staffing needs, improve flow, or identify issues. Report any deficiencies to Administrator or designated employee.

3. Work with Supply Coordinator to ensure needed supplies. Report deficiencies to Administrator or designated employee.
4. Work with security to ensure safe operations.
5. Deal with issues brought forth by staff.
6. Refer media enquiries to PIO.
7. Monitor other personnel for fatigue or stress.

**Supervision Exercised:**

Area coordinators and staff beneath them

**Supervision Received:**

CCHC Administrator or designated employee

**Equipment:**

Clipboard

Pen

Paper

**Outer Wear:**

CCHC tee shirt and/or colored vest

**Position Title: Docent**

**Position Summary:**

Provides patient education on identified agent and process of clinic. Provides appropriate forms and instructions on completion to all patients.

**Skills Needed:**

Should have public speaking/training skills. Should have good communication skills. Can be non-licensed with some medical background preferred. Should have leadership skills and the ability to direct staff.

**Duties/Tasks:**

1. Keep group orderly and calm while waiting.
2. Answer questions or solicit answer from appropriate person.
3. Orient patients to process of clinic.
4. Provide patient information on agent.
5. Assist patients with completion of health history form.
6. Check identification for each health history form for each individual and document on health history form.
7. Check each form for completeness.

**Supervision Exercised:**

Indirect supervision of Docent Helper if one is assigned

**Supervision Received:**

Clinic Manager

**Equipment:**

1. Clipboard
2. Pen
3. Paper
4. Health History Forms
5. Symptom Checklist
6. Patient Information

**Outer Wear:**

CCHC tee shirt and/or Colored Vest

**Position Title: Greiage**

**Position Summary:**

Greet new arrivals, perform appropriate “Griiage” algorithm upon entry to the clinic.

**Skills Needed:**

Must be able to orally communicate effectively with the public. Respects cultural differences of the diverse group of citizens of Carter County. Has the ability to recognize symptoms of illness per symptoms checklist.

**Duties/Tasks:**

1. Ensure that your site is set up physically and ready for operations.
2. Be familiar with the flow and setup of the clinic.
3. Evaluate people using appropriate algorithm and direct them to proper areas for further evaluation.
4. Instruct patients exhibiting or verbalizing symptoms to go to treatment center for triage.
5. Greet patients as they arrive and briefly answer questions about the procedures at the facility if asked.
6. Identify patients with special needs and notify appropriate staff.
7. Communicate with Clinic Manager as needed
8. Document issues or problems on progress notes.

**Supervision Exercised:**

None

**Supervision Received:**

Supervised by the Clinic Manager

**Equipment:**

1. Clipboard
2. Pen
3. Paper
4. Greiage Algorithm
5. Symptoms Checklist

**Outer Wear:**

CCHC tee shirt and/or Colored Vest

**Position title: IT support**

**Position Summary:**

Communications/IT support personnel are responsible for keeping the tactical communication platforms up and running.

**Skills Needed:**

Should have the ability to take direction and follow orders. Should have good computer and data entry skills.

**Duties/Tasks:**

1. Responsible for overall communications systems (both internal and external) at the POD.
2. Set up technological equipment such as computers, etc.
3. Assist with technology problems when requested.
4. Assist with back up and protection of existing and on-going data on computer systems.

**Supervision Exercised:**

None

**Supervision Received:**

Clinic manager, Administrator

**Equipment:**

None

**Outer Wear:**

CCHC tee shirt and/or Colored Vest

**Position Title: Medication Administration RN**

**Position Summary:**

Under the medical direction of the signing physician of the Collaborative Practice Agreement, the dispensing RN is responsible for evaluation and treatment of patients, staff and volunteers as well as dispensing medications to patients.

**Skills Needed:**

Currently licensed by the state of Missouri as a physician, advanced practice nurse, or RN.

**Duties/Tasks:**

1. Review and be familiar with standing orders, including agent patient information sheet and drug information sheets.
2. Maintain infection control standards.
3. Evaluate patients presenting to the clinic.
4. Collect and review health history form and consent form for contraindications, make antibiotic selection, refer to physician if necessary, indicate selection of antibiotic treatment record and consent form.
5. Attach appropriate labels.
6. Document and have patient sign any medication refusals.
7. Document encounters on proper paperwork.
8. Provide patient counseling as needed.
9. Provide patient information on medication prescribed.
10. Document issues or problems in binder on progress notes.
11. Direct patient as needed.
12. Answer final patient questions

**Supervision Exercised:**

Indirect for Docent and Docent Helper

**Supervision Received:**

Area Lead (RN) in assigned area and/or Clinic Manager

**Equipment:**

1. Clipboard
2. Pen
3. Paper
4. Symptoms Checklist
5. Bins for medication
6. RN resource binder

**Outer Wear:**

CCHC tee shirt and/or colored vest

**Position title: Public Information Officer**

**Position Summary:**

Coordinate media relations and releases.

**Skills Needed:**

Trained in media interaction and public health information. Good organization skills, interpersonal skills, leadership experience, familiarity with Health Center PIO plan.

**Duties/Tasks:**

5. Determine overall media policy specific to incident; e.g. No comment, no media attendance, media visits permitted, media permitted to attend briefing.
6. Develop media statements as appropriate.
7. Brief all personnel on media policy.
8. Develop and disseminate all public information messages, methods, and materials to be used at a POD.
9. Coordinate media activities
10. Coordinate information with the JIC
11. Participate in meetings and briefings to ensure that media considerations are part of the plan at all times.
12. Document all media contacts
13. Monitor media outlets to check accuracy of information being reported
14. Contact media outlets to correct errors of fact and control rumors about the incident.

**Supervision Exercised:**

None

**Supervision Received:**

Clinic manager, Administrator

**Equipment:**

None

**Outer Wear:**

CCHC tee shirt and/or Colored Vest

**Position Title: Medication Supply Coordinator**

**Position Summary:**

The Supply Coordinator/Vaccine/Prophylaxis Coordinator works to ensure that all necessary medications are available in sufficient quantities during clinic operations. This includes maintaining an inventory and distributing medications. Accounts for chain of custody of vaccine or prophylaxis medications.

**Skills Needed:**

Should have the ability to take direction and follow orders. Should be able to lift heavy objects and travel on foot to each area as needed to deliver supplies. Should be detail oriented. Recommend previous experience with counting and stocking supplies. Should have some background in working with and recognizing names of medications.

**Duties/Tasks:**

1. Assists with unloading of supplies and medications.
2. Signs for and logs received medications or works with RN to sign for supplies.
3. Keeps Dispensing Site Leader up to date on medication needs. Works with Dispensing Site Leader and Clinic Manager to assure medications are available.
4. Works with area staff members on keeping medications available to dispensing RN's.
5. Keeps track of medication/vaccination.
6. Informs Clinic Manager of needed medications in writing for ordering purposes.
7. Keeps dispensing RN's and Clinic Manager aware of location at all times.

**Supervision Exercised:**

None

**Supervision Received:**

Dispensing Site Lead RN, Clinic Manager

**Equipment:**

Pen

Paper

Clipboard with compartment

Supply Delivery Cart

Dolly

**Outer Wear:**

CCHC tee shirt and/or colored vest

**Position Title: Runner****Position Summary:**

To assist patients and staff in maintaining the logistical support structure of the clinic and provide another level of communication.

**Skills Needed:**



Should have the ability to take direction and follow orders. Should be able to lift heavy objects and travel on foot to each area as requested. Should have the ability to move quickly from one area to another.

**Duties/Tasks:**

1. Relay messages to and from staff and area coordinators
2. Take supplies to areas as delegated by Supply coordinator.
3. Run errands as directed by area staff or Clinic Manager.
4. Keep your Area Coordinator aware of your location at all times.
5. Escort patients as requested by Area Coordinator.
6. Bring drinks to staff if they are unable to leave the work area.
7. Assist with flow if have free time.

**Supervision Exercised:**

None

**Supervision Received:**

Clinic Manager / Supply Coordinator

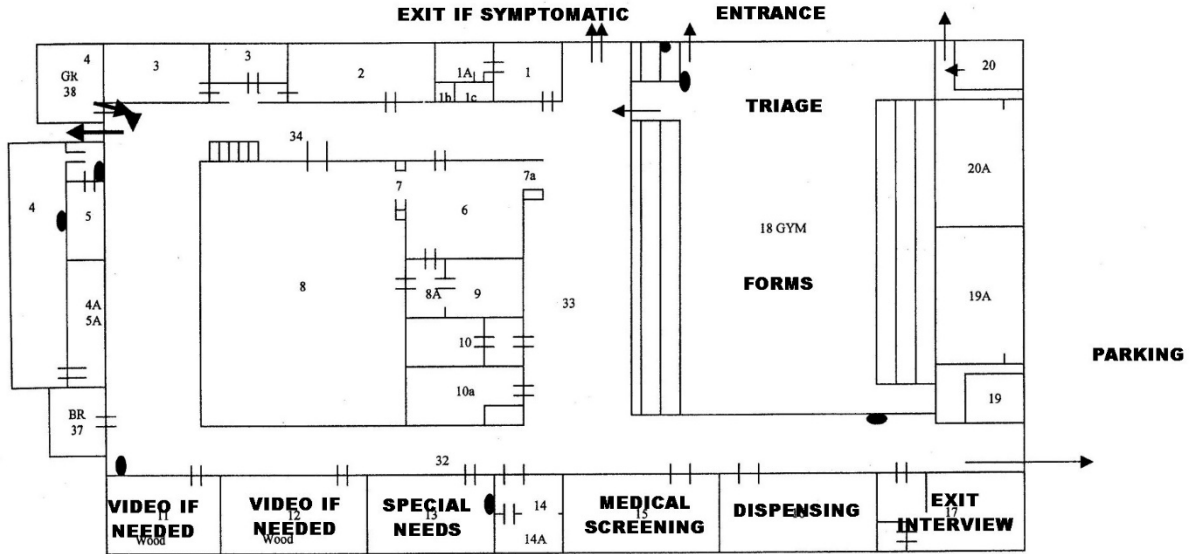
**Outer Wear:**

CCHC tee shirt and/or Colored Vest

PARKING

# CARTER COUNTY SNS SITE

Van Buren High School  
Downstairs - Building 07



See MOU Annex A, Appendix 5

## APPENDIX 5 TO ANNEX H

### MASS PROPHYLAXIS NEEDS AND RESOURCES

Purpose: Provide some information on county population that might be useful in time of emergency when mass prophylaxis would be needed.

1. Potential numbers that might require antibodies/vaccine:

County Population: 6265

Age Classes

0-<5	<u>394</u>
5-14	<u>870</u>
5-< 18	<u>1,497</u>
19-64	<u>3,258</u>
45-64	<u>1486</u>
65-100	<u>1,115</u>

Health Providers:

CCHC	<u>20</u>
Doctors/staff	<u>10</u>
Clinics	<u>12</u>
Pharmacies	<u>6</u>
EMS	<u>6</u>
Skilled and Residential Care Facilities	<u>65</u>

First Responders:

Fire and Rescue	<u>15</u>
Law Enforcement	<u>13</u>
Other(Carter County EOP Staff)	<u>20</u>

Potential Local Volunteers

NPS:	<u>100</u>
ECC R-II:	<u>103</u>
VB R-I:	<u>85</u>

**LOCAL SUPPLY OF MASS PROPHYLAXIS**

<b>PHARMACY</b>	<b>PHONE</b>	<b>ADDRESS</b>	<b>DOXY</b>	<b>CIPRO</b>
Van Buren Drug	323-8159	406 . Main	20 Dose packs	.10 Dose packs

**APPENDIX 6 TO ANNEX H**  
**COLLABORATIVE PRACTICE AGREEMENT**  
**WITH PHYSICIANS AND REGISTERED PROFESSIONAL NURSES**  
(For practices limited to administration and dispensing  
medication during a mass prophylaxis event)

THIS COLLABORATIVE PRACTICE AGREEMENT (hereinafter “Agreement”) is entered into by and between Dr. Tammy Lindsay, a physician licensed to practice medicine in the State of Missouri (hereinafter “Physician”) and Registered Professional Nurses (hereinafter “RNs”) employed by, or serving as volunteers for, the CCHC (hereinafter “Agency”), and shall be effective as of February 10, 2016.

The purpose of this Agreement is to delegate to the RNs authority to perform certain medical acts. This Agreement only applies to delegated medical acts and those nursing acts requiring physician orders and not to RN’s independent practice of nursing.

### **Section 1. Delegation, Scope of Collaborative Practice, Methods of Treatment**

- 1.1 Physician has considered RNs’ skill, training, education, and competence and has determined that,
  - (a) the responsibilities delegated herein are within the scope of practice of the RN and are consistent with RN’s skills, training, education, and competence; and
  - (b) the methods of treatment and the authority to administer and dispense drugs and medications delegated to RN herein are consistent with both the Physician’s and RN’s skill, training, education and competence, and within the scope of practice of both.
- 1.2 Physician hereby delegates to RNs the authority to administer and dispense drugs pursuant to this Agreement and Exhibit A attached hereto. Exhibit A, which is jointly agreed upon protocols or standing orders, describes a specific sequence of orders, steps or procedures to be followed by the RNs providing health care services in specific mass prophylaxis clinic situations. This delegation authorizes the RNs to provide health care services to individuals who have been exposed to a known or potentially harmful biological agent.
- 1.3 The methods of treatment and the authority to administer and dispense drugs delegated to the RNs may not be further delegated by the RNs to any other person except the RNs may communicate prescription drug orders of Physician or an advanced practice nurse to a pharmacist.
- 1.4 The authority to administer and dispense drugs delegated to the RNs pursuant to Section 1.2 of this Agreement is subject to the following conditions:
  - (a) RNs shall not, under any circumstances, prescribe drugs or medications. The administering or dispensing of controlled substances by the RNs under this Agreement shall be accomplished only under the direction and supervision of Physician, and shall only occur on a case-by-case determination of the patient’s needs following verbal consultation and order between Physician and the RN.
  - (b) As a publicly funded clinic in a community health setting that dispenses medications free of charge, RNs may dispense the recommended regime of antibiotic prophylactic treatment.
  - (c) All prescription container-labeling requirements outlined in Section 338.059 R.S.Mo. shall be followed.

- (d) Retrievable dispensing logs shall be maintained for all prescription drugs dispensed and shall include all information required by state and federal statutes, rules, or regulations.

## **Section 2. Geographic Restrictions**

- 2.1 Physician's practice is located at 402 Main St., Van Buren, MO 63965. The RNs will practice at designated dispensing sites located in Carter County. Physician(s) and RNs agree that the distance between these locations will not create an impediment to effective collaboration in the delivery of mass prophylactic services.

## **Section 3. Review of Services**

- 3.1 During the mass prophylaxis clinics the Physician shall at all times be immediately available for consultation to the RNs, either personally or via telecommunications.
- 3.2 Physician shall review the work, records, and practice of health care delivered pursuant to this Agreement at least two (2) weeks of delivery of service. Review shall be documented and signed by the physician.
- 3.3 In the case of collaborating physicians, registered professional nurses, or advanced practice nurses practicing in association with public health clinics that provide population-based health services related to epidemiologic investigations and related treatment. Methods of treatment and review of services shall occur as set forth in the collaborative practice arrangement. If the services provided in such settings include diagnosis and initiation of treatment of disease or injury not related to population-based health services, then the provisions of sections 2, 3, and 4 of the collaborative practice act shall apply (see attached copy).

*AUTHORITY: sections 334.104.3, RSMo Supp. 2002, and 334.125 and 335.036, RSMo2000. \* Original rule filed Jan. 29, 1996, effective Sept. 30, 1996. Amended: Filed April 1, 1998, effective Oct 30, 1998. Amended: Filed Oct 30, 2002, effective June 30, 2003. \* Original authority: 334.104.3, RSMo 1993 amended 2002; 334.125, RSMo 1959, amended 1993, 1995; and 335.036 RSMo 1975, amended, 1981, 1985, 1993, 1995, and 1999.*

## **Section 4. Miscellaneous Provisions**

- 4.1 Physician and the Agency agree to maintain copies of this Agreement, any and all amendments, all protocols and standing orders and amendments and modifications thereto and any notice of termination of this Agreement for a minimum of eight (8) years after termination of this Agreement.
- 4.2 The Agency agrees to maintain records of individuals receiving prophylaxis, or referral to a physician or health facility, according to the agency's current policy and procedure for record retention.
- 4.2 The process and documentation of review of health care services described in Sections 1.4(a) and 3.2 above shall be on file and maintained at the Agency.

- 4.3 Attached hereto and incorporated herein by reference as Exhibit B are guidelines for consultation and referral to Physician or a designated health facility for services or emergency care that is beyond the education, training, competence or scope of practice of the RNs.
- 4.4 Physician hereby designates Michelle Burnham, FNP to consult, direct or supervise RNs in the event Physician is unable due to temporary illness, injury, or absence.
- 4.5 This Agreement and all Exhibits and attachments shall be reviewed and revised as needed upon the mutual written consent of Agency, RN agent, and Physician.
- 4.6 This Agreement may be terminated at any time by Physician and/or upon agreement of the Agency and RN agent upon 10 day's written notice to the other.

By signing this Agreement, Physician and the RN agent for the Agency, represent that they have read this Agreement and all of its Exhibits and attachments, they are aware of the contents, and that they agree to follow their terms.

/s/ Kurt Zimmer, D.O.  
Physician

091912  
Date of Signature

/s/ Deborah S. Sandarciero, BSN, RN, BC  
RN (Agent of the LPHA)

091912  
Date of Signature

**Exhibit A: Medical Protocol**

**Mass Prophylaxis Treatment Clinics  
Dispensing of Antibiotics**

I direct Registered Professional Nurses (RNs) employed by, or serving as volunteers for, the CCHC, and working within the geographic area stated in the collaborative practice agreement, to dispense medications to individuals presenting for prophylactic treatment to a known or potentially harmful biological agent.

All medications must be dispensed in accordance with the following prophylactic treatment guidelines and within the restrictions of the guidelines of the Strategic National Stockpile program.

### G. Recommended Postexposure Prophylaxis for Inhalational Anthrax Infection

**Table 4.** Recommended Therapy for Inhalational Anthrax Infection in the Mass Casualty Setting or for Postexposure Prophylaxis\*

Category	Initial Oral Therapy†	Alternative Therapy if Strain Is Proved Susceptible	Duration After Exposure, d
Adults	Ciprofloxacin, 500 mg orally every 12 h	Doxycycline, 100 mg orally every 12 h‡ Amoxicillin, 500 mg orally every 8 h§	60
Children	Ciprofloxacin, 20-30 mg/kg per d orally taken in 2 daily doses, not to exceed 1 g/d	Weight ≥20 kg: amoxicillin, 500 mg orally every 8 h§ Weight <20 kg: amoxicillin, 40 mg/kg taken orally in 3 doses every 8 h§	60
Pregnant women¶	Ciprofloxacin, 500 mg orally every 12 h	Amoxicillin, 500 mg orally every 8 h§	60
Immunosuppressed persons	Same as for nonimmunosuppressed adults and children		

\*Some of these recommendations are based on animal studies or in vitro studies and are not approved by the US Food and Drug Administration.

†In vitro studies suggest ofloxacin (400 mg orally every 12 hours, or levofloxacin, 500 mg orally every 24 hours) could be substituted for ciprofloxacin.

‡In vitro studies suggest that 500 mg of tetracycline orally every 6 hours could be substituted for doxycycline. In addition, 400 mg of gatifloxacin or monifloxacin, both fluoroquinolones with mechanisms of action consistent with ciprofloxacin, taken orally daily could be substituted.

§According to the Centers for Disease Control and Prevention recommendations, amoxicillin is suitable for postexposure prophylaxis only after 10 to 14 days of fluoroquinolones or doxycycline treatment and then only if there are contraindications to these 2 classes of medications (eg, pregnancy, lactating mother, age <18 years, or intolerance of other antibiotics).

||Doxycycline could also be used if antibiotic susceptibility testing, exhaustion of drug supplies, adverse reactions preclude use of ciprofloxacin. For children heavier than 45 kg, adult dosage should be used. For children lighter than 45 kg, 2.5 mg/kg of doxycycline orally every 12 hours should be used.

¶See "Management of Pregnant Population" for details.

Inglesby TV, O'Toole T, Henderson DA, et al. Anthrax as a Biological Weapon, 2002: Updated Recommendations for Management. *JAMA* 2002; 287:2236-52.

### i. Recommended Postexposure Prophylaxis for Tularemia

**Table 3.** Working Group Consensus Recommendations for Treatment of Patients With Tularemia in a Mass Casualty Setting and for Postexposure Prophylaxis\*

Mass Casualty Recommended Therapy
<b>Adults</b>
Preferred choices Doxycycline, 100 mg orally twice daily Ciprofloxacin, 500 mg orally twice daily†
<b>Children</b>
Preferred choices Doxycycline; if ≥45 kg, give 100 mg orally twice daily; if <45 kg, give 2.2 mg/kg orally twice daily Ciprofloxacin, 15 mg/kg orally twice daily†‡
<b>Pregnant Women</b>
Preferred choices Ciprofloxacin, 500 mg orally twice daily† Doxycycline, 100 mg orally twice daily

\*One antibiotic, appropriate for patient age, should be chosen from among alternatives. The duration of all recommended therapies in Table 3 is 14 days.

†Not a US Food and Drug Administration–approved use.

‡Ciprofloxacin dosage should not exceed 1 g/d in children.

### Recommended Postexposure Prophylaxis for Pneumonic Plague

**Table 2.** Working Group Recommendations for Treatment of Patients With Pneumonic Plague in the Contained and Mass Casualty Settings and for Postexposure Prophylaxis\*

Patient Category	Recommended Therapy
------------------	---------------------



**Mass Casualty Setting and Postexposure Prophylaxis#**

Adults	Preferred choices
	Doxycycline, 100 mg orally twice daily†† Ciprofloxacin, 500 mg orally twice daily‡
	Alternative choice
	Chloramphenicol, 25 mg/kg orally 4 times daily§**
Children	Preferred choice
	Doxycycline,†† If ≥45 kg, give adult dosage If <45 kg, then give 2.2 mg/kg orally twice daily
	Ciprofloxacin, 20 mg/kg orally twice daily
	Alternative choices
	Chloramphenicol, 25 mg/kg orally 4 times daily§**
Pregnant women¶	Preferred choices
	Doxycycline, 100 mg orally twice daily†† Ciprofloxacin, 500 mg orally twice daily
	Alternative choices
	Chloramphenicol, 25 mg/kg orally 4 times daily§**

\*These are consensus recommendations of the Working Group on Civilian Biodefense and are not necessarily approved by the Food and Drug Administration. See "Therapy" section for explanations. One antimicrobial agent should be selected. Therapy should be continued for 10 days. Oral therapy should be substituted when patient's condition improves. IM indicates intramuscularly; IV, intravenously.

‡Other fluoroquinolones can be substituted at doses appropriate for age. Ciprofloxacin dosage should not exceed 1 g/d in children.

§Concentration should be maintained between 5 and 20 µg/mL. Concentrations greater than 25 µg/mL can cause reversible bone marrow suppression.<sup>35,62</sup>

||Refer to "Management of Special Groups" for details. In children, ciprofloxacin dose should not exceed 1 g/d, chloramphenicol should not exceed 4 g/d. Children younger than 2 years should not receive chloramphenicol.

¶Refer to "Management of Special Groups" for details and for discussion of breastfeeding women. In neonates, gentamicin loading dose of 4 mg/kg should be given initially.<sup>63</sup>

#Duration of treatment of plague in mass casualty setting is 10 days. Duration of postexposure prophylaxis to prevent plague infection is 7 days.

\*\*Children younger than 2 years should not receive chloramphenicol. Oral formulation available only outside the United States.

††Tetracycline could be substituted for doxycycline.

Inglesby TV, Dennis DT, Henderson DA, et al. Plague as a Biological Weapon: Medical and Public Health Management. *JAMA* 2000; 283:2281-90.

One of the attached postexposure prophylaxis dispensing algorithms must be followed (depending on which drug is designated by the Missouri Department of Health and Senior Services as the primary prophylactic drug):

**Attachment 1: Anthrax Post-Exposure Prophylaxis Dispensing Algorithm**

**Attachment 2: Tularemia Post-Exposure Prophylaxis Dispensing Algorithm**

Attachment 3: Plague Post-Exposure Prophylaxis dispensing Algorithm

Review of this order, and agency policies and procedures related to carrying out this order, shall occur at least once every year.

This order will terminate on 091913

/s/ Kurt Zimmer, D.O.  
Physician

091913  
Date of Signature

/s/ Deborah S. Sandarciero, BSN, RN, BC  
RN (Agent of the LPHA)

091913  
Date of Signature

Exhibit B: Medical Protocol

Mass Prophylaxis Clinic  
For Dispensing Antibiotics

Guidelines for Consultation and Referral to Physician or a  
Designated Health Facility for Services or Emergency Care

**All individuals presenting for prophylactic treatment should be screened before they are allowed into the dispensing area. Based on the agent information below, individuals should be asked the following questions:**

1. Do you have a fever?
2. Have you had a fever within the past 48 hours?
3. Do you have a cough?
4. Have you had episodes of chills?
5. Do you have any chest discomfort?
6. Do you feel short of breath?
7. Are you having difficulty breathing?
8. Do you have a headache?
9. Have you had any nausea or vomiting?
10. Do you have bloody diarrhea?
11. Do you have bloody sputum?
12. Do you feel extremely tired or fatigued?
13. Have you experienced profound sweating for no reason?
14. Have you developed unexplainable sores on your body within the past 24-48 hours?

Individuals answering yes to any question above should be immediately escorted from the dispensing area to a clinical evaluation area. If after evaluation it is determined that the individual has clinical symptoms of a potential biological agent, he/she should be referred to their primary care physician, or transported to a designated health facility. The Physician Referral Form should be completed, one copy given to the individual to present to their physician, and a second copy retained at the dispensing site for future follow-up.

### **Clinical Presentations**

**Inhalational Anthrax.** Initial phase: non-specific symptoms such as low-grade fever, nonproductive cough, headache, nausea, vomiting, malaise, fatigue, myalgias, profound sweats, chest discomfort (upper respiratory tract symptoms are rare); maybe rhonchi on chest exam, otherwise normal; chest x-ray may show mediastinal widening and/or pleural effusion; infiltrates might be present. Subsequent, fulminant phase: 1–5 days after onset of initial symptoms; may or may not be preceded by 1–3 days of improvement; abrupt onset of high fever and severe respiratory distress (dyspnea, stridor, cyanosis), shock, death within 24–36 hours. Hemorrhagic meningitis can be present. [Note that direct skin contact with anthrax spores can result in **cutaneous anthrax** (11 confirmed or probable cases of cutaneous anthrax, in addition to 11 cases of inhalational anthrax, were associated with the 2001 anthrax attacks). In cutaneous anthrax, an area of local edema becomes a pruritic macule or papule, which progresses to a vesicle in 1-2 days, followed by an ulcer with subsequent development of a depressed black eschar within 7–10 days of the initial lesion. There is usually surrounding local edema, and small (1-3 mm) vesicles may surround the ulcer. The lesion is usually painless, but patients may also have fever, malaise, headache, lymphangitis, and painful regional lymphadenopathy.]

**Pneumonic Plague.** Fever, headache, weakness, and rapidly developing severe pneumonia with cough, chest pain, dyspnea, and tachypnea (particularly in young children). Cough can be

productive of bloody, mucoid, or (less commonly) purulent sputum. Prominent gastrointestinal symptoms – including nausea, vomiting, diarrhea, and abdominal pain – may be present. Chest x-ray findings are variable but bilateral infiltrates or consolidation is common; pleural effusions may be present. Massive mediastinal adenopathy occurs rarely. Complications include septicemia and meningitis.

**Inhalational Tularemia.** May see abrupt onset of fever, chills, malaise, headache, myalgias, joint pain, nonproductive cough, and progressive weakness. Persons with pneumonia can develop chest pain, dyspnea, bloody sputum, and respiratory failure. However, inhalational exposures can commonly result in an initial clinical picture of systemic illness without prominent signs of respiratory disease. The earliest chest x-ray findings may be peribronchial infiltrates, typically advancing to bronchopneumonia in >1 lobes, and often accompanied by pleural effusions and hilar lymphadenopathy – such signs may, however, be minimal or absent. Aerosol exposures to *Francisella tularensis* can incapacitate some persons in the first 1-2 days of illness, and pulmonary infection can sometimes rapidly progress to severe pneumonia, respiratory failure, and death. Although exposure to aerosolized *F. tularensis* is expected to principally cause primary pleuropneumonic infection, some exposures might contaminate the eye (resulting in ocular tularemia with conjunctivitis), penetrate broken skin (resulting in ulceroglandular or glandular disease), or cause oropharyngeal disease (with pharyngitis and cervical lymphadenitis).

Mass Prophylaxis Clinic  
For Dispensing of Antibiotics  
Referral Form to Physician/Health Facility

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Referral Physician or Health Facility \_\_\_\_\_

Address: \_\_\_\_\_

**2. The above named individual was seen at a mass prophylaxis point of dispensing site managed by the \_\_\_\_\_ for a possible exposure to anthrax. He/she is being referred to a physician for evaluation of the following symptoms:**

- |  |  |
|--|--|
| <input type="checkbox"/> Cough                                   | <input type="checkbox"/> Severe headache/Meningeal signs |
| <input type="checkbox"/> Shortness of Breath                     | <input type="checkbox"/> New skin lesions                |
| <input type="checkbox"/> Chest pain or discomfort on inspiration | <input type="checkbox"/> Nausea and/or vomiting          |
| <input type="checkbox"/> Fever / Chills                          | <input type="checkbox"/> Bloody diarrhea                 |
| <input type="checkbox"/> Muscle aches / Joint pain               | <input type="checkbox"/> Mouth or throat sores           |
| <input type="checkbox"/> Bloody sputum                           |  |
| <input type="checkbox"/> Other symptoms (specify) _____          |  |

The following prophylactic medication has been prescribed:

- Doxycycline 100mg PO q12 hrs X 10 days
- Doxycycline 100 mg PO q12 hrs X 20 days
- Doxycycline \_\_\_\_mg PO \_\_\_\_Dx \_\_\_\_ days
- Ciprofloxacin 500 mg PO q12 hrs X 10 days
- Ciprofloxacin 500 mg PO q12hrs X 20 days
- Ciprofloxacin \_\_\_\_mg PO \_\_\_\_Dx \_\_\_\_ days
- NO** antibiotic prescribed

If none prescribed:

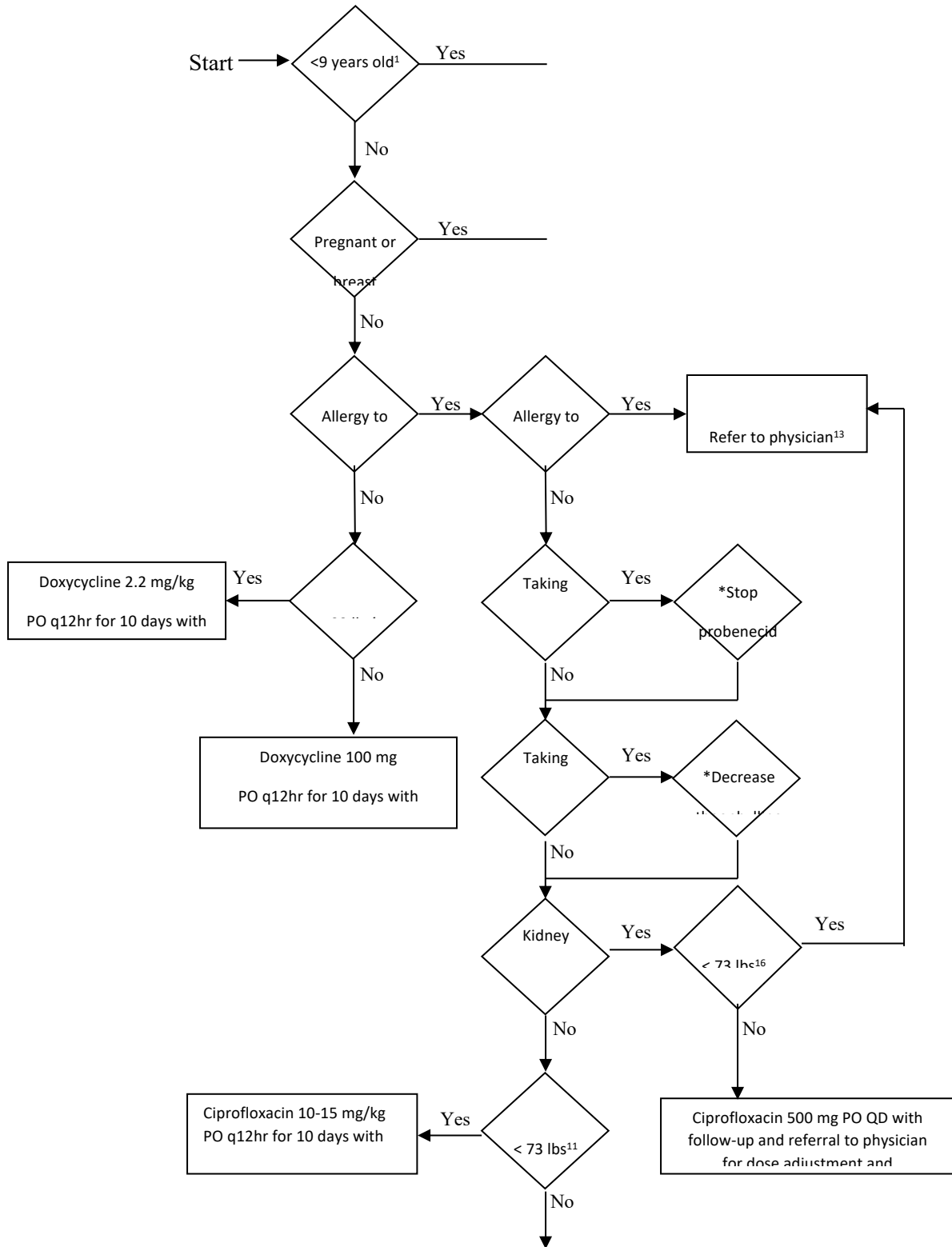
After evaluation, this individual should be started on a 10-day course of prophylactic antibiotic and will be notified if there is reason to continue beyond that time.

This individual does not require prophylaxis.

\_\_\_\_\_  
 Pharmacist                      Signature  
 Physician  
 Nurse

\_\_\_\_\_  
Date

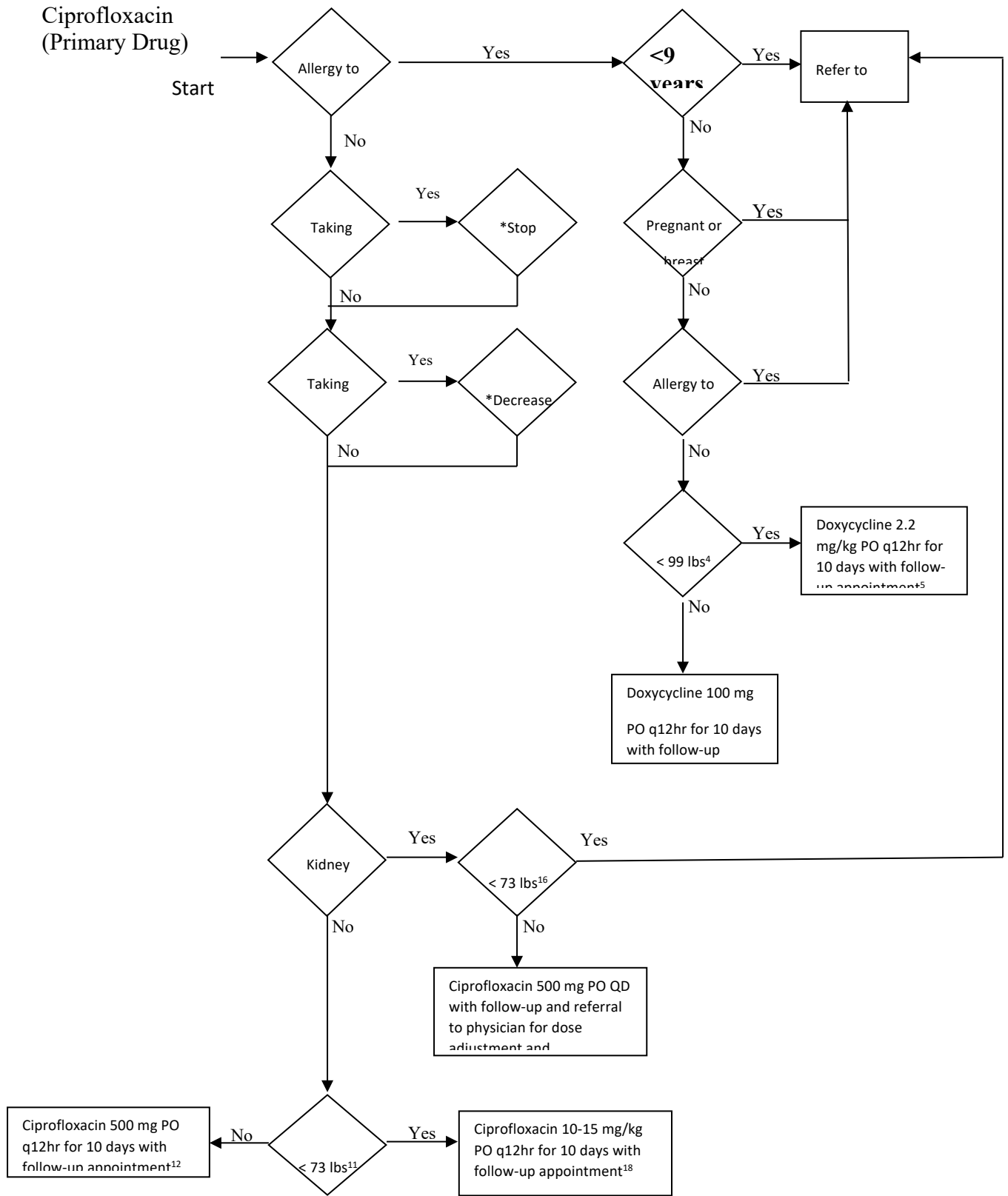
## Attachment 1: Anthrax Post-Exposure Prophylaxis Dispensing Algorithm Doxycycline (Primary Drug)



Ciprofloxacin 500 mg PO  
q12hr for 10 days with

\*14 & 15, Instruct individual to immediately contact their primary care physician for recommended duration of change in prescription medication.

### Anthrax Post-Exposure Prophylaxis Dispensing Algorithm



## Post-Exposure Prophylaxis Dispensing Algorithm

The above flow diagrams and these footnotes describe drug selection and dosing information for patients requiring post-exposure prophylaxis or preventative treatment after exposure to *Bacillus anthracis*, the bacteria that causes anthrax.

Reports have been published of engineered strains of tetracycline-resistant and quinolone-resistant *Bacillus anthracis*.<sup>1,2</sup> There is also a possibility for resistance to penicillins through induction of beta-lactamase enzymes. For these reasons, public health officials will test the antibiotic susceptibility of clinical specimens (blood, sputum, etc.), to determine drug selection. The most widely available, efficacious, and least toxic antibiotic will be dispensed for post-exposure prophylaxis based upon these susceptibility results.<sup>1</sup>

Until antibiotic susceptibility results of the implicated strain are available, initial therapy for post-exposure prophylaxis for prevention of anthrax after intentional exposure of *Bacillus anthracis* is doxycycline or ciprofloxacin.<sup>3</sup> Following a terrorist attack, the Missouri Department of Health and Senior Services (DHSS) will designate which of these two drugs will be the primary drug to use for prophylaxis.

Doxycycline and other tetracyclines are not normally recommended for children and pregnant women due to the risk of dental staining of the primary teeth, concerns about possible depressed bone growth, defective dental enamel, and rare liver toxicity. Therefore, children and pregnant and lactating women will not normally receive doxycycline.

Ciprofloxacin and other quinolones are not normally recommended in children and pregnant women due to the risk of arthropathy (joint disease).<sup>1,4,5</sup> This recommendation is based on studies in animals. Data in humans have not confirmed this risk. Therefore, children and pregnant and lactating women without an allergy to quinolones will receive ciprofloxacin according to this algorithm. The risks associated with the serious and life-threatening complications from anthrax outweigh any risks from taking ciprofloxacin.

As soon as penicillin susceptibility is confirmed, prophylactic therapy for children and pregnant women should be changed to amoxicillin.<sup>3</sup> The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice recommend the use of ciprofloxacin in pregnant or lactating women for post-exposure prophylaxis for prevention of anthrax after intentional exposure of *Bacillus anthracis*.<sup>6</sup>

This algorithm does not include the use of anthrax vaccine. At the time this algorithm was developed, anthrax vaccine for post-exposure prophylaxis was an investigational new drug. It is quite possible that once the release of anthrax has been confirmed the vaccine will be made available to the affected population. If so, DHSS will provide guidelines for administration.

All patients who have been potentially exposed to anthrax should receive an initial course of drug therapy (10 days). Public health officials will advise people to return for follow-up in 7-10 days to obtain an additional supply (50 days) of medication to complete a full course of therapy (60 days). The initial course of 10 days is recommended based upon the normal twice a day regimen of ciprofloxacin and doxycycline and the availability of 20 tablets in unit-of-use containers from the Strategic National Stockpile Program. At the follow-up visit, susceptibility data will be available and drugs may be changed.

The following steps and numbered paragraphs support and correspond to the flow diagram entitled "Post-Exposure Prophylaxis Dispensing Algorithm".

1. Is the patient younger than 9 years (yrs)? Due to the risk of teeth discoloration associated with tetracyclines, children without a quinolone allergy, who have not received all of their permanent teeth, should be prescribed ciprofloxacin. Since the age at which a child obtains his/her permanent teeth varies, it is possible for children under the age of 9 years to receive doxycycline. The parent or guardian of the child should be asked whether the child has a full-set of permanent teeth.

2. If the patient is female, is she pregnant or breast-feeding? The American College of Obstetricians and Gynecologists Committee on Obstetric Practice recommend the use of ciprofloxacin in pregnant or lactating women for anthrax post-exposure prophylaxis.<sup>6</sup>



3. Has the patient had an allergic reaction to any medication in the tetracycline class?

Allergic reactions may include: hives, redness of the skin, rash, difficulty breathing, or worsening of lupus after taking one of the tetracycline class drugs, including: demeclocycline (Declomycin); doxycycline (Adoxa, Bio-Tab, Doryx, Doxy, Monodox, Periostat, Vibra-Tabs, Vibramycin); minocycline (Arestin, Dynacin, Minocin, Vectrin); oxytetracycline (Terak, Terra-Cortril, Terramycin, Urobiotic-250); tetracycline (Achromycin V, Sumycin, Topicycline, Helidac).<sup>7,8</sup>

Patients that are allergic to any medication in the tetracycline class should receive another form of therapy such as ciprofloxacin.

4. Does the patient weight less than 99 pounds (lbs) or 45 kilograms (kg)?

5. Patients less than 99 pounds (45 kilograms), should receive an initial supply (10 days) of doxycycline 2.2 mg/kg (as described in the chart below) by mouth every 12 hours with a mandatory follow-up appointment within 10 days. At that time, information about the effectiveness of certain medications in preventing anthrax will be available and the drug may be changed. A minimum of 60 days of drug therapy is necessary for the full protective effect.<sup>3</sup>

Weight (lbs)	Weight (kg)	Dose (mg)	Available Dosage Forms of Doxycycline				
			20 mg tablet	50mg tablet or capsule	100mg tablet* or capsule	25mg/5mL suspension*	50mg/5mL syrup
5-10	2-5	10				2 mL	1 mL
11-20	6-9	20	1			4 mL	2 mL
21-30	10-14	30				6 mL	3 mL
31-40	15-19	40	2			8 mL	4 mL
41-50	20-22	50		1	½	10 mL	5 mL
51-60	23-27	60	3			12 mL	6 mL
61-70	28-32	70				14 mL	7 mL
71-80	33-36	80	4			16 mL	8 mL
81-90	37-41	90				18 mL	9 mL
91-100	> 42	100	5	2	1	20 mL	10 mL

\*Dosage Forms available through the CDC National Pharmaceutical Stockpile Program

6. Patients greater than 99 pounds should receive an initial supply (10 days) of doxycycline 100 mg by mouth every 12 hours with a mandatory follow-up appointment within 10 days. At that time, information about the effectiveness of certain medications in preventing anthrax will be available and the drug may be changed. A minimum of 60 days of drug therapy is necessary for the full protective effect.<sup>3</sup>

7. Has the patient had an allergic reaction to any medication in the quinolone class?

Allergic reactions may include: difficulty breathing, rash, itching, hives, yellowing of the eyes or skin, swelling of the face or neck, cardiovascular collapse, loss of consciousness, hepatic necrosis (death of liver cells), or eosinophilia (a rare skin disease) after taking a quinolone class drug, including: acrosloxacin or rosoxacin (Eradacil); cinoxacin (Cinobac); ciprofloxacin (Cipro, Ciloxan); gatafloxacin (Tequin); grepafloxacin (Raxar); levafloxacin (Levaquin, Quixin); lomefloxacin (Maxaquin); moxifloxacin (Avelox, ABC Pak); nadifloxacin (Acuatim); norfloxacin (Chibroxin, Noroxin); nalidixic acid (NegGram); ofloxacin (Floxin, Ocuflax); oxolinic acid; pefloxacin (Peflaxine); rifloxacin; sparfloxacin (Zagam, Respipac); temafloxacin; trovafloxacin or alatrofloxacin (Trovan).<sup>8</sup>

Patients that have had an allergic reaction to any medication in the quinolone class should be referred to a physician to receive another form of therapy.

8. Is the patient taking probenecid (Benemid)? Probenecid may decrease the renal excretion of ciprofloxacin, therefore increasing the risk of ciprofloxacin toxicity.

9. Is the patient taking theophylline (Theo-Dur, Slo-BID, Slo-Phyllin, Uniphyll)? Ciprofloxacin may increase the theophylline levels by inhibiting hepatic metabolism, and thus increase the risk of theophylline toxicity

10. Does the patient have known kidney (or renal) problems?

Patients with kidney problems include those receiving dialysis, with known kidney failure (end-stage renal disease) or who have reduced kidney function. Patients who have chronic kidney infections or kidney stones do not need an adjusted dose, unless they have been told by a health care professional that they have kidney damage. Patients with kidney problems who weigh less than 73 pounds should be referred to a physician.

11. Does the patient weigh less than 73 pounds (lbs) or 33 kilograms (kg)?

12. Patients 73 pounds (33 kilograms) or greater should receive ciprofloxacin 500 mg by mouth every 12 hours for 10 days with a mandatory follow-up appointment within 10 days. At that time, information about the effectiveness of certain medications in preventing anthrax will be available and the drug may be changed. A full course of therapy (60 days) is necessary for the full protective effect.<sup>3</sup>

13. Refer the patient to a physician for further assessment and drug selection. If a patient has had allergic reactions to drugs in the quinolone and tetracycline classes, other options for prophylactic (preventative) therapy include: amoxicillin/clavulanate, clindamycin, rifampin, imipenem, aminoglycosides, chloramphenicol, vancomycin, cefazolin, tetracycline, linezolid, or a macrolide (clarithromycin, erythromycin).<sup>1,10</sup> These other drugs are not approved by the Food and Drug Administration for preventative treatment of anthrax and require individual prescribing by a medical doctor or dispensing under an investigational new drug application.

14. Due to the interaction between probenecid and ciprofloxacin, probenecid should be temporarily stopped. The patient should be referred to their primary physician regarding when to restart probenecid and whether a dosage adjustment is necessary.

15. Due to the interaction between theophylline and ciprofloxacin, the dose of theophylline should be decreased by 50%. The patient should be referred to their primary physician regarding drug monitoring.

16. Does the patient weigh less than 73 pounds (lbs) or 33 kilograms (kg)? Patients less than 73 lbs should be referred to a physician for drug selection and monitoring.

17. Give patients 73 pounds (32 kilograms) or greater with kidney problems ciprofloxacin 500 mg by mouth **ONCE** a day and refer them to a physician for further assessment. Use the chart<sup>11</sup> below to determine the dose of ciprofloxacin required for patients with kidney problems when creatinine clearance is known or can be determined. Give all patients an initial supply of medication (10 days supply) and schedule a follow-up appointment within 10 days. At that time, information about the effectiveness of certain medications in preventing anthrax will be available and the drug may be changed. A minimum of 60 days of drug therapy is necessary for the full protective effect.<sup>3</sup>

<b>Kidney Function</b>	<b>Ciprofloxacin Dose (milligrams=mg)</b>
Creatinine Clearance >50 mL/min	500 mg every 12 hours
Creatinine Clearance = 30-50 mL/min	250 mg every 12 hours
Creatinine Clearance = 5-29 mL/min	250 mg every 18 hours
Hemodialysis	250 mg every 24 hours

18. Patients less than 73 pounds (33 kilograms) should receive an initial supply (10 days) of ciprofloxacin 10-15 mg/kg (as described in the chart below) by mouth every 12 hours with a mandatory follow-up appointment in 7-10 days. At that time, information about the effectiveness of certain medications in preventing anthrax will be available and the drug may be changed. A minimum of 60 days of drug therapy is necessary for the full protective effect.<sup>3</sup> This chart purposefully reflects more than one dose for a particular weight to permit flexibility in dosing based upon the products that are available at the time of dispensing. These doses are within the recommended dosing range of ciprofloxacin: 10-15 mg/kg.

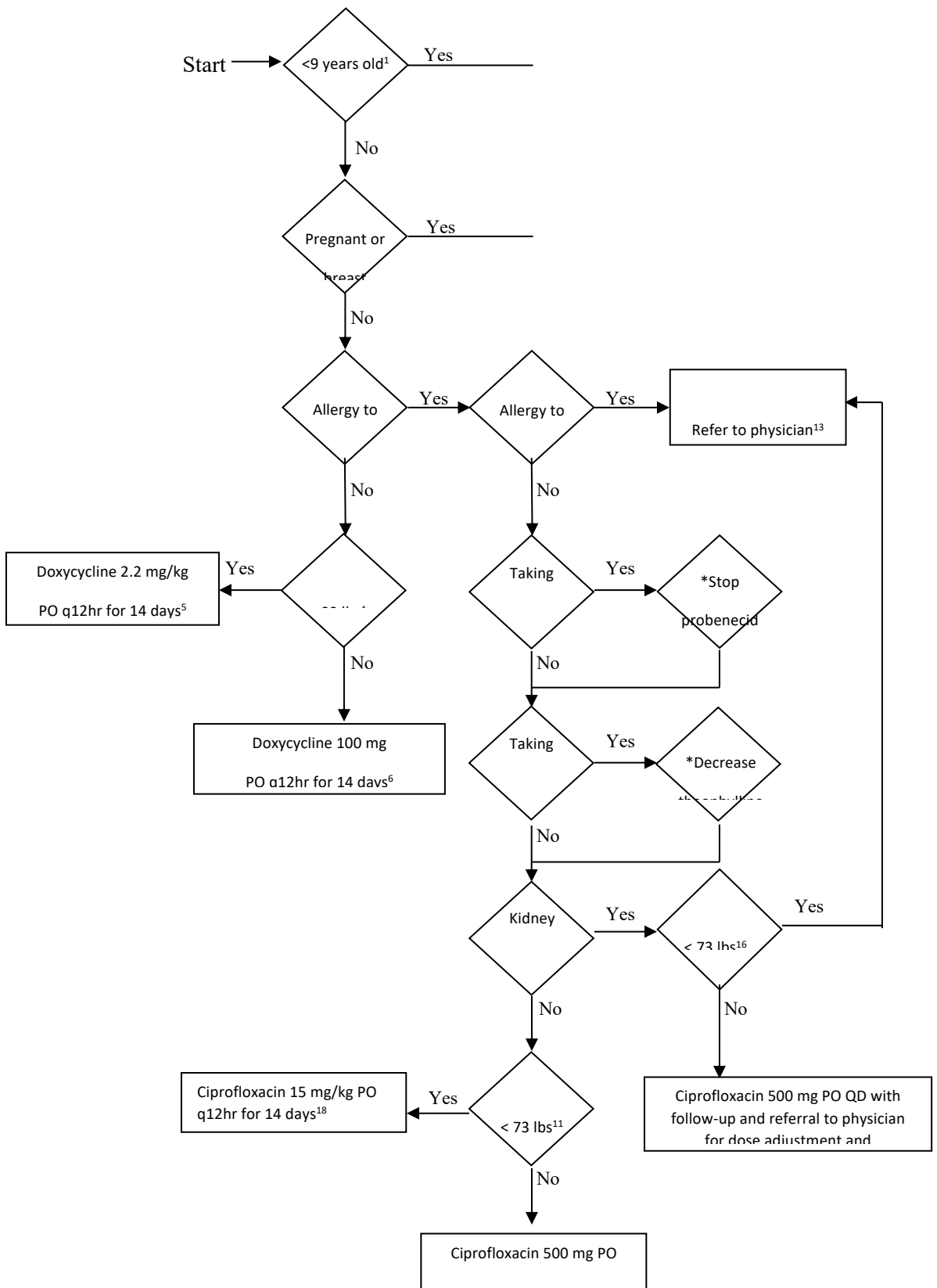
Weight (pounds)	Weight (kilogram)	Dose (mg)	Available Dosage Forms of Ciprofloxacin				
			100mg tablet	250mg tablet	500mg tablet*	250mg/5mL suspension*	500mg/5mL suspension
7-12 lbs	3-5 kg	50 mg PO BID	½	¼		1 mL (1 bottle)	0.5 mL (1 bottle)
13-22 lbs	6-10 kg	100 mg PO BID	1			2 mL (1 bottle)	1 mL (1 bottle)
18-28 lbs	8-13 kg	125 mg PO BID		½	¼	2.5 mL (1 bottle)	1.25 mL (1 bottle)
22-33 lbs	10-15 kg	150 mg PO BID	1½			3 mL (1 bottle)	1.5 mL (1 bottle)
29-44 lbs	13-20 kg	200 mg PO BID	2			4 mL (1 bottle)	2 mL (1 bottle)
36-56 lbs	16-25 kg	250 mg PO BID		1	½	5 mL (1 bottle)	2.5 mL (1 bottle)
55-83 lbs	25-37 kg	375 mg PO BID		1½	¾	7.5 mL (2 bottles)	3.75 mL (1 bottle)
≥73 lbs	≥ 33 kg	500 mg PO BID		2	1	10 mL (2 bottles)	5 mL (1 bottle)

\* Dosage Forms available through the CDC National Pharmaceutical Stockpile Program.

**ii. References:**

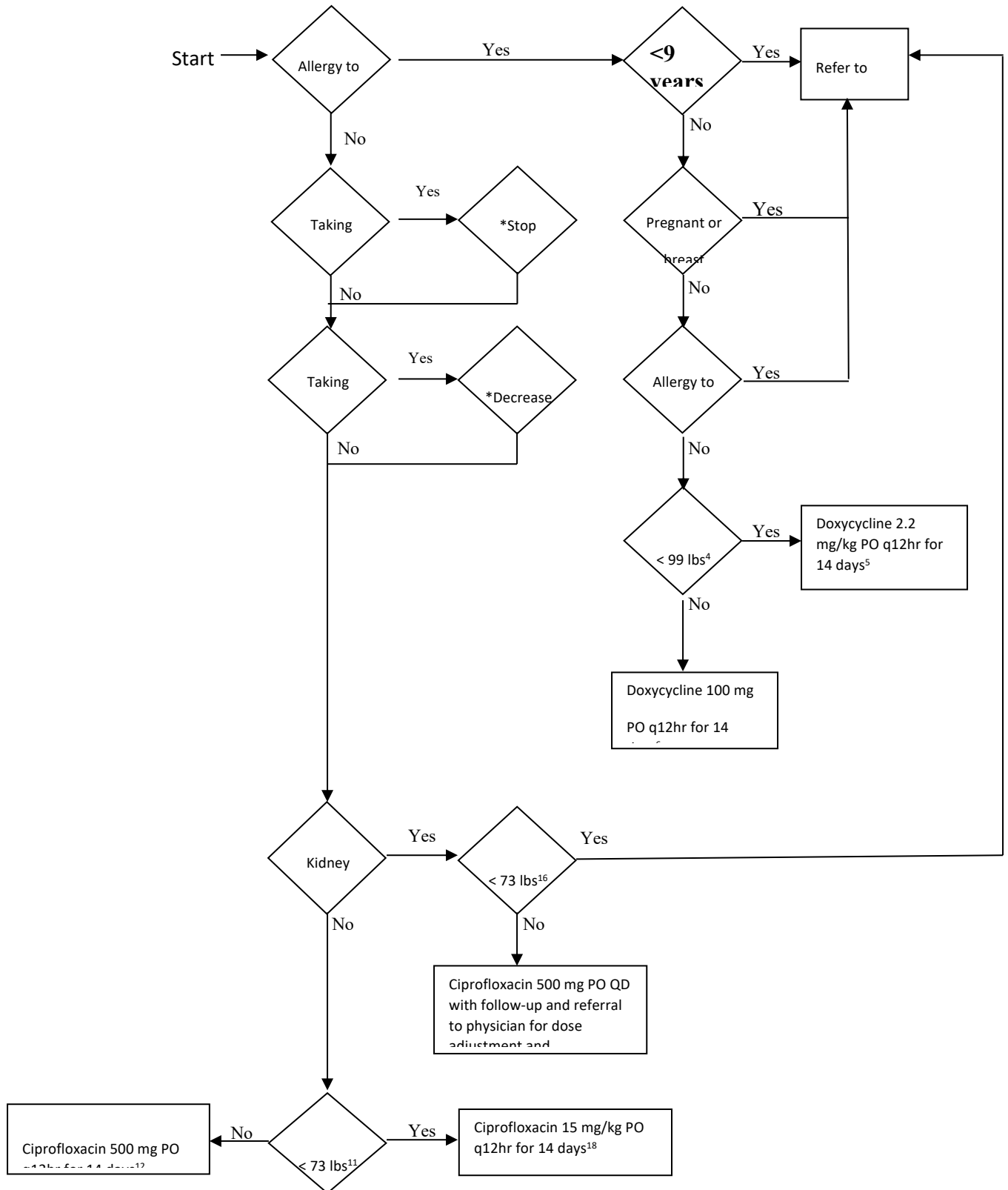
1. Inglesby TV, Henderson DA, Bartlett JG, et al. Anthrax as a biological weapon, 2002. *JAMA*. 2002;287:2236-2252.
2. Brook I, Elliott TB, Pryor HI, et al. In vitro resistance of bacillus anthracis Sterne to doxycycline, macrolides and quinolones. *International Journal of Antimicrobial Agents*. 18(2001);559-562.
3. Update: investigation of anthrax associated with intentional exposure and interim public health guidelines, October 2001. *MMWR*. October 19, 2001;50(41);889-893.
4. Notice to readers: updated recommendations for antimicrobial prophylaxis among asymptomatic pregnant women after exposure to bacillus anthracis. *MMWR*. November 2, 2001;50(43);960.
5. Notice to readers: update: interim recommendations for antimicrobial prophylaxis for children and breastfeeding mothers and treatment of children with anthrax. *MMWR*. November 16, 2001;50(45);1014-6.
6. Management of asymptomatic pregnant or lactating women exposed to anthrax. ACOG Committee Opinion No. 268. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 202;99:366-368.
7. Vibramycin® Package Insert. NY, NY, Pfizer Inc. 11/01
8. Sweetman SC. Martindale, The Complete Drug Reference, 33<sup>rd</sup> Edition. Great Britain; Pharmaceutical Press. 2002.
9. Harrison's Principles of Internal Medicine, 14<sup>th</sup> Edition. USA; McGraw Hill Companies Inc. 1998.
10. Update: investigation of bioterrorism-related anthrax and interim guidelines for exposure management and antimicrobial therapy, October 2001. *MMWR*. October 26, 2001;50(42);909-919.
11. Drug Information Handbook, 8<sup>th</sup> Edition. Hudson, OH; Lexi-Comp. 2000-2001.

**Attachment 2: Tularemia Post-Exposure Prophylaxis Dispensing Algorithm Doxycycline (Primary Drug)**



**Tularemia Post-Exposure Prophylaxis Dispensing Algorithm**

## Ciprofloxacin (Primary Drug)



\* 14 & 15, Instruct individual to immediately contact their primary care physician for recommended duration of change in prescription medication.

## Post-Exposure Prophylaxis Dispensing Algorithm

The above flow diagrams and these footnotes describe drug selection and dosing information for patients requiring post-exposure prophylaxis or preventative treatment after exposure to *Francisella tularensis*, the bacteria that causes tularemia.

Until antibiotic susceptibility results of the implicated strain are available, initial therapy for post-exposure prophylaxis for prevention of tularemia after intentional exposure of *F. tularensis* is doxycycline or ciprofloxacin.<sup>1</sup> Following a terrorist attack, the Missouri Department of Health and Senior Services (DHSS) will designate which of these two drugs will be the primary drug to use for prophylaxis.

All patients who have been potentially exposed to *F. tularensis* should receive a 14-day course of drug therapy.

The following steps and numbered paragraphs support and correspond to the flow diagram entitled “Post-Exposure Prophylaxis Dispensing Algorithm”.

1. Is the patient younger than 9 years (yrs)? Due to the risk of teeth discoloration associated with tetracyclines, children without a quinolone allergy, who have not received all of their permanent teeth, should be prescribed ciprofloxacin. Since the age at which a child obtains his/her permanent teeth varies, it is possible for children under the age of 9 years to receive doxycycline. The parent or guardian of the child should be asked whether the child has a full-set of permanent teeth.

2. If the patient is female, is she pregnant or breast-feeding?

3. Has the patient had an allergic reaction to any medication in the tetracycline class?

Allergic reactions may include: hives, redness of the skin, rash, difficulty breathing, or worsening of lupus after taking one of the tetracycline class drugs, including: demeclocycline (Declomycin); doxycycline (Adoxa, Bio-Tab, Doryx, Doxy, Monodox, Periostat, Vibra-Tabs, Vibramycin); minocycline (Arestin, Dynacin, Minocin, Vectrin); oxytetracycline (Terak, Terra-Cortril, Terramycin, Urobiotic-250); tetracycline (Achromycin V, Sumycin, Topicycline, Helidac).<sup>7,8</sup>

Patients that are allergic to any medication in the tetracycline class should receive another form of therapy such as ciprofloxacin.

4. Does the patient weight less than 99 pounds (lbs) or 45 kilograms (kg)?

5. Patients less than 99 pounds (45 kilograms), should receive a 14-day supply of doxycycline 2.2 mg/kg (as described in the chart below) by mouth every 12 hours.

Weight (lbs)	Weight (kg)	Dose (mg)	Available Dosage Forms of Doxycycline				
			20 mg tablet	50mg tablet or capsule	100mg tablet* or capsule	25mg/5mL suspension*	50mg/5mL syrup
5-10	2-5	10				2 mL	1 mL
11-20	6-9	20	1			4 mL	2 mL
21-30	10-14	30				6 mL	3 mL
31-40	15-19	40	2			8 mL	4 mL
41-50	20-22	50		1	½	10 mL	5 mL
51-60	23-27	60	3			12 mL	6 mL
61-70	28-32	70				14 mL	7 mL
71-80	33-36	80	4			16 mL	8 mL
81-90	37-41	90				18 mL	9 mL
91-100	> 42	100	5	2	1	20 mL	10 mL

\*Dosage Forms available through the CDC National Pharmaceutical Stockpile Program

6. Patients greater than 99 pounds should receive a 14-day supply of doxycycline 100 mg by mouth every 12 hours.

7. Has the patient had an allergic reaction to any medication in the quinolone class?

Allergic reactions may include: difficulty breathing, rash, itching, hives, yellowing of the eyes or skin, swelling of the face or neck, cardiovascular collapse, loss of consciousness, hepatic necrosis (death of liver cells), or eosinophilia (a rare skin disease) after taking a quinolone class drug, including: acrosloxacin or rososloxacin (Eradacil); cinoxacin (Cinobac); ciprofloxacin (Cipro, Ciloxan); gatafloxacin (Tequin); grepafloxacin (Raxar); levafloxacin (Levaquin, Quixin); lomefloxacin (Maxaquin); moxifloxacin (Avelox, ABC Pak); nadifloxacin (Acutim); norfloxacin (Chibroxin, Noroxin); nalidixic acid (NegGram); ofloxacin (Floxin, Ocuflax); oxolinic acid; pefloxacin (Peflacin); rufloxacin; sparfloxacin (Zagam, Respipac); temafloxacin; trovafloxacin or alatrofloxacin (Trovan).<sup>8</sup>

Patients that have had an allergic reaction to any medication in the quinolone class should be referred to a physician to receive another form of therapy.

- 8. Is the patient taking probenecid (Benemid)? Probenecid may decrease the renal excretion of ciprofloxacin, therefore increasing the risk of ciprofloxacin toxicity.
- 9. Is the patient taking theophylline (Theo-Dur, Slo-BID, Slo-Phyllin, Uniphyll)? Ciprofloxacin may increase the theophylline levels by inhibiting hepatic metabolism, and thus increase the risk of theophylline toxicity
- 10. Does the patient have known kidney (or renal) problems?

Patients with kidney problems include those receiving dialysis, with known kidney failure (end-stage renal disease) or who have reduced kidney function. Patients who have chronic kidney infections or kidney stones do not need an adjusted dose, unless they have been told by a health care professional that they have kidney damage. Patients with kidney problems who weigh less than 73 pounds should be referred to a physician.

- 11. Does the patient weigh less than 73 pounds (lbs) or 33 kilograms (kg)?
- 12. Patients 73 pounds (33 kilograms) or greater should receive ciprofloxacin 500 mg by mouth every 12 hours for 14 days.
- 13. Refer the patient to a physician for further assessment and drug selection.
- 14. Due to the interaction between probenecid and ciprofloxacin, probenecid should be temporarily stopped. The patient should be referred to their primary physician regarding when to restart probenecid and whether a dosage adjustment is necessary.
- 15. Due to the interaction between theophylline and ciprofloxacin, the dose of theophylline should be decreased by 50%. The patient should be referred to their primary physician regarding drug monitoring.
- 16. Does the patient weigh less than 73 pounds (lbs) or 33 kilograms (kg)? Patients less than 73 lbs should be referred to a physician for drug selection and monitoring.
- 17. Give patients 73 pounds (32 kilograms) or greater with kidney problems ciprofloxacin 500 mg by mouth **ONCE** a day and refer them to a physician for further assessment. Use the chart<sup>11</sup> below to determine the dose of ciprofloxacin required for patients with kidney problems when creatinine clearance is known or can be determined. Give all patients a 14-day supply of medication.

<b>Kidney Function</b>	<b>Ciprofloxacin Dose (milligrams=mg)</b>
Creatinine Clearance >50 mL/min	500 mg every 12 hours
Creatinine Clearance = 30-50 mL/min	250 mg every 12 hours
Creatinine Clearance = 5-29 mL/min	250 mg every 18 hours
Hemodialysis	250 mg every 24 hours



18. Patients less than 73 pounds (33 kilograms) should receive a 14-day supply of ciprofloxacin 15 mg/kg by mouth every 12 hours

References:

1. Dennis DT, Inglesby TV, Henderson DA, et al. Tularemia as a Biological Weapon, *JAMA*. 2001;285:2763-2773.
7. Vibramycin® Package Insert. NY, NY, Pfizer Inc. 11/01
8. Sweetman SC. Martindale, The Complete Drug Reference, 33<sup>rd</sup> Edition. Great Britain; Pharmaceutical Press. 2002.
11. Drug Information Handbook, 8<sup>th</sup> Edition. Hudson, OH; Lexi-Comp. 2000-2001.

**Health Assessment Form for Post-Exposure Prophylaxis**

DATE: \_\_\_/\_\_\_/\_\_\_ Exposure Verified: Yes  No  ID# Number: \_\_\_\_\_ SSN  Passport  Drivers License

Section 1: DEMOGRAPHICS (TO BE COMPLETED BY INDIVIDUAL)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ WT: \_\_\_\_\_ (if needed) Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Telephone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Current Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Parent Name if Different from Child (under age 18) \_\_\_\_\_

Section 2: HEALTH ASSESSMENT (TO BE COMPLETED BY THE INDIVIDUAL)

Recent Illness: Have you developed any of the following symptoms in the past few days?

Cough, shortness of breath, or chest pain yes  no  New skin lesions yes  no   
Fever, shills, or muscle aches yes  no  Nausea, vomiting, or bloody diarrhea/sputum yes  no   
Severe headaches yes  no  Mouth or throat ulcers yes  no

Do you have any drug allergies? Yes  No  If yes, please list medications: \_\_\_\_\_

Have you ever had any of the following medical conditions?

Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Organ Transplant	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sickle Cell Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma/Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Spleen Removal	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stomach Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	kidney/renal disease	Yes <input type="checkbox"/> No <input type="checkbox"/>

Are you presently taking any medications, including over the counter medications? If yes, please list them:  
\_\_\_\_\_

Have you ever had a serious reaction after receiving any medication? Yes  No

Females: Are you pregnant Yes  No  Are you breast-feeding? Yes  No  Do you use hormonal birth control? Yes

SECTION 3: INFORMED CONSENT (TO BE COMPLETED BY THE INDIVIDUAL)

“I, \_\_\_\_\_” am seeking antibiotic medication in accordance with the recommendations of the Missouri Department of Health and Senior Services. I have received and read the information sheets about the disease and medication. I do / do not (circle one) consent to the treatment prescribed.

\_\_\_\_\_  
Signature (Self or Guardian)

\_\_\_\_\_  
Date

SECTION 5: INDIVIDUAL DECLINES ANTIBIOTIC TREATMENT

The risk and benefit of the use of antibiotics to prevent disease from exposure has been explained to me. I decline treatment at this time.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness (Printed Name/Signature) \_\_\_\_\_

**b. Do Not Write Below This Box**

- Ciprofloxacin 500 mg q12 hrs x 10 days or \_\_\_\_\_ mg PO \_\_\_\_\_ Dx \_\_\_\_\_ days RX# \_\_\_\_\_ Quantity \_\_\_\_\_ Lot \_\_\_\_\_
- Doxycycline 100 mg q12 hrs x 10 days or \_\_\_\_\_ mg PO \_\_\_\_\_ Dx \_\_\_\_\_ days RX# \_\_\_\_\_ Quantity \_\_\_\_\_ Lot \_\_\_\_\_
- Amoxicillin Dose \_\_\_\_\_ RX# \_\_\_\_\_ Quantity \_\_\_\_\_ Lot \_\_\_\_\_

Health Care Professional's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Anthrax

### What is anthrax?

Anthrax is a serious disease caused by *Bacillus anthracis*, a bacteria that forms spores. A spore is a cell that is dormant (asleep) but may come to life under the right conditions. Spores can survive outside the body for long periods of time.

There are three types of anthrax, which involve the:

1. Skin (**cutaneous anthrax**) - The first symptom is a raised itchy bump that resembles an insect bite but within 1-2 days develops into a blister and then a painless ulcer. Fever and painful swollen lymph nodes can be present.
2. Lungs (**inhalational anthrax**) - The first symptoms are like cold or flu symptoms and can include sore throat, fever and muscle aches. Later symptoms include cough, chest discomfort, shortness of breath, tiredness, and muscle aches. (But don't assume that just because a person has cold or flu symptoms, he/she has inhalational anthrax.)
3. Digestive system (**gastrointestinal anthrax**) - The first symptoms are nausea, loss of appetite, bloody diarrhea, and fever, followed by bad stomach pain.

### How do you get it?

Humans can become infected with anthrax by handling products from infected animals or by breathing in anthrax spores from infected animal products (like wool, for example). People can become infected with gastrointestinal anthrax by eating undercooked meat from infected animals.

Anthrax can be used as a weapon. This happened in the United States in 2001, when anthrax was deliberately spread through the postal system by sending letters with powder containing anthrax. This caused 22 cases of anthrax infection.

Anthrax is not known to spread from one person to another.

### How soon do infected people get sick?

Symptoms can appear within 7 days of coming in contact with anthrax spores for all three types of the disease. For inhalation anthrax, symptoms can appear within a week or can take up to 42 days to appear.

### How dangerous is anthrax? Is there a treatment?

Antibiotics are used to treat all three types of anthrax. Treatment is usually for 60 days. Success depends on the type of anthrax and how soon treatment begins.

**Usually early treatment with antibiotics will cure cutaneous anthrax. Even if untreated, 80% of people with cutaneous anthrax do not die. Gastrointestinal anthrax is more serious, resulting in death in 25-60% of cases. Inhalational anthrax is much more severe. In the 2001 outbreak, about half of the cases of inhalational anthrax ended in death; in previous**

**outbreaks, the death rate has been much higher. Early identification and treatment are important.**

**Can a person who is exposed to anthrax spores be treated so that they will not become sick?**

If a person is thought to have recently breathed in anthrax spores, they will generally be given an antibiotic (such as ciprofloxacin or doxycycline) to prevent illness from occurring.

**Is there a vaccine for anthrax?**

There is a vaccine to prevent anthrax, but it is not yet available for the general public.

**What should I do if I think I have anthrax?**

If you are showing symptoms of anthrax infection, call your health-care provider right away.

**What should I do if I think I have been exposed to anthrax?**

Contact local law enforcement officials immediately if you think that you may have been exposed to anthrax. This includes being exposed to a suspicious package or envelope that contains powder.

**What should I do if cases of anthrax start to occur in my community?**

Your local Health Center and the Missouri Department of Health and Senior Services will provide with information. Adaped CDC . *Anthrax: What You Need To Know*. July 31, 2003

## **Tularemia**

Center for Emergency Response/Terrorism

Missouri Department of Health & Senior Services

**What is tularemia?**

Tularemia is an infectious disease caused by a bacterium, *Francisella tularensis*, which is found in numerous wild animals, especially rodents, rabbits, and hares. *F. tularensis* is highly infectious; a small number of bacteria (10-50 organisms) can cause disease.

**How do people become infected with the tularemia bacteria?**

Typically, persons become infected through the bites of arthropods (most commonly, ticks and deerflies) that have fed on an infected animal, by handling infected animal carcasses, by eating or drinking contaminated food or water, or by inhaling infected aerosols. Note that persons with tularemia have not been known to transmit the infection to others, so infected persons do not need to be isolated.

There is concern that tularemia bacteria might be used by terrorists, who would likely disseminate the organisms through the air in the form of an aerosol, resulting in cases of inhalational tularemia. Persons with inhalational tularemia generally experience severe respiratory illness, including life-threatening pneumonia and systemic infection, if they are not treated.

**Does tularemia occur naturally in the United States?**

Yes. It is a widespread disease of animals. Approximately 200 cases of tularemia in humans are reported annually in the United States, mostly in persons living in the south-central and western states (including Missouri). Nearly all cases occur in rural areas and are associated with the bites of infectious ticks and biting flies, or with the handling of infected rodents, rabbits, or hares.

**What are the signs and symptoms of tularemia?**

Depending on the route of exposure, infection with *F. tularensis* may result in skin ulcers, swollen and painful lymph glands, inflamed eyes, sore throat, oral ulcers, or pneumonia. If the bacteria is inhaled, symptoms can include the abrupt onset of fever, chills, headache, muscle aches, joint pain, dry cough, and progressive weakness. Persons with pneumonia can develop chest pain, difficulty breathing, bloody sputum, and respiratory failure, and 40% or more of persons with the lung and systemic forms of tularemia may die if they are not treated with appropriate antibiotics.

The time from initial infection until the appearance of symptoms is typically 3-5 days, with a range of 1-14 days.

**How is tularemia diagnosed?**

When tularemia is suspected based on the patient’s history and physical examination, specimens such as blood or sputum will be collected and tested for evidence of tularemia infection (and other potential infections) in a medical laboratory.

**Can tularemia be treated?**

Yes, tularemia can be treated effectively with antibiotics. As with any infection, early diagnosis is important.

**If a person is thought to have been exposed to the tularemia bacteria, what can be done?**

If an individual is believed to have been very recently exposed to *F. tularensis*, treatment with antibiotics for 14 days may be recommended as a means of preventing disease.

**Is there a vaccine available for tularemia?**

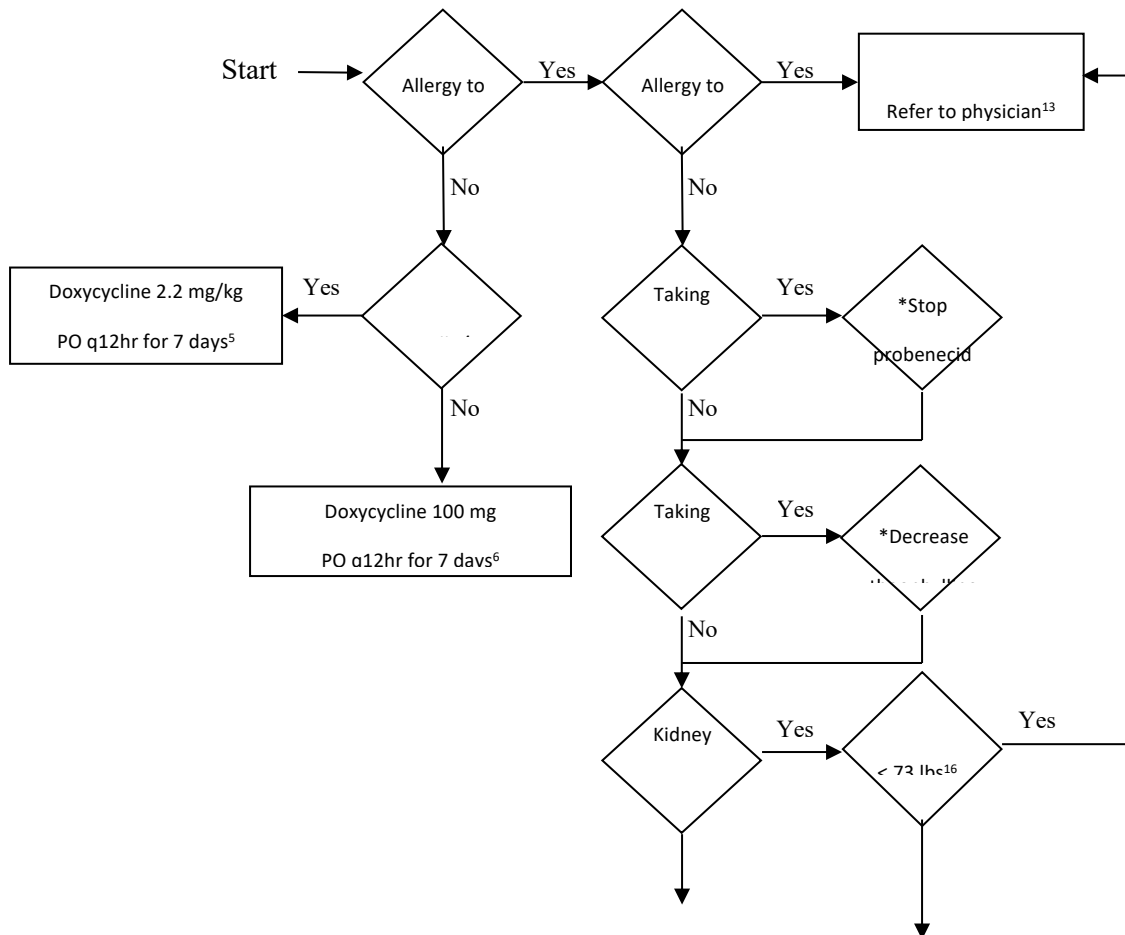
A tularemia vaccine is currently under review by the Food and Drug Administration (FDA).

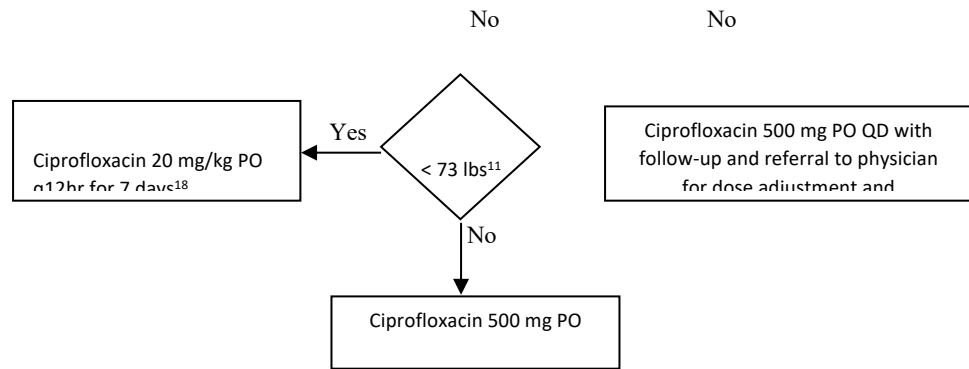
**What should I do if cases of tularemia start to occur in my community?**

Local and state public health officials will provide you with the information you will need.

Adapted from CDC. Frequently Asked Questions (FAQ) About Tularemia. July 2, 2003.

**Attachment 3: Plague Post-Exposure Prophylaxis Dispensing Algorithm Doxycycline (Primary Drug)**





\*14 & 15, Instruct individual to immediately contact their primary care physician for recommended duration of change in prescription medication.

## Post-Exposure Prophylaxis Dispensing Algorithm

The above flow diagram and these footnotes describe drug selection and dosing information for patients requiring post-exposure prophylaxis or preventative treatment after exposure to *Yersinia pestis*, the bacteria that causes plague.

Until antibiotic susceptibility results of the implicated strain are available, initial therapy for post-exposure prophylaxis for prevention of plague after intentional exposure to *Y. pestis* is doxycycline.<sup>1</sup>

Recommendations for antimicrobial prophylactic treatment with efficacy against plague are conditioned by balancing risks associated with treatment against those posed by pneumonic plague. Children aged 8 years and older can be treated with tetracycline antibiotics safely. However, in children younger than 8 years, tetracycline antibiotics may cause discolored teeth, and rare instances of retarded skeletal growth have been reported in infants. The assessment of the Working Group on Civilian Biodefense is that the potential benefits of these antimicrobials in the treating of pneumonic plague infection substantially outweigh the risks. The Working Group specifically recommends that doxycycline be used for postexposure prophylaxis in children.<sup>1</sup> If the child is unable to take doxycycline or the medication is unavailable, ciprofloxacin would be recommended.

The tetracycline class of antibiotics has been associated with fetal toxicity including retarded skeletal growth, although a large case-control study of doxycycline use in pregnancy showed no significant increase in teratogenic risk to the fetus. Liver toxicity has been reported in pregnant women following large doses of intravenous tetracycline (no longer sold in the United States), but it has also been reported following oral administration of tetracycline to nonpregnant individuals. Balancing the risks of pneumonic plague infection with those associated with doxycycline use in pregnancy, the Working Group recommends that pregnant women receive doxycycline for postexposure prophylaxis.<sup>1</sup> If the woman is unable to take doxycycline or the medication is unavailable, ciprofloxacin would be recommended.

All patients who have been potentially exposed to *Y. pestis* should receive a 7-day course of drug therapy.

The following steps and numbered paragraphs support and correspond to the flow diagram entitled “Post-Exposure Prophylaxis Dispensing Algorithm”.

3. Has the patient had an allergic reaction to any medication in the tetracycline class?

Allergic reactions may include: hives, redness of the skin, rash, difficulty breathing, or worsening of lupus after taking one of the tetracycline class drugs, including: demeclocycline (Declomycin); doxycycline (Adoxa, Bio-Tab, Doryx, Doxy, Monodox, Periostat, Vibra-Tabs, Vibramycin); minocycline (Arestin, Dynacin, Minocin, Vectrin); oxytetracycline (Terak, Terra-Cortril, Terramycin, Urobotic-250); tetracycline (Achromycin V, Sumycin, Topicycline, Helidac).<sup>7,8</sup>

Patients that are allergic to any medication in the tetracycline class should receive another form of therapy such as ciprofloxacin.

4. Does the patient weight less than 99 pounds (lbs) or 45 kilograms (kg)?
5. Patients less than 99 pounds (45 kilograms), should receive a 7-day supply of doxycycline 2.2 mg/kg (as described in the chart below) by mouth every 12 hours.

Weight (lbs)	Weight (kg)	Dose (mg)	Available Dosage Forms of Doxycycline				
			20 mg tablet	50mg tablet or capsule	100mg tablet* or capsule	25mg/5mL suspension*	50mg/5mL syrup
5-10	2-5	10				2 mL	1 mL
11-20	6-9	20	1			4 mL	2 mL
21-30	10-14	30				6 mL	3 mL
31-40	15-19	40	2			8 mL	4 mL
41-50	20-22	50		1	½	10 mL	5 mL
51-60	23-27	60	3			12 mL	6 mL
61-70	28-32	70				14 mL	7 mL
71-80	33-36	80	4			16 mL	8 mL
81-90	37-41	90				18 mL	9 mL
91-100	≥ 42	100	5	2	1	20 mL	10 mL

\*Dosage Forms available through the CDC National Pharmaceutical Stockpile Program

- Patients greater than 99 pounds should receive a 7-day supply of doxycycline 100 mg by mouth every 12 hours.
- Has the patient had an allergic reaction to any medication in the quinolone class?

Allergic reactions may include: difficulty breathing, rash, itching, hives, yellowing of the eyes or skin, swelling of the face or neck, cardiovascular collapse, loss of consciousness, hepatic necrosis (death of liver cells), or eosinophilia (a rare skin disease) after taking a quinolone class drug, including: acrosloxacin or rosoxacin (Eradacil); cinoxacin (Cinobac); ciprofloxacin (Cipro, Ciloxan); gatafloxacin (Tequin); grepafloxacin (Raxar); levafloxacin (Levaquin, Quixin); lomefloxacin (Maxaquin); moxifloxacin (Avelox, ABC Pak); nadifloxacin (Acuatim); norfloxacin (Chibroxin, Noroxin); nalidixic acid (NegGram); ofloxacin (Floxin, Ocuflax); oxolinic acid; pefloxacin (Peflacin); rifloxacin; sparfloxacin (Zagam, Respipac); temafloxacin; trovafloxacin or alatrofloxacin (Trovan).<sup>8</sup>

Patients that have had an allergic reaction to any medication in the quinolone class should be referred to a physician to receive another form of therapy.

- Is the patient taking probenecid (Benemid)? Probenecid may decrease the renal excretion of ciprofloxacin, therefore increasing the risk of ciprofloxacin toxicity.
- Is the patient taking theophylline (Theo-Dur, Slo-BID, Slo-Phyllin, Uniphyll)? Ciprofloxacin may increase the theophylline levels by inhibiting hepatic metabolism, and thus increase the risk of theophylline toxicity
- Does the patient have known kidney (or renal) problems?

Patients with kidney problems include those receiving dialysis, with known kidney failure (end-stage renal disease) or who have reduced kidney function. Patients who have chronic kidney infections or kidney stones do not need an adjusted dose, unless they have been told by a health care professional that they have kidney damage. Patients with kidney problems who weigh less than 73 pounds should be referred to a physician.

- Does the patient weigh less than 73 pounds (lbs) or 33 kilograms (kg)?
- Patients 73 pounds (33 kilograms) or greater should receive ciprofloxacin 500 mg by mouth every 12 hours for 7 days.
- Refer the patient to a physician for further assessment and drug selection.
- Due to the interaction between probenecid and ciprofloxacin, probenecid should be temporarily stopped. The patient should be referred to their primary physician regarding when to restart probenecid and whether a dosage adjustment is necessary.

15. Due to the interaction between theophylline and ciprofloxacin, the dose of theophylline should be decreased by 50%. The patient should be referred to their primary physician regarding drug monitoring.
16. Does the patient weigh less than 73 pounds (lbs) or 33 kilograms (kg)? Patients less than 73 lbs should be referred to a physician for drug selection and monitoring.
17. Give patients 73 pounds (32 kilograms) or greater with kidney problems ciprofloxacin 500 mg by mouth **ONCE** a day and refer them to a physician for further assessment. Use the chart<sup>11</sup> below to determine the dose of ciprofloxacin required for patients with kidney problems when creatinine clearance is known or can be determined. Give all patients a 7-day supply of medication.

<b>Kidney Function</b>	<b>Ciprofloxacin Dose (milligrams=mg)</b>
Creatinine Clearance >50 mL/min	500 mg every 12 hours
Creatinine Clearance = 30-50 mL/min	250 mg every 12 hours
Creatinine Clearance = 5-29 mL/min	250 mg every 18 hours
Hemodialysis	250 mg every 24 hours

18. Patients less than 73 pounds (33 kilograms) should receive a 7-day supply of ciprofloxacin 20 mg/kg by mouth every 12 hours

**i. References:**

1. Inglesby TV, Dennis DT, Henderson DA, et al. Plague as a Biological Weapon, *JAMA* 2000;283:2281-2290.
7. Vibramycin® Package Insert. NY, NY, Pfizer Inc. 11/01
8. Sweetman SC. Martindale, The Complete Drug Reference, 33<sup>rd</sup> Edition. Great Britain; Pharmaceutical Press. 2002.
11. Drug Information Handbook, 8<sup>th</sup> Edition. Hudson, OH; Lexi-Comp. 2000-2001.



This drug belongs to a class of drugs called quinolone antibiotics. You have been given this drug for protection against possible exposure to infection-causing bacteria. This drug prevents:

### **Anthrax**

You have been provided a limited supply of medicine. Public health officials will inform you if you need more medicine after you finish this supply. If so, you will be told how to get more medicine. You will be told if no more medicine is needed. You may also be switched from this medicine to a different medicine based on laboratory tests. Since the disease associated with anthrax can develop quickly and be life threatening, it is very important that you complete the full course of therapy recommended by public health officials.

### DOSING INSTRUCTIONS:

**Take this medicine: one tablet by mouth, two times a day unless otherwise prescribed.**

- You will be provided special dosing instructions for children.
- Keep taking your medicine, even if you feel okay, unless your doctor tells you to stop. If you stop taking this medicine too soon, you may become ill.
- You should take this medicine with a full glass of water. Drink several glasses of water each day while you are taking this medicine. It is best to take this medicine 2 hours after a meal. If it upsets your stomach, you may take it with food, but do not take it with dairy products such as milk, yogurt, or cheese.
- If you miss a dose, take the missed dose as soon as possible. If it is almost time for your next regular dose, wait until then to take your medicine, and skip the missed dose. Do not take two doses at the same time.
- This medication has been prescribed for your current condition only. Do not use it later for another infection or give it to someone else.

### WARNINGS:

- Do not take this medicine if you have had an allergic reaction to ciprofloxacin or other quinolone medicines such as gatafloxacin (Tequin), levofloxacin (Levaquin), norfloxacin (Noroxin), ofloxacin (Floxin) or nalidixic acid (NegGram).
- If you have epilepsy or kidney disease, or if you are pregnant, become pregnant, or are breastfeeding, notify emergency healthcare workers before you start taking this medicine.
- Until information is obtained about which drug is most effective against anthrax, medical experts from the Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists, recommend children and pregnant and breast-feeding women receive ciprofloxacin to prevent the life-threatening complications of anthrax. If you are currently breast-feeding and have concerns about exposing your baby to ciprofloxacin, you may consider discarding the breast milk until you have finished the medication.
- This medicine may make you dizzy or lightheaded. Avoid driving or using machinery until you know how it will affect you.
- This medicine increases the chance of sunburn; avoid prolonged exposure to sunlight or tanning equipment. If you have to be in the sun, make sure to use sunscreen (SPF 15 or greater) to protect your skin.

### ADVERSE REACTIONS:

Stop taking ciprofloxacin and call your doctor or seek medical attention right away by visiting an emergency room if you are having any of these side effects: rash or hives; swelling of face, throat, or lips; shortness of breath or trouble breathing; seizures; or severe diarrhea.

### SIDE EFFECTS:

Rare side effects may occur that usually do not need medical attention. These side effects may go away while your body adjusts to the medicine. These side effects include nausea, mild diarrhea, stomach pain, dizziness, and headache. If you experience diarrhea, consider adding yogurt or lactobacillus to your diet. A re-hydration solution such as Pedialyte is helpful if you have severe diarrhea. Talk with your doctor if any of these side effects become bothersome.

### FOOD INTERACTIONS:

Avoid drinking more than one or two caffeinated beverages (coffee, tea, soft drinks) per day.<sup>1,2</sup> Avoid taking this medicine within 2 hours of dairy products containing large amounts of calcium such as milk, yogurt, or cheese. <sup>1,2</sup>

### DRUG INTERACTIONS:

Take the following drugs 2 hours after or 6 hours before ciprofloxacin:

Antacids (Maalox®, Mylanta®) <sup>1,2</sup>	Sucralfate (Carafate®) <sup>1,2</sup>
Calcium supplements (Oscal®) <sup>1</sup>	Vitamins with mineral supplements (Centrum®, Theragran-M®)
Didanosine (Videx®) <sup>1,2</sup>	Zinc supplements <sup>1,2</sup>
Iron supplements (Vitron-C®, Feosol®) <sup>1,2</sup>	

Consult a health care professional within 3-5 days after starting ciprofloxacin for monitoring and possible dosage change if you are taking one of the following medications:

Cyclosporine (Neoral®) <sup>2</sup>	Mexiletine (Mexitol®) <sup>2</sup>	Theophylline (Theo-Dur®) <sup>1,2</sup>
Foscarnet (Foscavir®) <sup>2</sup>	Phenytoin (Dilantin®) <sup>1,2</sup>	Warfarin (Coumadin®) <sup>1,2</sup>
Fosphenytoin (Cerebyx®) <sup>1,2</sup>	Probenecid (Benemid®) <sup>1</sup>	

You may experience more side effects from the following medications, when taken with ciprofloxacin. Please consult your health care professional.

Caffeine (Vivarin®) <sup>1,2</sup>	Glyburide (Diabeta®) <sup>1</sup>	Propranolol (Inderal®) <sup>1</sup>
Clozapine (Clozaril®) <sup>2</sup>	Methadone (Dolophine®) <sup>2</sup>	Olanzapine (Zyprexa®) <sup>1,2</sup>
Diazepam (Valium®) <sup>2</sup>	Metoprolol (Lopressor®) <sup>1,2</sup>	Ropinirole (Requip®) <sup>1</sup>

Oral corticosteroids such as cortisone, hydrocortisone, prednisolone, prednisone, methylprednisolone, triamcinolone, dexamethasone, betamethasone may increase your risk for tendon rupture. Use precaution when exercising and report any tendon pain or inflammation. <sup>1</sup> Consult your doctor if you are taking any other antibiotic.

### HERBAL INTERACTIONS:

Do not take fennel or dandelion within 2 hours of taking ciprofloxacin. You may take them 2 hours after or 6 hours before ciprofloxacin.<sup>1</sup>

### STORAGE:

To store this medicine:

- Keep this medicine out of the reach of children.
- Store away from heat and direct light.
- Ciprofloxacin oral suspension may be refrigerated. However, keep this medicine from freezing.
- Do not store this medicine in the bathroom, near the kitchen sink, or in other damp places. Heat or moisture may cause this medicine to not work.

- Keep this medicine from freezing.

REFERENCES:

1. DRUG-REAX Interactive Drug Interactions; *MICROMEDEX Healthcare Series*, 2002.
2. Drug Interaction Facts; *Facts and Comparisons*, 2002.

## **PATIENT INFORMATION: DOXYCYCLINE 100 MG TABLET**

This drug belongs to a class of drugs called tetracycline antibiotics. You have been given this drug for protection against possible exposure to infection-causing bacteria. This drug prevents: **Anthrax**

You have been provided a limited supply of medicine. Public health officials will inform you if you need more medicine after you finish this supply. If so, upon your follow-up visit, you will be told how to get more medicine. You will be told if no more medicine is needed. You may also be switched from this medicine to a different medicine based on laboratory tests. Since the disease associated with anthrax can develop quickly and be life threatening, it is very important that you complete the full course of therapy recommended by public health officials.

### DOSING INSTRUCTIONS:

**Take this medicine: one tablet by mouth, two times a day unless otherwise prescribed.**

- Keep taking your medicine, even if you feel okay, unless your healthcare provider tells you to stop. If you stop taking this medicine too soon, you may become ill.
- You may take your medicine with or without food or milk, but food or milk may help you avoid stomach upset.
- If you miss a dose, take the missed dose as soon as possible. If it is almost time for your next regular dose, wait until then to take your medicine, and skip the missed dose. Do not take two doses at the same time.
- This medication has been prescribed for your current condition only. Do not use it later for another infection or give it to someone else.

### WARNINGS:

- Do not take this medicine if you have had an allergic reaction to any tetracycline antibiotics such as demeclocycline, doxycycline, minocycline, or oxytetracycline.
- If you have liver disease, or if you are or might be pregnant, or if you are breastfeeding, tell emergency healthcare workers before you start taking this medicine.
- This medicine increases the chance of sunburn; avoid prolonged exposure to sunlight or tanning equipment. If you have to be in the sun, make sure to use sunscreen (SPF 15 or greater) to protect your skin.
- Women may have vaginal yeast infections from taking this medicine. An over-the-counter vaginal, antifungal product will help this problem.

### ADVERSE REACTIONS:

Stop taking doxycycline and call your doctor or seek medical attention right away by visiting an emergency room if you are having any of these side effects: skin rash, hives, or itching; wheezing or trouble breathing; swelling of the face, lips, or throat.

### SIDE EFFECTS:

Rare side effects may occur that usually do not need medical attention. These side effects may go away while your body adjusts to the medicine. These side effects include diarrhea, upset stomach, nausea, sore mouth or throat, sensitivity to sunlight, or itching of the mouth or vagina lasting more than 2 days. If you experience diarrhea, consider adding yogurt or lactobacillus to your diet. A re-hydration solution such as Pedialyte is helpful if you have severe diarrhea. Talk with your doctor if any of these side effects become bothersome.

### DRUG INTERACTIONS:

The following medications and over-the-counter products should be taken three hours before or two hours after taking doxycycline:

Antacids (Maalox®, Mylanta®) <sup>1,2</sup>	Iron supplements (Vitron-C®, Feosol®) <sup>1,2</sup>
Bismuth subsalicylate (Pepto-Bismol®) <sup>1,2</sup>	Potassium Citrate (Urocit-K®) <sup>2</sup>
Calcium supplements (Oscal®) <sup>1</sup>	Magnesium-containing products (Mag-Ox®, Milk of Magnesia) <sup>1,2</sup>
Choline and magnesium salicylates combination (Trilisate®)	Sodium bicarbonate (baking soda) <sup>2</sup>
Cholestyramine (Questran®)	Vitamin preparations that contain minerals (Centrum®, Theragra-M®)
Colestipol (Colestid®) <sup>2</sup>	

Doxycycline may affect the following medications. Consult your doctor within 3-5 days if you are currently taking any of the following medications:

Digoxin (Lanoxin®) <sup>2</sup>	Isotretinoin (Accutane®) <sup>1</sup>	Methotrexate <sup>1,2</sup>
Dicumarol <sup>1</sup>	Methoxyflurane	Theophylline (Theo-Dur®) <sup>2</sup>
Insulin (Humulin®, Novolin®) <sup>2</sup>	(Penthrane®) <sup>2</sup>	Warfarin (Coumadin®) <sup>1,2</sup>

Oral contraceptives (birth control pills) containing estrogen may not work properly if you take them while you are taking this medicine. Unplanned pregnancies may occur. You should use a different or additional means of birth control while you are taking this medication. If you have questions about this, consult your doctor or pharmacist.<sup>1,2</sup>

The following medications may decrease the amount of doxycycline in your body. Consult your doctor whether you need to receive a higher dose of doxycycline:

Carbamazepine (Tegretol®) <sup>1,2</sup>	Phenobarbital <sup>1,2</sup>	Rifabutin (Mycobutin®) <sup>2</sup>
Fosphenytoin (Cerebyx®) <sup>1</sup>	Phenytoin (Dilantin®) <sup>1,2</sup>	Rifampin (Rifadin®) <sup>1,2</sup>

Consult your doctor if you are taking any other antibiotic.

#### HERBAL INTERACTIONS:

The herbal supplements, St John's wort and Dong quai, should be avoided when taking doxycycline.

#### STORAGE:

To store this medicine:

- Keep this medicine out of the reach of children.
- Store away from heat and direct light.
- Do not store this medicine in the bathroom, near the kitchen sink, or in other damp places.
- Heat or moisture may cause this medicine to not work.
- Keep this medicine from freezing.

#### REFERENCES:

1. DRUG-REAX Interactive Drug Interactions; *MICROMEDEX Healthcare Series*, 2002.
2. Drug Interaction Facts; *Facts and Comparisons*, 2002.

## **Botulism**

### **What is botulism?**

Botulism is a rare but serious paralytic illness caused by a nerve toxin produced by the bacterium *Clostridium botulinum*.

1. Foodborne botulism is caused by eating foods that contain the botulism toxin. Foodborne botulism can be especially dangerous because many people can be poisoned by eating a contaminated food.
2. Wound botulism is caused by toxin produced from a wound infected with *C. botulinum*. The number of cases of wound botulism has increased in recent years because of the use of black-tar heroin.
3. Infant botulism occurs when an infant consumes the spores of *C. botulinum*, which then grow in the intestines and release toxin.

There is concern that botulism toxin might be used by terrorists, who could disseminate it through the air in the form of an aerosol (resulting in cases of inhalational botulism), or use it to contaminate food (resulting in cases of foodborne botulism).

### **How common is botulism?**

In the United States an average of 110 cases of botulism are reported each year. Of these, about 25% are foodborne, 72% are infant botulism, and the rest are wound botulism. Outbreaks of foodborne botulism occur most years, and are usually caused by eating contaminated home-canned foods.

### **What are the symptoms of botulism?**

Symptoms include double vision, blurred vision, drooping eyelids, slurred speech, difficulty swallowing, dry mouth, and muscle weakness. Infants with botulism appear lethargic, feed poorly, are constipated, and have a weak cry and poor muscle tone. These are all symptoms of the muscle paralysis caused by the botulism toxin. If untreated, these symptoms may progress to cause paralysis of the arms, legs, trunk and respiratory muscles (potentially leading to death from respiratory failure). Death occurs in 5-10% of foodborne botulism cases. In foodborne botulism, symptoms generally begin 18-36 hours after eating a contaminated food, but they can occur as early as 6 hours or as late as 10 days.

### **How is botulism diagnosed?**

Physicians may consider the diagnosis if the patient's history and physical examination suggest botulism. However, these clues are usually not enough to allow a diagnosis of botulism since certain other diseases can have similar symptoms, and special tests may be needed to exclude these other conditions. The most direct way to confirm the diagnosis is to demonstrate botulism toxin in the patient's serum or stool by injecting serum or stool into mice and looking for signs of botulism. The *C. botulinum* bacteria can also be isolated from the stool of persons with foodborne and infant botulism.

### **How can botulism be treated?**

All forms of botulism can be fatal and are considered medical emergencies. After several weeks, the paralysis slowly improves, but with severe botulism, the patient may have to be on a breathing machine (ventilator) for weeks or months, along with receiving intensive medical and nursing care. If diagnosed early, foodborne, wound, and inhalational botulism can be treated with botulism antitoxin which blocks the action of toxin circulating in the blood. This can prevent patients from worsening, but recovery still takes many weeks to months. Wounds should be treated, usually surgically, to remove the source of the toxin-producing bacteria.

### **How can botulism be prevented?**

Proper precautions should be taken by persons preparing home-canned foods. Instructions on safe home canning can be obtained from county extension services or from the U.S. Department of Agriculture (see *The USDA Complete Guide to Home Canning* at <http://foodsafety.cas.psu.edu/canningguide.html>). Because honey can contain spores of *C. botulinum* and this has been a source of infection for infants, children less than 12 months old should not be fed honey. Honey is safe for persons 1 year of age and

older. Wound botulism can be prevented by promptly seeking medical care for infected wounds and by not using injectable street drugs. Note that botulism cannot be spread from person to person.

**What should I do if cases of botulism start to occur in my community?**

Your local Health Center and the Missouri Department of Health and Senior Services will provide you with information.

Adapted from CDC. *Botulism: General Information*. October 18, 2001.

**ANNEX I**

**MASS PATIENT CARE**

**1. PURPOSE:** To provide effective, rapid medical care on a large scale after a local public health emergency, to include counseling for the worried-well, and mental health counseling for emergency workers, victims and their families. Events could include natural disasters, HAZMAT incidents, or chemical, biological, nuclear, radiological hazards.

**2. CONCEPT OF OPERATIONS:**

- A. Big Springs Medical Clinic and the CCHC will initiate mass patient care. The CCHC Administrator and BSMA Director will coordinate staff and supplies available. A site at the Baptist Assembly Camp on D Hwy. may be used. This site is also used to provide patient care to confirmed smallpox cases.
  
- B. Once an event has been declared the CCHC and BSMC will coordinate with the Carter County Emergency Management Agency for support. Support items needed will include:
  - 1. Beds/Cots
  - 2. Linens
  - 3. Bandages
  - 4.
  
- C. If the emergency is local in nature and not a statewide or nation wide event, the American Red Cross may be able to assist in locating beds/cots. If this is a BioTerrorism event, the ARC may only be able to provide limited local support. The Salvation Army may also help with the above items.



## **APPENDIX 1 TO ANNEX I**

### **MEDICAL TREATMENT SITES**

Riversways Manor Nursing Home: 573-323-4282: 60 Beds

Big Springs Medical Clinic: 573-323-4253

Van Buren Medical Clinic: 573-323-4812

Pryor Family Dental: 573-323-4287

### **SUITABLE BUILDINGS FOR TREATMENT**

East Carter R-II Schools  
Van Buren R-I Schools  
Van Buren Youth and Community Center  
Van Buren Assembly of God Church  
Van Buren First Baptist Church  
Souls Harbor Church Van Buren  
Ellsinore First Baptist Church  
Ellsinore First Assembly of God Church  
Van Buren Nutrition Center  
Ellsinore Nutrition Center  
Ellsinore Community Center  
Van Buren Methodist Church  
Van Buren Church of God of Prophecy  
East Carter Head Start

## **APPENDIX 2 TO ANNEX I**

## **PHYSICIANS**

Dr. Tammy Lindsay  
Big Springs Medical Clinic  
Van Buren, MO 63965  
573-323-4253

Dr. Michael Moore  
Big Springs Medical Clinic  
Van Buren, MO 63965  
573-323-4253

## **NURSE PRACTITIONERS**

Michelle Burnham, APN, RNC  
Big Springs Medical Clinic  
Van Buren, MO 63965  
573-323-4253

Susan Norris, FNP  
Big Springs Medical Clinic  
Van Buren, MO 63965  
573-323-4253

## **DENTISTS**

Dr. Christy Pryor, DDS  
PO Box 548  
Van Buren, MO 63965  
573-323-4287

## **SPECIAL MEDICAL EQUIPMENT AND SUPPLIES**

Poplar Bluff Hospitals and Medical Clinics  
Poplar Bluff Medical Equipment Supplies  
John J. Pershing Medical Center in Poplar Bluff  
Salvation Army  
Home Medical Supply- Poplar Bluff  
Key Drug- Poplar Bluff  
Vendor Managed Inventory- DHSS

## PHARMACIES

Van Buren Drug	Van Buren	573-323-8159
Key Drug	Poplar Bluff	573-785-8218
K Mart	Poplar Bluff	573-785-4557
Kneibert Clinic Pharmacy	Poplar Bluff	573-778-7190
Kroger Pharmacy	Poplar Bluff	573-686-6974
Letassy Pharmacy	Poplar Bluff	573-785-8421
The Medicine Shoppe	Poplar Bluff	573-785-7216
Northwest Pharmacy, Inc.	Poplar Bluff	573-686-6211
Super D Express RX	Poplar Bluff	573-785-0127
Super Saver Pharmacy	Poplar Bluff	573-686-1919

### Appendix 3 to Annex I

Mental Health Counseling Services

Name of Agency	Phone Number
Van Winkle & Associates	573-323-0411
Missouri Victim Assistance Network	800-698-9199
MO Highlands Health Care (Debra Wyatt, LCSW)	573-663-2977
Melissa Meloy, LPC	573-648-1203
Linda Potter, LPC	573-631-8764 or 573-663-7324
Casa Guadalupe Domestic Violence Shelter	888-228-8122
New Way Shelter	800-663-9929
Haven House	800-491-1138
Suicide Prevention	800-638-4357
School Violence Hotline	866-748-7047
Parental Stress Helpline	800-367-2543
National Domestic Violence Hotline	800-799-7233

**APPENDIX 4 TO ANNEX I**

Van Buren Ambulance: 573-323-8323

East Carter Ambulance District: 573-322-5555

**AIR EVAC LIFE TEAM: 1-800-247-3822**

### **CARTER COUNTY LANDING ZONES**

Hwy. 60 BP/McDonald's Station Parking Lot- Van Buren

Van Buren Airport

Van Buren R-I Schools

East Carter R-II Schools

Van Buren River Park

### **APPENDIX 5 to ANNEX I**

### **CARTER COUNTY FIRE DEPARTMENTS**

Aldridge Valley Fire Department  
C/O Doral Rymer  
HCR 2, Box 2663A  
Van Buren, MO 63965  
573-323-4325

Ellsinore Fire Department  
Chief Stanley Julian  
C/O Ellsinore City Hall  
11 W. Cleveland St.  
Ellsinore, MO 63937  
573-322-8148

Van Buren Fire Department  
C/O VB City Hall  
PO Box 40  
Van Buren, MO 63965  
(city hall- 323-4335)

Grandin Fire Department  
Chief James Tucker  
PO Box 104  
Grandin, MO 63943

Fremont Fire Protection (5)  
Chief Joe Brown  
HCR 67, Box 104  
Fremont, MO 63941

Little Black Rural Fire Department (5)  
Chief Richard Kearbey  
PO Box 100  
Grandin, MO 63943

Eastwood Fire Protection District (5)  
Chief Joel Gordon  
Van Buren, MO 63965  
573-593-4817

## **APPENDIX 6 to ANNEX I**

### **CARTER COUNTY LAW ENFORCEMENT**

Van Buren Chief of Police  
Justin P. Eudaley

1301 Main St.  
Van Buren, MO 63965  
573-323-4394 (city hall)

Carter County Sheriff  
Rick Stephens  
PO Box 817  
Van Buren, MO 63965  
573-323-4510 (sheriff's office)  
573-300-9390 (cell)

Ozark National Scenic Riverways  
Larry Johnson, Superintendent  
PO Box 490  
Van Buren, MO 63965  
573-323-4236

Mr. Terry Richardson  
Missouri State Water Patrol  
HCR 1, Box 98A  
Van Buren, MO 63965  
573-323-1272

MSHP Troop G  
Willow Springs, MO  
417-469-3121

## **ANNEX J**

### **MASS FATALITY MANAGEMENT**

- 1. PURPOSE:** To develop guidelines for handling mass fatalities.
- 2. CONCEPT OF OPERATIONS:**

- A.** Mass fatalities may be caused by many different events requiring special handling procedures. Fatalities affected by biological weapons will need specific guidance to prevent the spread of the agent to emergency workers.
- B.** If the fatality was caused by a bio-terrorist attack, CCHC will request from the CERT Fact Sheets to educate workers at makeshift morgues.
- C.** See Appendix 1 to this annex for Funeral Home contacts.
- D.** During a mass fatality the Carter County EMA will operate the EOC. Through the EOC the CCHC will coordinate fatality management through the Carter County Coroner and through the Funeral Homes.



**APPENDIX 1 TO ANNEX J  
FUNERAL HOMES**

McSpadden Funeral Home	Van Buren	573-323-4222
McSpadden Funeral Home	Ellsinore	573-323-5222

## APPENDIX 2 TO ANNEX J

### CARTER COUNTY MORTUARY PLAN

#### CONCEPT OF OPERATIONS

To establish means and methods for the most reasonable and proper care and handling of the dead in multi-death disaster situations. The Mortuary Disaster Response Team is responsible for aiding the Carter County Coroner in the recovery, evacuation, identification, sanitation and preservation (such as embalming if necessary), notification of the next of kin and facilitating means for release of the identified dead to the next of kin or their agent.

#### COMMUNICATION PROCEDURES

Upon the event of a disaster of any nature, which has caused multiple deaths the following persons should be notified immediately. Preferably in the order shown below but not limited to this order of priority;

1. Eric McSpadden, Carter County Coroner  
Van Buren, Missouri 63965  
573-323-4222
2. Curt Majors, Carter County Emergency Management Director  
Van Buren, MO 63965  
870-275-5053
3. Alternate contact is through the Carter County Sheriff: 573-323-4510

One of the above persons will immediately notify the Certified Disaster Coordinator listed below:

MFDA Disaster Response Team—

Scott Amick  
Missouri Funerals Directors Association (Area 7)  
Amick Burnett Funeral Home  
403 N. Kings Highway  
Sikeston, MO 63801  
573-471-8824

(MFDA- Missouri Funeral Directors Association)

This Coordinator has been trained at the national level by the Federal Management Agency and the National Funeral Directors Association. This individual will go immediately to the site to lend their expertise and to act as liaison between the Missouri Funerals Directors Disaster Teams and the National Association should the scope of the disaster require supplies or personnel beyond our resources.

The Disaster Coordinator will notify the Missouri State Funeral Directors Association and will from time to time as conditions will permit issue briefings to the M.F.D.A. office with regard to additional supplies and as to progress with the mission

### **AUTHORIZATION FOR ADMISSION OF DISASTER WORKERS INTO DISASTER SITE**

All disaster workers must have in their possession the necessary identification card or pass, tec., as developed by the Emergency Management Director or responsible official to gain admission into the immediate disaster site area. These workers and members of the Mortuary Disaster Response Team will be required to register their name and address at the EOC or area designated for such purpose.

### **RECOVERY OPERATIONS GUIDELINES**

1. None of the dead shall be removed or touched by workers until approval has been given by the Coroner.
2. Operations will be coordinated by the Coroner and MFDA Disaster Response Team Coordinator.
3. A survey and assessment of the situation will be made by the Coroner and Mortuary Disaster Response Team Coordinator. They will note the approximate number of dead, equipment and personnel needed.
4. Once workers have reported to the scene a briefing will be held, assignments will be given at this time and workers will be divided into teams if necessary.
5. Photos or a sketch will be made of the disaster site, and if desired the scene will be divided into sections with the recovery teams assigned to particular sections.
6. Suitable stakes or markings will be placed at the location of each body and numbers will be assigned to each body.
7. Bodies will be tagged and records kept noting the location in which the body was found. (This tag numbering system will be developed by the County Coroner).
8. Personal effects of the dead will be tagged and data recorded noting locating found.
9. When necessary bodies will be placed in a body pouch and a tag with corresponding numbers will be placed on the pouch.

10. Valuables such as wallets, attached jewelry, etc. WILL NOT be removed at the disaster site. They will remain on the body.
11. Bodies will be removed from immediate disaster site via litter or stretcher into the evacuation area.
12. The major support group for this recovery task will be members of the MFDA Disaster Response Team

### **BODY EVACUATION OPERATIONAL GUIDELINES:**

1. Evacuation operations will be coordinated by the Coroner and MFDA Disaster Response Team Coordinator.
2. A survey and assessment of the situation will be made by the Coroner and the Mortuary Disaster Response Team Coordinator. They will note the approximate number of dead, type of terrain, necessary personnel and equipment needed.
3. Before operations begin, a briefing will be held, assignments given and teams formed if desired.
4. Bodies will be covered when transported.
5. All vehicles used for transport will be covered except when not possible.
6. Vehicles should travel the same route from disaster site to morgue site. This route will be established in coordination with local traffic control agencies.
7. Vehicles should travel at a moderate pace and in convoy style.
8. Records will be kept noting vehicle IC and body tag number, as well as driver ID.
9. Evacuation teams will take care not to overload the morgue site with incoming bodies.
10. The major support group for this task will be the MFDA Disaster Response Team.

### **MORGUE SITE:**

1. A list of possible morgue sites will be maintained for use in the event of a disaster.
2. Once a morgue site has been selected the Coroner and the MFDA Disaster Response Team Coordinator will organize its operations and assign personnel to come or all of the following job titles: ( Uniformed Guards, Information Clerks, Counselors, Interviewers, Telephone Communicators, Admissions Clerk, General Supervisor, ID Personnel, Orderlies, Personal Effects Custodian, Embalming Supervisor, Embalmers, Secretaries, Inventory Clerk, Distribution Clerk, etc.).

3. The morgue site will be used for the storage, identification, sanitation, preservation if desired, as well as the distribution point for release of the dead to their next of kin or their agent.
4. Refrigeration units will be utilized as necessary.
5. Bodies admitted to the morgue will be logged and necessary information gathered and recorded about each body.
6. Personal effects will be recorded and placed in a secure area.
7. Should embalming be necessary the Coroner will rely on the MFDA Disaster Response Team to organize the operations, equipment, supplies, and personnel needed.
8. An area will be designated for the press.
9. Counselors such as members of clergy will be present in waiting areas to assist persons visiting the morgue.

#### **IDENTIFICATION OF THE DEAD**

The Coroner will arrange for the necessary equipment and staff to accomplish this task. The members of the MFDA Disaster Response Team will be at his/her disposal to be of assistance where needed.

#### **NOTIFICATION OF THE NEXT OF KIN**

The Coroner, within the assistance of the MFDA Disaster Response Team, will determine the most practical method to be utilized in contacting the next of kin. Every effort will be made to lessen the extreme psychological impact on the families of the deceased. The nature and scope of the disaster will determine what methods will be used.

#### **COUNSELING OF SURVIVORS**

The Coroner and the MFDA Disaster Response Team will keep listing of local clergy and/or responsible persons trained in counseling with grieving survivors. These personnel will be asked to report to the waiting areas of the morgue site to assist families that visit the morgue site. Phone counselors will also assist persons calling the morgue site. Efforts will be made to keep the families of the dead posted as to what is taking place and information will be released to them as best possible.

#### **DISTRIBUTION OF THE DEAD:**

Once the body has been positively identified the next of kin will be contacted with this confirmation. At this point the Coroner or MFDA Disaster Response Team personnel will coordinate the release of the body to the next of kin or their agent. All efforts will be made to cooperate with the receiving agent or family. However, the nature and scope of the disaster may require policies that may appear unfair or delayed. These policies may be necessary for the

smooth flow of operations at the morgue site. All policies will be made or approved by the Coroner Before implemented.

In situations where there are UNIDENTIFIED dead, the Coroner will make the decision about their disposition. Mass burial may be necessary and location of burial sites will be determined at the time. It is suggested, however, that cremation not be utilized as later identification and exhumation may be practical and necessary. Records will be kept of burial locations and body tag number will be interred with the body to make later efforts of identification easier.

#### **TERMINATION PROCEDURES:**

After the disaster clean-up operations are completed, efforts will be made to return donated equipment and supplies. Cleaning and sanitizing of the morgue site will be necessary. Records compiled during the operations will be arranged in some type of systematic order and efforts will be made to preserve and store these records for future use if necessary.

#### **MORTUARY RESOURCES:**

Resource lists pertaining to mortuary services will be compiled by the County Coroner. This information will be furnished to the Emergency Management Director who will incorporate it into the County resource file.

## ANNEX K

### NUCLEAR AND CHEMICAL INCIDENTS

**1. PURPOSE:** To provide an effective response to a local public health emergency due to a chemical or nuclear incident, released accidentally or with malicious intent.

**2. CONCEPT OF OPERATIONS:**

- A.** Any incidents involving chemical or nuclear will be coordinated by Carter County EMD and/or his assistant. The EMD will involve the Carter County EMA HAZMAT/WMD Team and the Region G HazMat Team. (contact person; Tim Beam –West Plains fire Department- 417-256-2424, 417-257-2010 or fax 417-257-2194). This team has the equipment to monitor the air for materials present.
- B.** The Missouri DHSS- Section for Environmental Public Health Services will be contacted at 573-751-6080 for assistance, as well as SEMA (314-751-2748). Specific guidelines will be utilized from the DHSS Appendix of the State Emergency Response Plan- Annex K.
- C.** GIS mapping will be accomplished by CERT (DHSS Center for Emergency Response and Terrorism-1-800-392-0272) will be used to show areas of contamination. This information will be used to possibly evacuate people to safe areas.
- D.** Contaminated soil and water will be analyzed by DNR (Department of Natural Resources). The local office is DNR SE Office at 2155 N. Westwood Blvd. PO Box 1450 Poplar Bluff, MO 63901. Phone number: 573-840-9750.
- E.** Contaminated victims must be decontaminated prior to treatment at a medical facility. Personnel at the facilities must know that potential victims who have not been decontaminated might respond to the hospital.
- F.** Carter County Health Center’s Environmental Public Health Specialist will embargo food and milk when indicated to prevent further spread of contaminated items.
- G.** Chemical decontamination will be accomplished by removing the clothing and using soap and water to wash away the contamination. Cold or lukewarm water is best, because hot water will open the pores of the skin, allowing the spread of contamination into the skin.
- H.** Nuclear or radiological contamination will normally be accomplished by brushing off the exposed areas. Clothing may have to be removed, and the hair will have to be brushed or washed.
- I.** Exposure limits must be established for the emergency workers protection. The type and amount of radiation will determine exposure limits. Using dosimeters from the Carter County Emergency Management Agency each worker, along with potential victims will be tracked carefully of the time in the hot zone and amount of radiation received. Each

trip into the hot zone will be added together to give a final dose of radiation. Once the worker has reached his or her limit they will not be allowed to return to the hot zone.

- J.** See Appendix 2 to this annex for exposure control records. Each emergency worker who enters the hot or warm zones will have a detailed record showing time in the zones, time out, total time exposed and total dose received.
- K.** In some instances it may be appropriate to issue Potassium Iodide (KI) to protect individuals from the effects of certain types of radiation. If radioactive iodine is not present then KI pills will not be issued. KI is used to protect the thyroid gland. KI should be issued as soon as the radioactive cloud containing iodine from the explosion is close by. See Appendix 2 to this annex for dosing requirements.
- L.** The key to effective exposure control is time, distance and shielding. If at all possible people should be evacuated from the effected area, if not they should be sheltered in concrete buildings until the radiation peaks and starts to decline. Each individual in the shelter should have a record to show exposure to the radiation.
- M.** CCHC will provide technical assistance to the first responders, hospitals, governmental agencies, etc. in regards to specific medical issues associated with the incident.
- N.** The CCHC, in cooperation with local emergency management and other local agencies, will assist in relocating populations from high dose rate areas. The CCHC will also work with local hazmat teams and Department of Natural Resources Environmental Emergency Response staff in regards to chemical incidents and the need for in-place sheltering or relocation of populations from affected areas.
- O.** The CCHC, in conjunction with DHSS, will make recommendations as to the need to embargo affected crops, restrict contaminated milk from entering the food supply, restrict use of contaminated water, embargo of adulterated food and drugs.
- P.** CCHC will recommend dose limits to the community based on information received from DHSS.
- Q.** Carter County Health Center with assistance from the MO DHSS will monitor the health of the public.

**APPENDIX 1 TO ANNEX K**  
**Treatment Recommendations for Potassium Iodide (KI)**



<b>Threshold Thyroid Radioactive Exposures and Recommended Doses of KI for Different Risk Groups</b>				
	Predicted Thyroid exposure(cGy)	KI dose (mg)	# of 130 mg tablets	# of 65 mg tablets
Adults over 40 yrs	$\geq 500$	130	1	2
Adults over 18 through 40 yrs	$\geq 10$			
Pregnant or lactating women	$\geq 5$			
Adoles. over 12 through 18 yrs*		65	1/2	1
Children over 3 through 12 yrs		32	1/4	1/2
Over 1 month through 3 years				
Birth through 1 month		16	1/8	1/4

\*Adolescents approaching adult size ( $\geq 70$  kg) should receive the full adult dose (130 mg).



**Emergency Worker:** \_\_\_\_\_  
**Last Name** **First Name** **MI**

**Organization:** \_\_\_\_\_

Taking KI is voluntary. Do not take any until you are told by the EOC that conditions warrant taking KI. Do not take KI if you are allergic to Iodine – notify your supervisor.

One KI tablet is sufficient for 24 hours. Do not take more than one tablet per day. Record on this for when you take each tablet.

If you start taking KI, continue taking it each day until told by the EOC that it is no longer necessary.

Sign and date the bottom of this form when you turn it back in to the EOC.

	<u>Date</u>	<u>Time</u>		<u>Date</u>	<u>Time</u>
1st Tablet	_____	_____	6 <sup>th</sup> Tablet	_____	_____
2 <sup>nd</sup> Tablet	_____	_____	7 <sup>th</sup> Tablet	_____	_____
3 <sup>rd</sup> Tablet	_____	_____	8 <sup>th</sup> Tablet	_____	_____
4 <sup>th</sup> Tablet	_____	_____	9 <sup>th</sup> Tablet	_____	_____
5 <sup>th</sup> Tablet	_____	_____	10 <sup>th</sup> Tablet	_____	_____

I voluntarily took potassium iodide tablets in accordance with the dosage information recorded above

\_\_\_\_\_  
Emergency Worker Signature

\_\_\_\_\_  
Date

## ANNEX L

### FOODBORNE/WATERBORNE OUTBREAKS

#### I. Purpose

To provide an effective response to a foodborne or waterborne outbreak, whether accidental or deliberate.

#### II. Organization and Responsibilities

- A. Carter County Sanitarian will be responsible for the investigation of a foodborne or waterborne outbreak. The Carter County Sanitarian will be assisted by Russell Lilly from DHSS (Jefferson City) @573-751-6095.
- B. Support staff would be contacted if needed from DHSS in Jefferson City.  
Steps in disease investigation:
1. Verify the diagnosis or develop case definition.
  2. Establish the existence of an epidemic.
    - a. Greater than the expected number of cases?
  3. Make a quick survey of known cases and the community situation.
  4. Formulate tentative hypothesis.
  5. Plan a detailed epidemiological investigation:
    - a. Develop interview questionnaires.
    - b. Select comparison groups.
    - c. Define time, place and person variables.
    - d. Identify relevant exposures.
    - e. Environmental investigation.
    - f. Laboratory specimens.
  6. Conduct the investigation.
  7. Analyze data.
    - a. Line listing.
    - b. Epidemic curve.
    - c. Sex, age graphs.
    - d. Rates.
  8. Test hypothesis.
    - a. Statistical analysis.
  9. Formulate conclusions.
  10. Implement control measures.
  11. Make report.
- C. The CCHC will conduct suspected foodborne or waterborne disease investigations in accordance with the CDC VPH's Communicable Disease Investigative Reference Manual.
- D. The LPHA will work with the Department of Agriculture concerning raw agricultural products. Contact for the Department of Agriculture is Fred Ferrell,

Director at PO Box 630 1616 Missouri Blvd. Jefferson City, MO 65102.  
Telephone #: 573-751-4211. Email at [aginfo@mda.mo.gov](mailto:aginfo@mda.mo.gov). URL;  
[www.mda.mo.gov](http://www.mda.mo.gov). The first contact would be DHSS: Russell Lilly @ 573-751-  
6095. The USDA will be contacted by DHSS- Jefferson City.



## MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

### Section 2.02 Center for Emergency Response and Terrorism

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## Food and Water Safety Related to Tampering

January 24, 2005

### Section 2.03 Background

Every day, every Missourian, as a basic necessity of life, depends on a safe and abundant supply of food, milk, and water. Intentional sabotage of this “critical infrastructure,” as so designated by Presidential Directive, could have catastrophic health and economic effects on the state.

Missouri’s food and water systems, as are the nation’s, are robust, open, interconnected, and reflect the diversity of goods made available by free and open markets throughout the world. Products on Missouri grocery store shelves and ingredients in restaurant meals come from every country. On the other hand, many of these products also come from the backyards of Missourians. This diversity, while creating great selections, also creates a smorgasbord of opportunity for those with ill intent. Locally, the family farm has been viewed as a rural retreat immune from criminal activity, where neighbors help neighbors and gates and barns are open. The realization that the family farm is part of an international system of trade where stringent security measures may be needed, such as razor wire and surveillance cameras, cuts against the grain. Conversely, the volume of international product distribution from the massive corporations (at times better secured than the family farm) presents the possibility to the terrorist of wholesale distribution of an agent of mass destruction into millions of dollars of product and into the homes of thousands of families. Possible scenarios that continue to haunt those involved in food and water safety include:

- Contamination at the farm, with a biological, chemical, or radiological agent placed in crops, livestock, produce, or the bulk milk tank.
- Addition of a biological, chemical, or radiological agent during transportation or upon delivery.
- Contamination at processing plants for foods, milk, or meat.
- Contamination during preparation at restaurants, salad bars, or in grocery store produce aisles.
- Targeting high profile individuals through poisoning of a catered meal, or at the point of service.

These acts could be done by:

- Disgruntled or extremist individuals

- Cults (political, economic, social ideology)
- Terrorists (domestic and foreign)

The above scenarios are not the product of idle speculation, but are representative of the types and kinds of tampering occurrences that have occurred around the nation during the last several years. Consider:

- Oregon: In 1984 in The Dalles, Oregon the Rajneesh cult, in the largest bioterrorism event (in terms of people ill) in modern United States history sprinkled *Salmonella* organisms across salad bars and into coffee creamers in 10 restaurants in an attempt to influence local elections. At least 750 individuals were known ill; nine of the 10 restaurants went out of business.
- Maine: In 2003, 16 congregation members at the Gustaf Adolph Lutheran Church in rural Maine were poisoned with arsenic when a member spiked the coffee. One died, and Maine Associated Press members voted the incident the top Maine news story of 2003.
- Michigan: December 2002, a supermarket employee intentionally dumped an insecticide called Black Leaf 40 into 200 pounds of ground beef being processed at the store. Approximately 150 individuals who purchased the product reported burning of the mouth, nausea, vomiting, and dizziness. For this incident, 1,700 pounds of ground beef were recalled.
- California: July 2004, a former grocery worker added ground up castor beans (the source of ricin) into baby food jars and left threatening notes in the jars. Parents discovering the notes rushed their infants to hospitals; fortunately, the ricin was not refined and the children did not die.
- Missouri: a number of incidents since 2001 involving milk, food, and water, including: 1) threatening notes in pudding mix; 2) claims of tampering and illness by individuals concerning bottled water, candy bars, gummy worms, baby food, and milk in cartons; 3) insertion of pills in meat products at grocery stores; 4) numerous incidents of suspected or claimed intentional tampering of public water supplies.

These recent events in Missouri had at times a fairly significant localized impact, and sometimes involved state and federal officials as well. All of these were handled appropriately without public panic, significant public health impact, or impact on the public perception of the safety of food and water sources.

## **Section 2.04 DHSS Accomplishments**

Much of the success in handling recent events is attributable to the increased capacities and training done in Missouri since the events of 2001, most of which has been done in Department of Health and Senior Services (DHSS) with the financial support of the Public Health Preparedness and Response for Bioterrorism grant from the Centers for Disease Control and Prevention (CDC). These planning and training efforts have been urgent, serious, and ongoing. They include:

- Increased laboratory capacity to test for radiological, chemical, and biological agents in food, milk, and water through staffing and equipment updates and inclusion of the State Public Health Laboratory in the Laboratory Response Network (especially the Food Emergency Response Network (FERN). A statewide courier service now ensures that specimens from every county throughout the state arrive at the laboratory each morning.
- Continued work by the Food Safety Task Force, a multi-agency group headed by DHSS (including representatives from the state departments of Natural Resources (DNR) and Agriculture (MDA), Food and Drug Administration (FDA), U.S. Department of Agriculture (USDA) and local public health agencies (LPHAs), industry representatives and concerned citizens) to address food safety issues (e.g. vulnerability assessments).
- Completed a Food Security Surveillance Assignment exercise in collaboration with the FDA, sampling specified industry segments (engaged in food and milk production) considered vulnerable to intentional contamination, thereby increasing the proficiency of staff and the FERN.
- In-depth training of key public health staff on threat assessment related to food safety in conjunction with USDA and MDA staff.
- Increased capacity in planning for, responding to, and managing outbreaks and tampering events through the addition of 33 local planners, 29 epidemiology specialists, seven public information officers, and three trainers within local public health agencies.
- Formation of Rapid Response Teams in DHSS comprised of environmental and epidemiology experts to quickly and efficiently identify and control outbreaks (including foodborne/waterborne outbreaks) and respond to overt terrorist attacks against public health infrastructure.
- Disease-reporting systems are used by local public health agencies, hospitals, schools, health care providers and large employers to constantly monitor the health of the public, so an unusual disease or an unusual number of cases of a disease are identified quickly. These heightened surveillance systems are used to rapidly identify foodborne or waterborne outbreaks and signs and symptoms consistent with foodborne illness.
- Improved around-the-clock reporting and response to outbreaks and tampering incidents through the formation of the DHSS Department Situation Room (DSR). A duty officer staffs the DSR 24 hours a day, 7 days a week, with a toll-free number available for emergencies or disease reporting.
- The Health Alert Network will be used to rapidly receive and disperse communications among public health partners at the local, regional, state and federal levels.
- A hospital tracking system, EMSystem, detects possible outbreaks by monitoring the number of admissions and ambulance diversions at hospitals. The system provides a linkage for hospitals to obtain instant messages and alerts.
- Statewide training programs conducted by DHSS to make local public health agencies [and other attendees such as representatives from the State Emergency Management Agency (SEMA)] aware of tampering possibilities and the expected measure of response.
- Bioterrorism (involving food) tabletop exercises drilling the roles and responsibilities of federal, state, and local agencies from a regional perspective are continuing around the state.



- Agroterrorism drills and exercises at the state and local levels involving local and state health department staff, MDA staff, DNR staff, etc.
- Increased capacity (equipment and staff) in the DHSS Section for Environmental Public Health and training in the use of Personal Protective Equipment, in environmental sampling for biological agents (in food or water), in the detection of radiological agents, and additional proficiency in determining chemical agents thresholds for public health protection.
- Memoranda of Understanding (MOUs) updated between DHSS and DNR to better delineate roles and responsibilities related to terrorist incidents.
- Improved cooperation and collaboration with the FBI in the sharing of information relevant to tampering incidents.
- Development of new manuals, procedures, and forms (e.g. Food tampering report form) in DHSS to better manage tampering incidents.
- The department is prepared to immediately expand its hotline capabilities by 10 additional lines. DHSS staff has been trained and are available through a 24/7 call-down list.
- DHSS is prepared to provide immediate translation of messages and materials for non-English speaking residents.

## **Mechanisms of Response**

The response to and the management of tampering associated with food and water products or systems is a fluid and dynamic multi-agency collaborative effort. Describing the process in detail would entail a massive document repeating a multitude of manuals and guidelines issued by the involved agencies. A summary of the process follows:

There are two main goals in any response, first, to protect the public health, and second, to protect the food and water supplies and the confidence the consumer has in those systems. In considering the response, the main divergent in the process is the manner of incident awareness.

Historically, the vast majority of tampering incidents involving food and water systems were not known as such at the time they occurred. There were no bells or whistles, or an incident scene in which to rush in first responders. Time elapsed, hours or days went by depending on the nature of the disease-causing agent introduced, and then illnesses began emerging in the exposed population. Once known and reported, investigations of these illnesses occur by state and local disease control staff, and as these individuals are interviewed concerning foods they have eaten and places they have been a picture begins to emerge of a common source of exposure.

Clinical samples are taken and sent to the State Public Health Laboratory for analysis.

Public health environmental staff, usually from the local public health agency, are dispatched to investigate the food(s) being named by the ill individuals.

Inspections are made of the establishment where the food was eaten or purchased, and samples of food are submitted to the State Public Health Laboratory (SPHL) for analysis if available. Tracebacks begin on the source of the foods, and DHSS environmental staff is enlisted to coordinate this process with the FDA, USDA, or Milk Board, depending on the product involved. The State Epidemiologist may become involved and may request additional assistance from the CDC if the number of ill becomes overwhelming. If at some point suspicions are raised (by the nature of the agent, comments from those interviewed, observations at the site, etc.) that the incident was intentionally caused then law enforcement is called. Otherwise, the combined local, state, and federal food safety regulatory agencies implement appropriate control measures (such as facility closures, product embargo, destruction, or recall, and public information messages) dependent on the findings during the investigation to insure the public health and food supply is protected.

For example, despite the Rajneesh incident in Oregon causing over 750 illnesses and involving a host of local, state, and federal agencies in response, the incident was chalked up as naturally occurring (blamed on some food workers) and not known as a tampering event until a couple of years later when a defector from the cult confessed. Single-source food and water borne outbreaks in the past, not caused by tampering, have been responsible for hundreds of thousands of illnesses.

On the other hand, there have been some incidents of overt threat. In these instances, the criminal (individual or group) makes a claim of contamination of the food or water supply by note, media claim, telephone call, or so forth. By the nature of the criminal act, these incidents change the dynamic of the response and immediately involve, and are under the direction of, law enforcement. However, by and large, the role of the disease investigation and regulatory agencies involved in food and water safety does not change substantially in these circumstances. They still are working to determine through public health methods, 1) the nature of the threat, 2) the extent of its spread, and 3) the threat to the public, in order to implement timely and effective interventions.

The main role change for disease investigative and regulatory agencies is to recognize the role of criminal investigative, emergency management, and public officials in these incidents and understand that they as well are working to determine 1) the nature of the threat, 2) the extent of its spread, and 3) the threat to the public, in order to implement timely and effective interventions. Good communication and cooperation is essential between the two groups to assure a joint investigative process.

DHSS has developed these relationships by planning, drilling, and working on the actual response to incidents. These joint communications and collaborative efforts illustrate our unified response to tampering incidents.

A flow chart indicating the information flow during a response to a food tampering incident and a table providing further detail of roles and responsibilities are attached.

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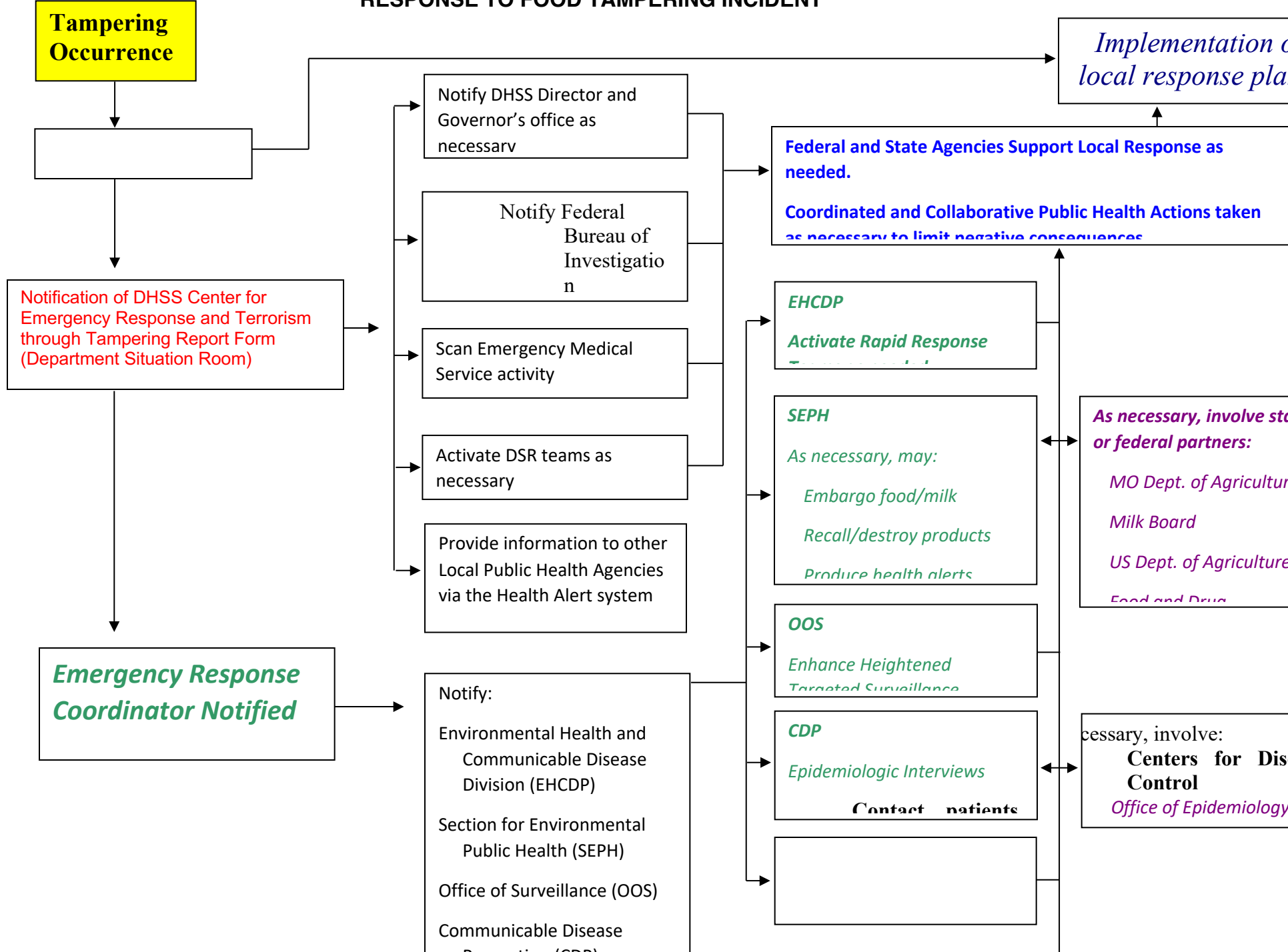
<b>AGENCY</b>	<b>RESPONSIBILITY</b>	<b>Regulatory Authority*</b>
<b>State Agencies:</b>		
Center for Emergency Response and Terrorism – DHSS	Coordinate DHSS response, activate Department Situation Room, serve as central information repository	<b>Authorities/Operations:</b> RSMO 192.020 DHSS Emergency Response Plan
Section for Communicable Disease Control and Prevention – DHSS	Disease investigation related to the event	<b>Authorities/Operations:</b> RSMO 192.006 and 192.020 19CSR 20-20.010-.060 Communicable Disease Investigation Manual DHSS Emergency Response Plan
Section for Environmental Public Health – DHSS	Facility closure, embargo of food product, assist in inspection of facility, provide health protection information to public, issue boil orders or limit use orders on private water supplies, issue statewide recalls	<b>Products:</b> Bottled water, private water, seafood, all processing plants except beef, pork, and poultry, all products (including milk, shell eggs, beef, pork, poultry and water safety) at the retail level <b>Authorities/Operations:</b> RSMO 196.010-196.271, 192.006 and 192.020 19CSR 20-1.040 Missouri Food Code

		Environmental Health Operational Guidelines DHSS Emergency Response Plan
State Public Health Laboratory – DHSS	Analyze food and water samples	
Office of Epidemiology – DHSS	Assist in disease investigation, provide epidemiological expertise	
Department of Natural Resources	Take appropriate actions with public drinking water supplies including boil orders or limit-use orders	<b>Product:</b> Public Drinking Water
Department of Agriculture	Investigate illness in livestock, assure safe processing of meat products, including inspections of processing plants	<b>Products:</b> Livestock Crops Shell Eggs Plants Processing: Beef, Pork, Poultry
State Milk Board	Inspect Grade A milk facilities, condemnation of dairy products	<b>Product:</b> Fluid Milk
<b>AGENCY</b>	<b>RESPONSIBILITY</b>	<b>Regulatory Authority*</b>
State Emergency Management Agency	Coordinates statewide response to event	
Highway Patrol	State lead for criminal investigation	

<b>AGENCY</b>	<b>RESPONSIBILITY</b>	<b>Regulatory Authority*</b>
<b>Federal Agencies:</b>		
Centers for Disease Control and Prevention	Provide epidemiological assistance, technical expertise, laboratory assistance	

Food and Drug Administration	Assist in trace back investigations of contaminated foods, exercise seizure powers, provide lab capacity, provide assistance in tampering investigations, issue nationwide or regional recalls	<b>Products:</b> Bottled water, private water, seafood, all processing plants except beef, pork, and poultry, all products (including milk, shell eggs, beef, pork, poultry and water safety) at the retail level
Environmental Protection Agency	Assist in investigation of water tampering, provide technical expertise	<b>Product:</b> Public Drinking Water
United States Department of Agriculture	Issue nationwide recalls for meat products, investigation of illness in livestock, assure safe processing of meat products sold in interstate commerce	<b>Products:</b> Livestock Crops Shell Eggs Plants Processing: Beef, Pork, Poultry
Federal Bureau of Investigation	Lead for criminal investigation	
Department of Homeland Security	Coordinates the Response at the Federal Level	
<b>Local Agencies:</b>		
Local Public Health Agencies	Provide primary first response at facility, conduct facility inspections, ensure compliance with closing orders and embargo orders, conduct water/food sampling, assist with disease investigation	

## RESPONSE TO FOOD TAMPERING INCIDENT



## ANNEX M

### VOLUNTEER MANAGEMENT

#### I. Purpose

To develop a volunteer management plan for use during a local public health emergency.

#### II. Organization and Responsibilities

- A. The CCHC Assistant Administrator and Financial Coordinator will have joint responsibility of organizing and managing the volunteers during a local public health emergency. These staff members will be assisted by the Administrator, Clerk II-Imm/Gen. Clerical, and Carter County EMD. This will include individuals authorized through Emergency Management Assistance Compact (EMAC).
- B. CCHC staff will manage spontaneous volunteers who may request to support the public health agency's response, either through incorporating them into the response or by triaging them to other potential volunteer resources, or through Carter County EMD.
- C. CCHC staff will assist Carter County EMD in volunteer support, and will assist with volunteer's being reassigned as needed.
- B. The volunteer management plan for Carter County will serve to supplement those individuals who are covered in the Carter County EOP dated January 2015. The number of volunteers needed for any given situation will be dictated by the scope and the severity of the emergency.
- C. In order to assure that the volunteers utilized will have clear credentials, CCHC Emergency Plan will use those individuals, if available, who are required by their place of employment to have a clear criminal background check in order to be employed. The following agencies will be utilized for volunteers and the approximate numbers of volunteers which may be available to be used in an emergency:
  - a. National Park Service (Ozark National Scenic Riverways) –  
573-323-4236 - contact- Mr. Larry Johnson- Park Superintendent.  
**100 employees**
  - b. East Carter County R-II Schools, Ellsinore- 573-322-5325- contact Mr. Richard Sullivan  
**103 employees**

c. Van Buren R-I Schools- Van Buren- 573-323-4281 or 573-783-9579 - contact Jeff Davis.

**85 employees**

D. Other volunteer agencies that will work with the CCHC will include the American Red Cross from the Southern MO Region 2 218 Main St., West Plains, MO 65775, 573-707-4029 or 417-832-9500 (Chris Harmon) or 417-838-4084 (Greg Gaines) and/or local Red Cross representative 417-372-3203 (Elle McClendon), 705-955-1882, if no response call 314-559-1009, and the Salvation Army at 314-771-7366.





## ANNEX N

### RECOVERY

#### I. Purpose

To develop a recovery strategy for use after a local public health emergency.

#### II. Organization and Responsibilities

- A. The Carter County Health Center Administrator will work with county and city officials and members of the community to organize recovery efforts after a local public health emergency.
- B. The Carter County Health Center will work with DHSS, DNR, FBI and local hazmat/wmd teams to survey damages and assure proper decontamination of facilities that may have been exposed to a biological agent.
- C. The staff of the Carter County Health Center will keep a daily log of all hours worked and detailed summary of all activities during a local public health emergency.
- D. After a public health emergency, the Carter County Health Center Administrator will summarize the events in a report that will be shared with county and city officials. The report should include cause of the emergency and lessons learned from the overall response to the emergency.
- E. The Carter County Health Center will ask Department of Mental Health to provide mental health services to the responders, medical staff and the public after a public health emergency.

**CARTER COUNTY HEALTH DEPARTMENT  
EMERGENCY RESPONSE PLAN**

**ANNEX O  
PANDEMIC INFLUENZA**

**1. PURPOSE**

This Annex will provide a guide for the department on how to respond before, during and after a pandemic influenza event. It is also intended to serve as the template for responding to a severe seasonal flu epidemic or a large-scale outbreak of other highly infectious respiratory diseases such as Severe Acute Respiratory Syndrome (SARS).

This Annex incorporates CDC guidance pertaining to pandemic influenza response planning and is intended as a companion to Missouri's "Pandemic Influenza Plan," developed and maintained by the Missouri Department of Health and Senior Services (DHSS). The department's pandemic response plan will be interpreted in the context of the state plan which details activities identified by DHSS as the responsibility of the local health departments across the state.

The information contained herein should be read and understood prior to the occurrence of a pandemic event. It is a dynamic document that will be updated as needed to reflect new developments in the understanding of the disease agent, communicability, treatment and prevention, as well as changes in response roles and capabilities identified through ongoing planning efforts. The elements of this plan are based on the existing emergency response structure of the department and the two counties.

**2. SITUATION AND ASSUMPTIONS**

**A.** Pandemic influenza refers to a global influenza epidemic that, in contrast to seasonal influenza is a novel influenza virus that has undergone an antigenic shift; has high population susceptibility worldwide; shows evidence of high person-to person transmissibility; and is spread over a broad range of geographic areas causing unusually high rates of morbidity and mortality because of its virulence. A pandemic will be due to a new subtype of influenza A, and emergence of new influenza A viruses is inevitable.

**B.** By definition, a novel virus is one that has not previously infected humans, or has not infected humans for a long time. This said, it is likely that almost no one will have immunity or antibodies to protect them against the novel virus and anyone exposed to the virus could become infected and get sick. The clinical disease attack rate could be as high as 30% in the overall population. Illness rates among school-aged children could reach 40% and decline with age. Among working adults, an average of 20% could become ill during a community outbreak.

**C.** The primary disease prevention strategy for epidemic influenza includes:

1. Targeted vaccination and anti-viral usage aimed at high-risk populations so as to minimize the effects of expected outbreaks.
2. Public information and education.
3. Enhanced surveillance.
4. Isolation, quarantine, public facility closures and other control measures.

**D.** The pandemic phases described below have been excerpted from the World Health Organization (WHO) global influenza preparedness plan published in 2005. It is important to understand that actual spread of the virus may or may not be described by these phases.

<b>WHO Pandemic Phase</b>	<b>Definition</b>
<b>Inter-Pandemic Period</b> (WHO Phase 0, Preparedness Level 0)	No indications of any new virus type have been reported. Influenza viruses antigenically related to those recently circulating among humans continue to evolve and cause disease.
<b>Novel Virus Alert</b> (WHO Phase 0, Preparedness Level 1-2)	A novel influenza strain has been identified in at least one human. A substantial portion of the population has little or no antibody to the novel virus, but the ability of the virus to rapidly spread person-to-person and cause multiple outbreaks of disease remains questionable
<b>Pandemic Alert</b> (WHO Phase 0, Preparedness Level 3)	Human transmission of the new virus subtype has been confirmed through clear evidence of person-to-person spread in the general population, with at least one outbreak lasting over a minimum of a two-week period in one country.
<b>Pandemic</b> (WHO Phases 1-3)	The new virus subtype has been shown to cause several outbreaks in at least one country, and to have spread to other countries with consistent disease patterns indicating that serious morbidity and mortality is likely in at least one segment of the population. This phase will result in influenza activity in initially affected regions until it has stopped or reversed while outbreaks of the new virus are still occurring elsewhere.
<b>Second Wave</b> (WHO Phase 4)	A second outbreak of disease within the same geographic area that occurs 3-9 months after the initial wave of disease.
<b>Post-Pandemic</b> (WHO Phase 5)	Indices of influenza activity have returned to essentially normal inter-pandemic levels and immunity to the new virus subtype is widespread in the general population.

**E.** Assumptions concerning preparations for a pandemic include:

1. There may be as little as a three month warning of a coming pandemic, and preparations should be geared toward a 1918 level event. In Carter County alone, this would extrapolate to (without effective interventions) approximately 1,773 people ill, 871 seeking outpatient care, 197 hospitalizations, and 35 deaths. These estimates underscore the need for planning to lessen the impact of a pandemic.
2. An influenza pandemic of this magnitude will affect all segments of society and will overwhelm health care and mortuary systems. It may severely disrupt commerce and economic activity, break down normal societal patterns and cause psychosocial trauma.
3. An effective response to such a pandemic will require a coordinated community-wide effort. Of those who become ill with influenza, 50% will likely seek outpatient medical care.
4. Risk groups for severe and fatal infections cannot be predicted with certainty.
5. The seasonality of a pandemic cannot be expected with certainty.
6. The typical incubation period for influenza averages 2 days. We assume this would be the same for a novel strain that is transmitted between people by respiratory secretions.
7. People who become ill may shed virus and can transmit infection for one-half to one day before they feel the onset of illness. Viral shedding and the risk for transmission will be greatest during the first 2 days of illness. Children will shed the greatest amount of virus and, therefore are likely to pose the greatest risk for transmission. On average, a single ill person will transmit 2 secondary infections
8. The pandemic will occur in waves, with at least two waves likely. In an affected community, a pandemic wave will last about 6-8 weeks with as little as 30 days between waves.
9. Preparations should be made for outbreaks that will likely occur simultaneously across the state and nation, limiting the ability of any one jurisdiction to provide support and assistance to others.
10. A new virus may be a re-emerging, previously known human virus subtype which has not recently been in circulation, or a virus of avian origin, emerging either through stepwise 'adaptation' conferring greater affinity for humans or through a process of genetic reassortment between the genes of an avian and human virus.
11. From time to time, avian influenza viruses will infect people directly exposed to infected poultry (as has been occurring mainly in the Far East since 1997) but may not necessarily evolve into pandemic viruses.
12. Such a strain could first emerge anywhere, including Missouri, but it is most likely to emerge in the Far East, the birthplace of recent pandemics, because:
  - a. Human proximity to poultry and domestic pigs in farming communities in South East Asia and China which facilitates mingling of human and animal viruses. The viruses may exchange genetic material, resulting in a new re-assorted strain.

- b. Viruses may transfer directly from birds (or animals) to humans and become able to infect people through genetic adaptation or mutation.
  - c. Viruses may re-emerge from unrecognized or unsuspected reservoirs.
  - d. There is already wide dissemination of H5N1 infection in poultry, domestic fowl and wild birds.
13. Whenever a new or novel influenza virus is isolated from an infected person, its potential to spread directly from person to person and cause outbreaks of illness needs to be assessed.
  14. False alarms are likely, but until it is known whether a new virus has developed which resulted in person-to-person transmission, its pandemic potential must remain under consideration and investigation.
  15. Vaccine for the novel influenza virus will not be available in Missouri before the virus reaches the state.
  16. Initial distribution of vaccine to Missouri will be extremely limited and must be prioritized to maximize effectiveness. Two doses of vaccine administered 30 days apart may be required to develop immunity to a novel virus.
  17. Effective antivirals will be in limited supply and must be prioritized to maximize effectiveness.
  18. Education, public health interventions, basic public health measures and social controls must be relied upon initially to slow the spread of the disease in Carter and Maries County.

**F.** If an unexpected epidemic should occur as a result of a known circulating strain of influenza, parts of this annex could be implemented to minimize the outbreak. The portions implemented would depend upon the specifics of the outbreak and would be determined in consultation with CDC, DHSS, local health care providers and local and state elected officials.

### **3. ORGANIZATION AND RESPONSIBILITIES**

**I. Command and Control:** The existing departmental command structure is being applied to pandemic influenza planning and response. During a single agency response, the Administrator or designee will employ a command structure consistent with requirements of the National Incident Management System (NIMS). This structure will delineate operational priorities and identify who is responsible for making decisions related to the public health response to a pandemic, for carrying out response activities before, during and after a pandemic and for preparing and maintaining the pandemic response plan. In the event of a multi-agency or multi-jurisdictional response, the Administrator or designee will ensure that department staff and resources are properly assimilated into the larger command structure.

#### **A. Inter- or Pre-Pandemic:**

1. The department will take the lead in planning the public health response to pandemic influenza for Carter County.
2. The department's Communicable Disease Nurse and the Regional Epidemiology Specialist will coordinate surveillance and epidemiological

investigation activities including implementing ongoing influenza surveillance, planning for pandemic epidemiological investigation and coordinating specimen testing with the State Public Health Laboratory.

3. DHSS has defined priority population groups to receive vaccine or antiviral medications in case of a vaccine shortage during a pandemic
4. The department will coordinate planning for the procurement of vaccines, antivirals and supplies and their distribution.
5. The department will maintain information about the capacity of hospitals and treatment centers in the adjacent counties.
6. The department will coordinate activities with the Missouri Department of Agriculture and local veterinary health partners related to planning a public health response to an identification of avian influenza in an animal population.
7. The department PIO will coordinate the planning of communications activities for a pandemic response.
8. The Regional Planner will review and update this Annex on an annual basis or as needed, and will coordinate pandemic response planning with DHSS.

## **B. Novel Virus Identified in a Single Human Case/Human-to-Human Transmission Confirmed**

### **\*If the novel virus appears first in Carter:**

1. The Administrator or designee will initiate communication with local, state and national counterparts, including County EMD's, County Commissions, DHSS, CDC, etc.
2. The department's Communicable Disease Nurse and the Regional Epidemiology Specialist will increase local surveillance and initiate case tracking activities
3. The department will issue an alert to the health community providing an advisory to the area hospital and health care providers to implement severe respiratory illness precautions
4. The department will coordinate with the local hospital to ensure samples are directed to the correct laboratory for testing
5. The department will also confirm availability of resources to support a pandemic response.
6. The department PIO will develop and disseminate appropriate information to the public

### **\*If the novel virus appears first elsewhere:**

1. The Administrator will ensure ongoing communication with local and state counterparts, including County EMD's, County Commissions, DHSS, CDC, etc.
2. The department's Communicable Disease Nurse and the Regional Epidemiology Specialist will monitor the health alert network (HAN) and other channels of information and provide ongoing assessments of the situation to the Administrator and other relevant department personnel.
3. The department will increase local surveillance activities

4. The department will alert the local health community through the HAN, providing an advisory to the area hospital and health care providers to inquire about recent travel to affected areas among patients presenting with severe respiratory illness and to consider implementing severe respiratory illness precautions

### **C. Confirmation of Onset of Pandemic, Regional and Multi-Regional Epidemics**

1. The Administrator will activate an incident command structure to:
  - a. Continue surveillance and tracking activities
  - b. Determine the need for and scope of mass vaccination activities
  - c. Coordinate delivery of vaccine and/or antivirals with DHSS and local partners.
  - d. Carry out mass vaccination activities in accordance with Annex H of this plan.
  - e. Assess the capacity of the area hospital and identify their resource needs.
  - f. Develop and disseminate appropriate information to the public.
  - g. Ensure ongoing communication with local, state and federal authorities.
2. The Administrator, as the Public Health Authority, will consider implementing quarantine and isolation measures for residents of Carter County as appropriate.

### **D. Second or Later Waves**

1. The Administrator will review procedures conducted during the first wave and continue response activities as appropriate.

### **E. Post-Pandemic**

1. The Administrator will convene relevant parties to debrief from response activities.
2. The Administrator will communicate the status of the response to appropriate local, state and federal authorities.
3. The Regional Planner will review and update the department's ERP based on lessons learned from response activities.

**II. Surveillance:** The department will establish and coordinate the following local surveillance activities related to pandemic influenza. Additional information regarding surveillance activities is contained in Annex D of this plan.

### **A. Inter- or Pre-Pandemic**



1. The department will establish and coordinate the CDC sentinel surveillance system within Carter County. The department will attempt to recruit representation from the following disciplines – internal medicine, family practice, infectious disease, emergency medicine, urgent care, pediatric, obstetrics/gynecology and student health.
2. The department will collaborate with Big Springs Medical Clinic laboratories within the county to establish a system whereby counts of positive rapid influenza test kits and influenza viral cultures are provided to the department on a weekly basis during the months of September through May.
3. The department will collaborate with area school districts to develop a system whereby counts of reports of influenza-like illness (ILI) occurrences are provided to the department on a regular basis.
4. The department will establish a system for monitoring over-the-counter drug sale information through local pharmacies.

## **B. Novel Virus Identified in a Single Human Case/Human-to-Human Transmission Confirmed**

### **\*If the novel virus appears first in Carter County:**

1. The department's Communicable Disease Nurse and the Regional Epidemiology Specialist will ensure that all inter-pandemic influenza surveillance activities are underway regardless of the time of year, enhancing activities and investigating the epidemiology of early cases through case tracking activities.
2. The Administrator or designee will inform state and federal partners about increased local surveillance activities. The department will request additional resources for local surveillance and case tracking activities (e.g. CDC Epidemiological Intelligence Officers, reagents to detect and identify the novel strain, instructions for safe handling and testing of a potential novel influenza virus, etc).
3. The department will coordinate the collection of ILI specimens among area providers and laboratories and facilitate the transfer of ILI specimens to DHSS and/or CDC.
4. The department will coordinate with the local physicians and medical centers to provide instructions for directing samples from patients presenting with severe or unusual ILI to the appropriate laboratory for testing. The department will provide instructions for the safe handling of a potential novel influenza virus.
5. The department will assess the completeness and timeliness of reports from all participating laboratories and sentinel providers, and will collaborate with these partners to enhance and facilitate complete and timely reporting.
6. The department will issue regular alerts regarding surveillance and case tracking activities to the health community through the HAN.

### **\*If the novel virus appears first elsewhere:**

1. The department's Communicable Disease Nurse and the Regional Epidemiology Specialist will monitor the HAN, CDC's Epi-X and other appropriate sources for updates regarding international, federal and state surveillance activities.
2. The department will ensure that all inter-pandemic influenza surveillance activities are underway regardless of the time of year, enhancing activities as needed based on information from HAN alerts, Epi-X alerts, communication from state and federal partners and other sources.
3. The department will monitor and institute recommendations from DHSS and CDC for any additional surveillance activities that should be undertaken.
4. The department will assess the need to screen travelers arriving in the area from affected countries.
5. The department will notify hospitals in close proximity to the county, physicians and urgent care centers requesting they increase laboratory diagnosis of influenza for persons presenting with ILI, especially those with recent travel history to regions where the pandemic strain of influenza is circulating or those with unusual or severe symptoms. The department will provide instructions for the safe handling of a potential novel influenza virus.
6. The department will assess the completeness and timeliness of reports from all participating laboratories and sentinel providers, and will collaborate with these partners to enhance and facilitate complete and timely reporting.

### **C. Confirmation of Onset of Pandemic, Regional and Multi-Regional Epidemics**

1. The department will enhance ongoing surveillance activities to include the following:
  - a. Monitoring health impacts, including deaths and hospitalizations.
  - b. Monitoring community impacts, including absenteeism in schools and essential services.
  - c. Monitoring antiviral resistance.
  - d. Monitoring vaccine effectiveness.

### **D. Post-Pandemic**

1. The department will develop a detailed summary of the pandemic, utilizing surveillance data to evaluate the efficacy of local response activities. Analysis may include:
  - a. Severity of influenza outbreaks among demographic groups.
  - b. Age-specific attack rate, morbidity and mortality.
  - c. Efficacy of vaccination and infection control measures.
  - d. Extent of medical, social and economic impact.

## **III. Vaccine Management: Distribution and Administration**

Vaccine will serve as the primary preventive strategy during an influenza pandemic. Unlike annual production of influenza vaccine, wherein strains are selected in the spring and vaccine is

manufactured and delivered during the summer to be used during the fall and winter influenza season, a pandemic strain could be detected at any time. Because current manufacturing procedures require six to eight months before large amounts of vaccine are available for distribution, there could be a large gap between identification of a pandemic strain and availability of vaccine.

#### **A. Inter- or Pre-Pandemic**

1. The department will continue activities to enhance annual influenza vaccination coverage levels in traditional high-risk groups. Activities will be carried out prior to the beginning of the traditional influenza season each year and will include:
  - a. Disseminating educational materials to area health care providers including a summary of the most current influenza vaccine recommendations, suggested strategies for reaching at-risk populations and a list of resources to help promote and deliver influenza vaccine to patients.
  - b. Providing education to the local physician's office staff about the importance of vaccinating healthcare workers and patients with high-risk medical conditions.
  - c. Providing education to area nursing home and assisted living facility staff about the importance of vaccinating persons over the age of 65.
  - d. Recommending that schoolchildren over age 5 receive intranasal influenza vaccine and communicating with area pediatricians regarding this recommendation.
  - e. Recommending that all persons responsible for community safety and security receive annual influenza vaccination, including emergency medical personnel, police and firefighters.
  - f. Utilizing traditional and non-traditional communications channels to educate the general public about the importance of influenza vaccination.
  - g. Maintaining current information about influenza and influenza vaccination on the department website. Information will be targeted to both the healthcare community and the general public.
  - h. Educating corporate partners about the importance of a vaccinated workforce.
2. The department will continue activities to enhance pneumococcal vaccination coverage levels in traditional high-risk groups to reduce the incidence and severity of secondary bacterial pneumonia. Such activities will occur in concert with the activities described in 1a, 1b and 1c above.
3. Based on guidelines from DHSS and CDC, the department will review locally defined priority populations that will receive initial doses of vaccine during a pandemic before it is widely available to all citizens through mass vaccination activities. These priority populations are detailed in Appendix 1.

4. The department will determine and maintain estimates of the number of persons within each priority population, revising the estimates on an annual basis. These estimates are included in Annex H of this plan.
5. The department will review and update its plan for providing vaccination to priority groups during a pandemic in the event of a severe or moderately severe vaccine shortage.
6. The department will review and update Annex H of this plan to ensure it addresses issues specific to influenza vaccination.
7. The department will maintain information about local sources of supplies needed for administering vaccine.
8. The Administrator will ensure that appropriate legal authorities are in place to allow for the implementation of measures relevant to mass vaccination activities during a pandemic.
9. The department will collaborate with DHSS, local healthcare partners and other area jurisdictions to coordinate plans for mass vaccination efforts.

#### **B. Novel Virus Identified in a Single Human Case/Human-to-Human Transmission Confirmed**

1. The department will review and modify its plan, as needed, to account for updates received regarding the novel virus. Such updates may include recommended target groups and projected vaccine supply.
2. The Administrator or designee will assess department human resources and logistics capabilities to ensure that appropriate staff and supplies are available to begin vaccination activities, if necessary.

#### **C. Confirmation of Onset of Pandemic, Regional and Multi-Regional Epidemics**

1. The department will communicate with DHSS regarding the availability and delivery of vaccine, and provide them with an estimated number of persons within each priority population as well as the population as a whole.
2. Prior to widespread vaccine availability, the department will provide vaccine as it is available to priority groups based on the methodology described in Annex H of this plan.
3. Upon widespread vaccine availability, the department will fully activate mass vaccination activities according to Annex H.
4. The department will collaborate with DHSS, local healthcare partners and other area jurisdictions to coordinate plans for mass vaccination efforts.
5. Suspected adverse reactions to vaccination can be reported by providers, vaccine recipients, or anyone with responsibility for the health care of vaccine recipients. They can be reported to the Vaccine Adverse Event Reporting System (VAERS) on the web at <http://www.vaers.org/>, by mail using the VAERS form, which is attached, or by calling 800-822-7967. The designated VAERS coordinator at the Missouri Department of Health and Senior Services can obtain information on all reporting of adverse events by calling 866-628-9891.

#### **D. Post-Pandemic**

1. The department will discontinue and demobilize mass vaccination activities, ensuring that supplies are inventoried and returned as appropriate.
2. The department will evaluate vaccine delivery and administration procedures and modify plans as necessary.

#### **IV. Acquisition and Use of Antivirals**

Prior to or during a pandemic, the department may be responsible for the storage and distribution of antivirals. At present, the limited supply of these drugs coupled with manufacturing processes and the lack of definitive information or direction creates uncertainty surrounding the use of these agents in an influenza pandemic. Targeted recipients for existing supplies of these drugs have been identified and prioritized by DHSS based on guidance from the federal government (see appendix 2).

##### **A. Inter- or Pre-Pandemic**

1. Based on guidelines from DHSS, the department will review locally defined priority populations that will receive antivirals for prophylaxis and therapy during a pandemic before they are widely available to all citizens. These priority populations are detailed in Appendix 2.
2. The department will determine and maintain estimates of the number of persons within each priority population to receive prophylaxis and therapy, revising the estimates on an annual basis.
3. The department will collaborate with DHSS, local healthcare partners and other area jurisdictions to coordinate plans for the provision of antiviral prophylaxis and therapy.

##### **B. Novel Virus Identified in a Single Human Case/Human-to-Human Transmission Confirmed**

1. The department will consult with DHSS regarding its plan to provide antivirals. The plan will be modified as needed to account for updates regarding the novel virus, recommended target groups and projected antiviral supply.
2. The Administrator or designee will assess the department's human resources and logistics capabilities to ensure that appropriate staff and supplies are available to begin activities associated with the provision of antivirals, if necessary.
3. The department will notify the local medical community of the status of antiviral availability and plans to disseminate them to established priority groups.
4. The department will disseminate antiviral use guidelines to the medical community based on guidance from DHSS and CDC.

### **C. Confirmation of Onset of Pandemic, Regional and Multi-Regional Epidemics**

1. The department will communicate with DHSS regarding the availability and delivery of antivirals. The department will provide DHSS with an estimated number of persons within each priority population as well as the population as a whole.
2. The department will activate its plan for providing antiviral prophylaxis and therapy as it is available to priority groups based on the methodology described in Annex H of this plan.
3. The department will collaborate with DHSS, local healthcare partners and other area jurisdictions to coordinate plans for the provision of antiviral prophylaxis and therapy.

### **D. Post-Pandemic**

1. The department will discontinue and demobilize antiviral administration, ensuring that supplies are inventoried and returned as appropriate.
2. The department will evaluate antiviral delivery and administration procedures and modify plans as necessary.

### **V. Implementation of Community Level Control Measures**

The goal of community level containment measures is to slow the spread of pandemic influenza as much as possible and to provide additional time for the development, manufacture, distribution and administration of influenza vaccine and antiviral medications. Strategies to achieve this goal must take into consideration the modes of transmission of influenza, the short incubation period, the non-specific clinical presentation, the likelihood of asymptomatic infected persons who may be transmitting infection and past experience in the use of containment measures during a pandemic influenza event.

There are two key strategies for preventing transmission, each with varying degrees of efficacy. The first involves decreasing the probability that contact will result in infection, and may include activities such as providing education to the public about practicing cough etiquette and proper hand and respiratory hygiene. The second involves decreasing contact between infected and uninfected individuals, and may include activities such as isolating suspected cases and quarantining case contacts, issuing travel advisories and canceling schools and large gatherings.

#### **A. Inter- or Pre-Pandemic**

1. The department will not recommend any community or individual level containment measures other than ongoing education regarding the importance of hand hygiene, cough etiquette and annual influenza vaccination.
2. The Administrator will review appropriate legal authorities regarding the implementation of community level control measures, including quarantine laws. The department will maintain templates of documentation needed to enact community level control measures.

3. The department will develop and maintain contact information with community partners through whom the department may communicate information about community level control measures. These partners include hospitals, school districts, private schools, parks and recreation departments, the child day care licensing authority, homeowners associations, chambers of commerce, etc.
4. The department will maintain plans for communicating information to the public about community level control measures.

**B. Novel Virus Identified in a Single Human Case/Human-to-Human Transmission Confirmed**

**\*Possible containment measures if cases are first detected outside the United States:**

1. The department may recommend isolation of persons who are recent travelers to affected regions if they have ILI. If influenza is suspected or confirmed, the department may recommend isolation at home or in a hospital until isolate subtyping is accomplished. Isolation should continue for at least seven days, until viral shedding is no longer detected or until the isolate is laboratory confirmed not to be a novel influenza A virus
2. The department may recommend quarantine for contacts of cases.
3. The department may issue an advisory recommending limiting travel to the affected region and screening travelers arriving from the affected region for illness compatible with influenza.
4. The department will increase education about the importance of hand hygiene, cough etiquette and annual influenza vaccination.

**\*Possible containment measures if cases are first detected in the United States outside Carter County:**

1. The Administrator or designee may recommend persons testing positive for influenza A be placed in isolation at home or in a hospital until isolate subtyping can be accomplished. Isolation should continue for at least seven days, until viral shedding is no longer detected or until the isolate is laboratory confirmed not to be the novel virus
2. The Administrator or designee may recommend quarantine for contacts of cases.
3. The department will increase public education regarding the importance of hand hygiene and cough etiquette.

**\*Possible containment measures if cases are first detected in Carter County:**

1. The Administrator or designee may recommend or require that persons who have ILI be placed in isolation at home or in a hospital until subtyping of their isolate can be accomplished. Isolation should continue for at least seven days, until viral shedding is no longer detected or until the isolate is laboratory confirmed not to be the novel virus
2. The Administrator or designee may recommend or require quarantine for contacts of cases.

3. If an animal source is identified and there is ongoing transmission within the animal population, the department may recommend that persons who may be in contact with potentially infected animals wear appropriate personal protective equipment.
4. The department may recommend or require that citizens limit travel to destinations outside of Carter, as well as limit non-essential travel within the county.
5. The Administrator or designee may recommend or require cancellation of large gatherings depending on the level of person-to-person transmission. Based on the epidemiology of the known infected cases, the Administrator or designee may consider closure of schools and closure of office buildings or other large employers.
6. The department will increase public education efforts regarding the importance of hand hygiene and cough etiquette.

#### **C. Confirmation of Onset of Pandemic, Regional and Multi-Regional Epidemics**

1. The Administrator or designee may recommend or require that all persons who are ill and their contacts remain in isolation at home.
2. The Administrator or designee may recommend or require limitation or suspension of large gatherings and recreation activities.
3. The Administrator or designee may recommend or require the closure of schools and closure of office buildings or other large employers.
4. The Administrator or designee may recommend or require the limitation of non-essential work activities, encouraging telecommuting when possible.
5. The Administrator or designee may recommend or require an area wide quarantine.

#### **D. Post-Pandemic**

1. The Administrator or designee will suspend all community level control measures.
2. The department will assess compliance with community level control measures and evaluate their efficacy.

### **VI. Health and Medical Response and Maintenance of Critical Services**

While this plan and the Carter County disaster plans address all hazards, pandemic influenza differs from many threats due to the magnitude and duration of its impact and the likelihood of subsequent waves of disease. Of great concern during a pandemic event is its effect on the capacities of the healthcare system and other critical community services.

#### **A. Inter- or Pre-Pandemic**

1. In collaboration with community partners including hospitals within close proximity to the county, the department will develop and maintain an inventory of the following resources:



- a. Hospital and long-term care bed capacity.
  - b. Intensive Care Unit capacity.
  - c. Ventilators.
  - d. Personal protective equipment.
  - e. Specimen collection and transport materials.
  - f. Sources of consumable medical supplies.
  - g. Medical personnel who may be utilized during an emergency situation.
  - h. Pharmacies and pharmacists.
  - i. Contingency medical facilities.
  - j. Mortuary/funeral services.
  - k. Social, mental health and faith based services.
2. In collaboration the County EMD's and others, the department will develop and maintain a list of personnel whose absence would pose a serious threat to public safety or would significantly interfere with pandemic response activities.
  3. Using the above information, the department will estimate the impact of pandemic influenza on healthcare services and critical infrastructure within Carter County. The CDC's "FluAid" program may be used to derive these estimates.

**B. Novel Virus Identified in a Single Human Case/Human-to-Human Transmission Confirmed**

**\*If cases are first detected outside the United States:**

1. The department will provide regularly updated information regarding the epidemiology and spread of the novel virus to the local healthcare community.

**\*If cases are detected within the United States:**

1. The department will provide regularly updated information regarding the epidemiology and spread of the novel virus to the local healthcare community.
2. The department will recommend that EMS and the local hospital activate severe respiratory illness protocols and provide guidance about the appropriate use of personal protective equipment.
3. The department will establish communication with the county EMD's or EOC's providing updated information about epidemiology of the novel virus.

**C. Confirmation of Onset of Pandemic, Regional and Multi-Regional Epidemics**

1. The Administrator or designee will designate a liaison to the EOC to communicate timely and accurate information about the epidemiology of the pandemic.
2. The department will continually review information about the epidemiology of the pandemic. Based on this data, the department will develop and provide the EOC with protective action recommendations for the health, medical and essential services sectors.

#### **D. Post-Pandemic**

1. The department will participate in recovery and demobilization efforts in coordination with the local EOC's.
2. The department will provide an assessment of the impact, response and control of the public health response during the pandemic event.

#### **VII. Communicating with the Public**

Communicating information to the public about pandemic influenza will be carried out according to procedures described in Annex C of this plan.

**A.** The unique nature of a pandemic requires crisis and risk communications planning. Guided by Annex C, the department PIO will develop messages to ensure that the public receives timely and accurate information about the following during a pandemic event:

1. Basic information about influenza, high-risk populations and recommended preventive practices.
2. The epidemiology of the pandemic.
3. The symptoms that should prompt seeking medical assistance.
4. The availability of vaccines and antivirals and the rationale for providing medication to priority groups during vaccine and antiviral shortages.
5. Instructions for receiving vaccine and antivirals at mass vaccination sites.
6. Directives for community level containment activities.
7. Explanations of concepts such as isolation and quarantine.

## Appendix 1 to Annex O

### Carter County Targeted Recipient Groups for Vaccine Population Estimates\*

Tier	Subtier	Population	Rationale
1	A	<ul style="list-style-type: none"> <li>• Medical workers and public health workers who are involved in direct patient contact, other support services essential for direct patient care, and vaccinators.</li> </ul> <p><b>Approximately 162</b></p>	<ul style="list-style-type: none"> <li>• Healthcare workers are required for quality medical care. There is little surge capacity among healthcare sector personnel to meet increased demand.</li> </ul>
	B	<ul style="list-style-type: none"> <li>• People &gt; 65 years with 1 or more influenza high-risk conditions, not including essential hypertension Approximately 368</li> <li>• People 6 months to 64 years with 2 or more influenza high-risk conditions, not including essential hypertension Approximately 139</li> <li>• People 6 months or older with history of hospitalization for pneumonia or influenza or other influenza high-risk condition in the past year. Approximately 15</li> </ul> <p><b>Total: 522</b></p>	<ul style="list-style-type: none"> <li>• These groups are at high risk of hospitalization and death. Excludes elderly in nursing homes and those immunocompromised who would not likely be protected by vaccination</li> </ul>
	C	<ul style="list-style-type: none"> <li>• Pregnant women. Approximately 61</li> <li>• Household contacts of severely immunocompromised people who would not be vaccinated due to likely poor response to vaccine (Approximately 39 with transplants, AIDS, and incident cancer x 1.4 household contacts per person = 54)</li> <li>• Household contacts of children &lt;6 month old. Approximately 101</li> </ul> <p><b>Total: 216</b></p>	<ul style="list-style-type: none"> <li>• In past pandemics and for annual influenza, pregnant women have been at high risk; vaccination will also protect the infant who cannot receive vaccine.</li> <li>• Vaccination of household contacts of immunocompromised and young infants will decrease risk of exposure and infection among those who cannot be directly protected by vaccination</li> </ul>
	D	<ul style="list-style-type: none"> <li>• Public health emergency response workers critical to pandemic response (entire LPHA staff). Approximately 10</li> <li>• Key government leaders. 3.</li> </ul>	<ul style="list-style-type: none"> <li>• Critical to implement pandemic response.</li> <li>• Preserving decision-making capacity critical for managing response.</li> </ul>

2	A	<ul style="list-style-type: none"> <li>• Healthy 65 years and older. Approximately 359</li> <li>• 6 months to 64 years with 1 high-risk condition. Approximately 725</li> <li>• 6-23 months old, healthy. Approximately 113</li> </ul> <p><b>Total: 1197</b></p>	<ul style="list-style-type: none"> <li>• Groups are also at increased risk but not as high risk as population in Tier 1B</li> </ul>
	B	<ul style="list-style-type: none"> <li>• Public safety workers including police, fire, 911 dispatchers, and correctional facility staff. Approximately 60</li> <li>• Utility workers essential for maintenance of power, water, and sewage system functioning. Approximately 7</li> <li>• Workers transporting fuel, water, food, and medical supplies as well as public transportation. Approximately 77</li> <li>• Telecommunications/IT for essential network operations and maintenance. Approximately 22</li> </ul> <p><b>Total: 166</b></p>	<ul style="list-style-type: none"> <li>• Includes critical infrastructure groups that have impact on maintaining health (e.g., public safety or transportation of medical supplies and food); implementing a pandemic response; and on maintaining societal functions</li> </ul>
3	A	<ul style="list-style-type: none"> <li>• Other key government health decision-makers (estimated number not yet determined).</li> <li>• Funeral directors/embalmers Approximately 3</li> </ul>	<ul style="list-style-type: none"> <li>• Other important societal groups for a pandemic response, but of lower priority</li> </ul>
4	A	<ul style="list-style-type: none"> <li>• Healthy people 2-64 years not included in above categories. Approximately 3,632</li> </ul>	<ul style="list-style-type: none"> <li>• All people not included in other groups based on objective to vaccinate all those who want protection</li> </ul>

\*Carter County numbers extrapolated from federal estimates for entire United States based on county's percentage of 2004 U.S. Census Bureau population estimate for the country.

## Appendix 2 to Annex O

### Carter County Antiviral Drug Priority Group Recommendations\*

<b>Group</b>	<b>Population</b>	<b>Estimate **</b>	<b>Strategy***</b>	<b>Courses</b>	<b>Cum.</b>	<b>Rationale</b>
1	Patients admitted to hospital***	336	T			Consistent with medical practice and ethics to treat those with serious illness and who are most likely to die.
2	Health care workers (HCW) with direct patient contact and emergency medical service (EMS) providers	108	T			There is little surge capacity among healthcare sector personnel to meet increased demand.
3	Highest risk outpatients; immuno-compromised people and pregnant women	92	T			Greatest risk of hospitalization and death; immuno-compromised cannot be protected by vaccination.
4	Pandemic health responders (public health, vaccinators, vaccine and antiviral manufacturers), public safety (police, fire, corrections), and government decision-makers	40	T			Groups are critical for an effective public health response to a pandemic.
5	Increased risk outpatients—young children 12-23 months old, people >65 yrs old, and people with underlying medical conditions	1,002	T			Groups are at high risk for hospitalization and death.
6	Outbreak response in nursing homes and other residential settings	90	PEP			Treatment of patients and prophylaxis of contacts is effective in stopping outbreaks Vaccination priorities do not include nursing home residents.

7	HCWs in emergency departments, intensive care units, dialysis centers, and EMS providers	10	P			These groups are most critical to an effective healthcare response and have limited surge capacity. Prophylaxis may help prevent absenteeism.
8	Pandemic societal responders (critical infrastructure groups as defined in the vaccine priorities) and HCW without direct patient contact	10	T			Groups that have impact on maintaining health, implementing a pandemic response, and maintaining societal functions.
9	Other outpatients	400	T			Includes others who develop influenza and do not fall within the above groups.
10	Highest risk outpatients	100	P			Prevents illness in the highest risk groups for hospitalization and death.
11	Other HCWs with direct patient contact	20	P			Prevention may best reduce absenteeism and preserve optimal function.

\*The committee focused its deliberations on the domestic U.S. civilian population. NVAC recognizes that Department of Defense (DoD) needs should be given high priority. A separate DoD antiviral stockpile has been established to meet those needs. Other groups also were not explicitly considered in deliberations on prioritization. These include American citizens living overseas, non-citizens in the U.S., and other groups providing national security services such as the border patrol and customs service.

\*\*Carter County numbers extrapolated from federal estimates for entire United States.

\*\*\*Strategy: Treatment (T) requires a total of 10 capsules and is defined as 1 course. Post-exposure prophylaxis (PEP) also requires a single course. Prophylaxis (P) is assumed to require 40 capsules (4 courses) though more may be needed if community outbreaks last for a longer period.

\*\*\*\*There are no data on the effectiveness of treatment at hospitalization. If stockpiled antiviral drug supplies are very limited, the priority of this group could be reconsidered based on the epidemiology of the pandemic and any additional data on effectiveness in this population.

## APPENDIX 3 to ANNEX 0

### **Vaccine Management**

#### **Maintaining Cold Chain During Transport**

The Carter County Health Center utilizes the Vaccine Cold Chain Protocol developed by the Missouri Vaccines for Children Program. The Carter County Health Center will utilize this protocol for the novel H1N1 vaccines.

#### **Vaccine Emergency Plan**

The Carter County Health Center has a Vaccine Emergency Plan that addresses such issues as power outages. The Emergency Procedures given include:

- Emergency Phone numbers for:
  - Immunization Director
  - Immunization Director's Backup
  - Nursing Supervisor
  - Administrator
  - Electric Power Companies
  - Back-up locations
  - DHSS
  - National Weather Service(website)

The Carter County Health Center will include the novel H1N1 vaccine in our Vaccine Emergency Plan.

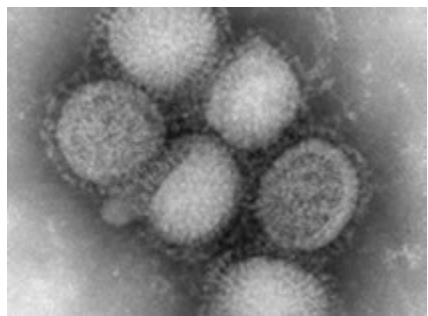
## **APPENDIX 4 TO ANNEX O CONSIDERATIONS FOR H1N1 (SWINE) INFLUENZA**

### **H1N1 Background**

On April 26, 2009, the Acting Secretary of Health and Human Services declared a public health emergency as a result of the detection of 20 known cases of individuals infected by a swine-origin influenza A virus, now known as novel Influenza A (H1N1), in the United States. On June 11, 2009, the World Health Organization declared the first pandemic in over 40 years in recognition of widespread, sustained human-to-human transmission of the virus in multiple regions around the globe. In light of the threat the pandemic poses to the nation's public health and security, Congress appropriated funding for the "Public Health and Social Services Emergency Fund" to prepare for and respond to an influenza pandemic.

### **Novel H1N1 (swine flu)**

Novel H1N1 (referred to as "swine flu" early on) is a new influenza virus causing illness in people. This new virus was first detected in people in the United States in April 2009. This virus is spreading from person-to-person worldwide, probably in much the same way that regular seasonal influenza viruses spread. On June 11, 2009, the [World Health Organization](#) (WHO) signaled that a pandemic of novel H1N1 flu was underway.



### **H1N1/Swine Flu**

This virus was originally referred to as "swine flu" because laboratory testing showed that many of the genes in this new virus were very similar to influenza viruses that normally occur in pigs (swine) in North America. But further study has shown that this new virus is very different from what normally circulates in North American pigs. It has two genes from flu viruses that normally circulate in pigs in Europe and Asia and bird (avian) genes and human genes. Scientists call this a

"quadruple reassortant" virus.

Lessons learned from past influenza pandemics indicate that influenza can strike a community, affect many individuals, and then appear to go away, only to come back to strike the community months later, possibly in a more severe manner.



## APPENDIX 5 TO ANNEX O

### CONSIDERATIONS FOR AVIAN INFLUENZA

Avian influenza viruses are endemic worldwide and are frequently associated with disease in domestic poultry. Not all strains cause disease and the ones that do can vary from low to high pathogenicity. The virus frequently mutates and can change from a low to a high pathogenic strain as well as develop the ability to infect mammals, such as pigs and humans.

Since the virus is usually found in fowl, the Missouri Department of Agriculture (MoAg) and the United States Department of Agriculture (USDA) are responsible for surveillance and control in the state of Missouri. Depending on the size of the response necessary and the pathogenicity of the virus strain, local and state governments may not have enough resources to handle all of the operations and activities involved in control of the disease. Therefore, the command structure will involve multiple jurisdictions and agencies.

There are many things to consider when working with avian influenza. The virus may be extremely difficult to isolate and control, especially if it moves into wild birds or mammals. Once the virus is identified, a “hot zone” will be identified by MoAg/USDA and all of the domestic fowl in this area will have to be identified, depopulated and disposed of properly. There will be a considerable amount of emotional stress for owners, responders and communities and all of the owners will expect reimbursement for the animals. During this process, certain groups that oppose the depopulation may require the presence of law enforcement.

MoAg/USDA Priorities will center on stopping the spread of the disease in animals and the economic implications, not the human health risks and the possibility for virus mutation.

#### **The department Response to the Identification of Avian Influenza in the Animal Population**

If avian influenza were identified among the animal population within Carter, the department will undertake the following activities:

1. The department may be asked to work with veterinary partners to identify and collect specimens in the hot zone.
2. The department’s Communicable Disease Nurse and the Regional Epidemiology Specialist will attempt to monitor persons who have had contact with infected birds or animals for any sign of respiratory illness. In coordination with DHSS, MoAg and USDA the Administrator or designee may recommend quarantine of these individuals.

3. The department will prepare information for distribution to area veterinarians describing the outbreak, discussing the clinical signs and encouraging local practitioners to report any suspect cases.

## ANNEX P

### SHELTERS

#### **I. Purpose**

- A. To define public health's role in sheltering following a local emergency where the need to open shelters have been identified. Events such as natural disasters, HAZMAT incidents or chemical, biological, nuclear, radiological hazards could result in the need to open local shelters.

#### **II. Organization and Responsibilities**

- A. The City or County EMA in coordination with the Division of Family Services has the primary responsibility for locating, staffing and opening shelters.
- B. The CCHC has the primary responsibility for inspecting the shelter for potential environmental health risks. Environmental health risks can occur from:
  - a. Water supply
  - b. Food supply
  - c. Solid waste disposal
  - d. Other identified
- C. The CCHC will work closely with the City or County EMA to secure any additional resources that are currently unavailable at the local level that could help identify additional environmental health risks.
- D. The CCHC is responsible for disease surveillance in any active shelter. Active surveillance will be conducted on a daily basis in an effort to minimize the risk of a disease outbreak.

- E. The CCHC will follow DHSS, EHOOG and CDRIM manuals when working with shelters.
  
- F. The CCHC will use CDC's "Environmental Health Assessment Form for Shelters" (Appendix 1) as a guide when inspecting the shelter. The guide can be found online here <http://www.bt.cdc.gov/shelterassessment/> , or Appendix 1 to Annex P

**Appendix 1 to AnnexP**

**ENVIRONMENTAL HEALTH ASSESSMENT FORM FOR SHELTERS  
For Rapid Assessment of Shelter Conditions during Disasters**



**I. ASSESSING AGENCY DATA**

<sup>1</sup>Agency /Organization Name \_\_\_\_\_ <sup>90</sup>Immediate Needs Identified:  Yes  No  
<sup>2</sup>Assessor Name/Title \_\_\_\_\_  
<sup>3</sup>Phone \_\_\_\_\_ <sup>4</sup>Email or Other Contact \_\_\_\_\_

**II. FACILITY TYPE, NAME AND CENSUS DATA**

<sup>5</sup>Shelter Type  Community/Recovery  Special Needs  Other \_\_\_\_\_ <sup>6</sup>ARC Facility  Yes  No  Unk/NA <sup>7</sup>ARC Code \_\_\_\_\_  
<sup>8</sup>Date Shelter Opened \_\_\_/\_\_\_/\_\_\_ (mm/dd/yr) <sup>9</sup>Date Assessed \_\_\_/\_\_\_/\_\_\_ (mm/dd/yr) <sup>10</sup>Time Assessed \_\_\_:\_\_\_ am  pm  
<sup>11</sup>Reason for Assessment  Preoperational  Initial  Routine  Other \_\_\_\_\_  
<sup>12</sup>Location Name and Description \_\_\_\_\_  
<sup>13</sup>Street Address \_\_\_\_\_  
<sup>14</sup>City / County \_\_\_\_\_ <sup>15</sup>State \_\_\_ <sup>16</sup>Zip Code \_\_\_\_\_ <sup>17</sup>Latitude/Longitude \_\_\_\_\_/\_\_\_\_\_  
<sup>18</sup>Facility Contact / Title \_\_\_\_\_ <sup>19</sup>Facility Type  School  Arena/Convention center  Other \_\_\_\_\_  
<sup>20</sup>Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ <sup>21</sup>Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ <sup>22</sup>E-mail or Other Contact \_\_\_\_\_  
<sup>23</sup>Current Census \_\_\_\_\_ <sup>24</sup>Estimated Capacity \_\_\_\_\_ <sup>25</sup>Number of Residents \_\_\_\_\_ <sup>26</sup>Number of Staff / Volunteers \_\_\_\_\_

**III. FACILITY**

<sup>27</sup>Structural damage  Yes  No  Unk/NA  
<sup>28</sup>Security / law enforcement available  Yes  No  Unk/NA  
<sup>29</sup>Water system operational  Yes  No  Unk/NA  
<sup>30</sup>Hot water available  Yes  No  Unk/NA  
<sup>31</sup>HVAC system operational  Yes  No  Unk/NA  
<sup>32</sup>Adequate ventilation  Yes  No  Unk/NA  
<sup>33</sup>Adequate space per person  Yes  No  Unk/NA  
<sup>34</sup>Free of injury /occupational hazards  Yes  No  Unk/NA  
<sup>35</sup>Free of pest / vector issues  Yes  No  Unk/NA  
<sup>36</sup>Acceptable level of cleanliness  Yes  No  Unk/NA  
<sup>37</sup>Electrical grid system operational  Yes  No  Unk/NA  
<sup>38</sup>Generator in use, <sup>39</sup>If yes, Type \_\_\_\_\_  Yes  No  Unk/NA  
<sup>40</sup>Indoor temperature \_\_\_\_\_ °F  Unk/NA

**IV. FOOD**

<sup>41</sup>Preparation on site  Yes  No  Unk/NA  
<sup>42</sup>Served on site  Yes  No  Unk/NA  
<sup>43</sup>Safe food source  Yes  No  Unk/NA  
<sup>44</sup>Adequate supply  Yes  No  Unk/NA  
<sup>45</sup>Appropriate storage  Yes  No  Unk/NA  
<sup>46</sup>Appropriate temperatures  Yes  No  Unk/NA  
<sup>47</sup>Hand-washing facilities available  Yes  No  Unk/NA  
<sup>48</sup>Safe food handling  Yes  No  Unk/NA  
<sup>49</sup>Dishwashing facilities available  Yes  No  Unk/NA  
<sup>50</sup>Clean kitchen area  Yes  No  Unk/NA

**V. DRINKING WATER AND ICE**

<sup>51</sup>Adequate water supply  Yes  No  Unk/NA  
<sup>52</sup>Adequate ice supply  Yes  No  Unk/NA

**VIII. SOLID WASTE GENERATED**

<sup>66</sup>Adequate number of collection receptacles  Yes  No  Unk/NA  
<sup>67</sup>Appropriate separation  Yes  No  Unk/NA  
<sup>68</sup>Appropriate disposal  Yes  No  Unk/NA  
<sup>69</sup>Appropriate storage  Yes  No  Unk/NA  
<sup>70</sup>Timely removal  Yes  No  Unk/NA  
<sup>71</sup>Types  Solid  Hazardous  Medical  Unk/NA

**IX. CHILDCARE AREA**

<sup>72</sup>Clean diaper-changing facilities  Yes  No  Unk/NA  
<sup>73</sup>Hand-washing facilities available  Yes  No  Unk/NA  
<sup>74</sup>Adequate toy hygiene  Yes  No  Unk/NA  
<sup>75</sup>Safe toys  Yes  No  Unk/NA  
<sup>76</sup>Clean food/bottle preparation area  Yes  No  Unk/NA  
<sup>77</sup>Adequate child/caregiver ratio  Yes  No  Unk/NA  
<sup>78</sup>Acceptable level of cleanliness  Yes  No  Unk/NA

**X. SLEEPING AREA**

<sup>79</sup>Adequate number of cots/beds/mats  Yes  No  Unk/NA  
<sup>80</sup>Adequate supply of bedding  Yes  No  Unk/NA  
<sup>81</sup>Bedding changed regularly  Yes  No  Unk/NA  
<sup>82</sup>Adequate spacing  Yes  No  Unk/NA  
<sup>83</sup>Acceptable level of cleanliness  Yes  No  Unk/NA

**XI. COMPANION ANIMALS**

<sup>84</sup>Companion animals present  Yes  No  Unk/NA  
<sup>85</sup>Animal care available  Yes  No  Unk/NA  
<sup>86</sup>Designated animal area  Yes  No  Unk/NA  
<sup>87</sup>Acceptable level of cleanliness  Yes  No  Unk/NA

**XII. OTHER CONSIDERATIONS**

<sup>88</sup>Handicap accessibility  Yes  No  Unk/NA





January, 2010

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**I. BACKGROUND**

Building a competent, well-trained workforce of environmental, medical, and emergency response trained public health employees is a vital and necessary role for all local public health departments. Integrated training that reflects an all-hazard approach must include a thorough knowledge of the Incident Command System (ICS) as well as first responder-critical/crisis thinking, to enhance all aspects of public health across all levels of incident response. Developing training to accompany the all-hazards emergency approach is necessary to build a knowledgeable workforce, to improve staff confidence, and to minimize health threats during all public health-related emergencies.

Public health agencies have a major role in providing disease surveillance and intervention. The threat of biological terrorism, nuclear and/or radiological-type explosive devices has escalated the need for public health agencies to prepare for all types of emergency situations beyond the normal agency responsibilities and possibly beyond jurisdictional borders. Local public health departments must maintain their required and/or mandated programs and maintain a balance between these programs, staffing levels, and budgetary concerns in order to maintain required services.

A comprehensive training plan that complements the city-county all-hazard plan must provide a clear vision, anticipate responsibilities, and assure that resources are available to perform all necessary duties during any emergency response. The objective of this training plan is to define the strategies, tasks, and methods that will be used to meet the various training requirements for personnel attached to the local public health agencies in Region G. The goals and purpose of this training plan are:

1. To develop the skills and knowledge levels of all public health department individuals so they can perform their roles and responsibilities more effectively and efficiently.
2. Identifying the training needs of all individuals in the public health department and then developing and/or procuring training to address those identified needs.

3. Evaluate the current and future skill levels of all health department personnel and evaluate how  
to maintain those levels and to improve on those skill levels, as necessary.
4. Assist all employees with achieving all necessary Personnel Qualification Standards and Guidelines as well as required licenses that may be part of their job (position requirement).

## **II. INTRODUCTION**

### **1. Purpose**

The purpose of a Training Plan is to outline, in writing, the training goals of a department or division, as well as specific individuals within that department or division. The Region G Public Health training plan establishes procedures for the planning, development, implementation, tracking and maintaining the training program curriculum for the health departments and their respective staffs.

It is essential that public health department employees are trained in core public health competency areas such as emergency preparedness and response. As disaster service workers, public health employees serve as first responders during a public health emergency or natural disaster. Therefore, it is critical that public health employees have the skill level and proficiencies to respond efficiently to natural disasters, man-made disasters, and other public health threats.

This training plan is developed and will consist of two levels:

(1.) Departmental Training – This area of the plan has yet to be developed. This type of training will encompass the entire organization; everyone in the department will receive training in this category. It consists of:

- Continuing Training Goals
- New Training Goals
- Completed Goals

(2.) Specific Training [Individual Training] – this type of training will be specific (job-related training) specific individuals and/or work groups; i.e. Environmental Specialists will receive specific types of job-related training, Public Health Nurses will receive specific types of job-related training, etc.

### **1. Scope**



- a. This training plan will address priority training needs of the local public health agencies in Region in Emergency Preparedness and response and Core Public Health Competencies.
- b. The provisions of this document apply to all health department personnel assigned to the local public health agencies in Region G.

### **3. Objectives**

The objective of this training plan is to define the strategies, tasks and methods that will be used to meet the training requirements that have been identified by the health departments. Specifically:

- a. Assist employees in acquiring and maintaining the knowledge, skills and abilities to  
provide quality services to citizens of counties in Region in the most efficient and economical means possible.
- b. Provide employees with opportunities for personal growth and professional development.
- c. Prepare employees to assume broader responsibilities, adapt to mandated changes, and improve performance across the board.
- d. A wide variety and type of training undertaken by public health personnel will increase the number of public health workers that are prepared to fulfill their personal roles within their respective health department as well as other assigned roles within the first responder community.

### **4. Planning Principles**

Various man-made emergencies and disasters, natural disasters, and general health-related training scenarios were considered to form the basis for this plan. Because of this, multiple assumptions had to be made. The applicability of this plan is predicated on the fact that the local public health agencies within Region G will be expected to be an integral part of the county command structure in times of peril and will be expected to respond fully.

### **5. Training and Development**

Training and development can be initiated to address:

- a. A Performance Gap: learning needed to meet performance standards for a current task or job.
- b. A Growth Gap: learning needed to achieve career goals.
- c. An Opportunity Gap: learning needed to qualify for an identified new job or role.

## **1. Types of Training**

- a. On-the Job Training
- b. Seminars
- c. Workshops
- d. Attendance at Professional Meetings/Conferences/Training Venues
- e. On-Site Training – (using on-line/Internet assets and/or having trainers come in)
- f. Outside Training – (attending training away from the work place)
- g. In-Service Training

## **7. Target Capability Priorities**

The local public health agencies within Region G will focus on training that is required as part of the State Department of Health and Senior Services (DHSS) Public Health Grant, as well as additional pertinent public health and/or emergency management type training that may be recommended by DHSS, SEMA and/or FEMA.

## **8. Assumptions**

The training strategies, activities, and methods are predicated upon the following assumptions:

- a. Competencies can be acquired through formal training, but also through experience, performance support systems, and on-the-job training. In formal training programs, acquiring competency may require that classroom experience be applied and/or utilized.
- b. Much of the public health development program will be competency based, but there is no single uniform curriculum either in formal academic settings or in agency settings that will be followed.
- c. Competency statements will not make a distinction between “academic” and “practice” acquired knowledge and skills. They will link theory and research (academic learning) with the execution of work (experience and skill).
- d. Individual competencies intersect with, but do not replace organizational performance standards and organizational capacities. Organizations cannot meet performance standards if workers are not appropriately competent.
- e. Competency statements written with the workplace in mind, express a standard level of worker performance. Performance is intended to be measured over a period of time, not at the end of a specific training topic or subject.
- f. Training topics and competencies need to be routinely updated as science evolves or as new subject matter is presented into the public health arena.

What is a Competency: Broadly defined, competencies are “actions which are observable in the execution of one’s work. Competencies are *applied skills and knowledge* that enable people to perform work.

## **9. Review and Update of Training Plans**

Training plans should be reviewed and updated on a regular basis. A twelve (12) month cycle will be established. The review and update process allows the Departmental Training Manager to observe how things are going, review any new training needs that may have arisen since the last training plan was issued, and reassess priorities on continuing training goals.

If training is to play an important part in the management and operation of the health department, it must be examined on a regular basis and be an active, on-going process.

Individual Training Plans should be reviewed at the same time as other Departmental Training Plans. However, if a training need is discovered between regularly scheduled training reviews, this new training need will be added to the individual’s training plan and that person’s training program will be modified accordingly.

## **10. Monitoring a Training Plan**

The details of the Training Plan will be monitored and amended where required. Changes to the training plan may include, or may need to include:

- the time frames to complete training or the competencies may have changed
- the delivery modes that were used to do the training may have changed
- the person responsible for training may have change
- the competencies to be obtained may have changed
- entire training systems may have changed (i.e. ICS/NIMS, etc.)

Changes should be made to the Training Plan as often as needed. The Training Plan should also provide evidence that training and assessment is progressing satisfactorily and be entered on the Change Page of this plan.

## **11. Training Evaluation**

All training will be evaluated to ensure that learning has occurred. Participant surveys, pre-and post-tests, focus groups, and exercises and drills will be utilized to evaluate specific training courses as well as directly observing improvements in individual’s performances.

## **12. Training Records**

Training Records are a continuous record of all training that an individual completes. They will be maintained by the Departmental Training Manager. All training that an individual completes will be entered into their respective training record, and can move with the individual as he or she transfers to another job.

### **13. Constraints**

The following items may be considered constraints as part of the training plan, and need to be considered when planning for and scheduling departmental / divisional training:

- a. Training costs
- b. Travel
- c. Time to do formal (classroom) training
- d. Time to do informal (on-line) training
- e. Availability (or in-availability) of instructors
- f. Proper location to conduct training

## **III. ROLES AND RESPONSIBILITIES**

### **A. Health Department Administrator/Director**

Plans, directs, manages and evaluates the use of health services resources and personnel on an agency/organizational level. The Health Department Administrator/Director will:

- Assess the short-term and long-term training needs of their department and develop a training plan to meet those needs.
- Ensure that a training needs assessment is conducted in to ensure proper and necessary training is scheduled and conducted to help staff meet their own training needs.
- Ensure that personnel in his/her department that require specific licensing and/or certification, are given proper training to keep their specific licensing/certification current at all times.
- Develop a training program prioritizing those training needs that have been identified, including an estimated budget.
- Conduct, supervise, monitor and evaluate departmental training activities.
- (As required), ensure that a yearly departmental training activity tabulation is sent to the State Department of Health and Senior Services showing all training that has been given within the department as well as all training that has been received by departmental personnel.

## **B. Health Department Divisional Directors**

Plans, directs, manages and implements all public health programs under their respective division or area of responsibility. The Health Department Divisional Directors will:

- Assess the short-term and long-term training needs of their division and develop a training plan

to meet these needs.

• Ensure that all personnel under their direct supervision fill out a training needs assessment questionnaire and return it to the Training Manager to make sure their training needs and/or desires are made known.

- Conduct, supervise, monitor and evaluate divisional training activities.

• Develop a training program prioritizing those training needs that have been identified, including an estimated budget; present to Department Head in a timely manner.

• (As required), ensure that personnel in his/her division that require specific licensing and/or certification, are given proper training to keep their specific licensing/certification current at all times.

## **C. Health Department Training Manager(Assigned to existing staff)**

Develop and conduct a Training Needs Assessment as part of this training plan in an effort to address all areas of training, licensing, and certification that need to be considered for personnel in the health department. The Health Department Training Manager will:

- Conduct, supervise, monitor and evaluate all departmental and divisional training activities.
- Ensure that a training needs assessment is conducted to ensure proper and necessary training is being scheduled and conducted in order to help departmental members meet their own necessary training needs.
- Develop and update, on a regular basis, the curricula of all public health-related education programs in cooperation with all stakeholders.
- Assist in the formulation of general training and development strategy on matters of public health and management.
- Track training undertaken by different divisions within the health department and maintain proper training records for all personnel.

- Continuously assess the staff needs for in-service training in public health as well as other pertinent topics, conduct/organize trainings within the department as well as outside the department.
- Plan, prepare and disseminate training materials related to public health and other necessary topics, to all personnel within the health department.
- (As required), ensure that a yearly departmental training activity tabulation is sent to the State Department of Health and Senior Services showing all training that has been given within the department as well as all training that has been received by departmental personnel. Work with the Training Committee to ensure this is complete.

**D. Health Department Employees**

Will make known to their direct supervisor, all training needs they are required to have (yearly) as well as additional training needs they would like to see implemented. They will also ensure that any license and/or certification they are required to maintain, is known by their direct supervisor, specifically, so any costs can be captured in the yearly budget.

## ANNEX – A

### **PHASE-1: Required Training for Health Department Personnel**

#### **A. Administrators, Regional Emergency Planner and Regional Epidemiology Specialist:**

1. IS-700.a Introduction to the National Incident Management System  
Online
2. IS-800.b Introduction to the National Response Plan  
Online
3. IS-100.a Introduction to the Incident Command System  
Online
4. IS-200.a Basic Incident Command System  
Online
5. IS-300 Intermediate Incident Command System [classroom]  
24-hours
6. IS-400 Advanced Incident Command System [classroom]  
16-hours
7. (IS-808/ESF#8) “Public Health and Medical Services”  
Online

#### **B. Environmental Health Staff:**

- |   |          |
|---|----------|
| 1. IS-700.a Introduction to the National Incident Management System | Online   |
| 2. IS-800.b Introduction to the National Response Plan              | Online   |
| 3. IS-100.a Introduction to the Incident Command System             | Online   |
| 4. IS-200.a Basic Incident Command System                           | Online   |
| 5. IS-300 Intermediate Incident Command System [classroom]          | 24-hours |
| 6. IS-400 Advanced Incident Command System [classroom]              | 16-hours |
| 7. (IS-808/ESF#8) “Public Health and Medical Services”              | Online   |

**C. Medical Staff: [RN Supervisor]**

1. IS-700.a Introduction to the National Incident Management System  
Online
2. IS-800.b Introduction to the National Response Plan  
Online
3. IS-100.a Introduction to the Incident Command System  
Online
4. IS-200.a Basic Incident Command System  
Online
5. IS-300 Intermediate Incident Command System [classroom]  
24-hours
6. IS-400 Advanced Incident Command System [classroom]  
16-hours
7. (IS-808/ESF#8) “Public Health and Medical Services”  
Online

**E. WIC Personnel or other Administrative Assistants:**

8. IS-700.a Introduction to the National Incident Management System  
Online
9. IS-800.b Introduction to the National Response Plan  
Online
10. IS-100.a Introduction to the Incident Command System  
Online
11. IS-200.a Basic Incident Command System  
Online



**ANNEX – B**

**PHASE 2:            Recommended Training for Health Department Personnel**

A.     The following Health Department personnel should take the below listed courses in an effort to assist them in developing their necessary “First Responder” skills and better prepare them for their first responder roles:

- 1.) Administration-Senior Staff personnel
- 2.) Environmental Health and Epidemiology personnel
- 3.) Medical Staff personnel
- 4.) Animal Control personnel
- 5.) Emergency Preparedness/Epidemiology personnel

<b><u>“Professional Development Series” (PDS):</u></b>			
--	--	--	--

1.	Exercise Design (FEMA)	(IS-139)	Self-Study
2.	Principles of Emergency Management	(IS-230)	“
3.	Emergency Planning	(IS-235)	“
4.	Leadership & Influence	(IS-240)	“
5.	Decision Making & Problem Solving	(IS-241)	“
6.	Effective Communication	(IS-242)	“
7.	Developing & Managing Volunteers	(IS-244)	“

*All seven courses have to be completed.* You receive a certificate for each course and once you complete all of them, you submit a letter and a copy of all of the certificates to FEMA (Emergency Management Institute) and they send you a very nice certificate showing that you completed the entire “Professional Development Series.”

**B.   Specific Training:    Medical-Epidemiology Courses/Training Classes**

[For Nurses, Epidemiologist, Communicable Disease Specialists (Nurses), etc.]

1.     Principles of Epidemiology (classroom)  
[2 days]
2.     MOHSIS / WEBSURV (classroom)  
[1 day]
3.     ESSENCE (classroom)  
[1 day]

4. Epi-Ready Training/Workshop (classroom)  
[2 days]
  
5. Laboratory Specimen Training (classroom)  
[1 day]
  
6. “Focus on Field Epidemiology” (online)
  
7. Health Agency Training: “Introduction to Basic Epidemiology” (classroom)  
[2 days]
  
8. “Community Health Assessment and Intervention Planning” (classroom)  
[1 day]

## ANNEX-C

### PHASE – 3: “Other” Recommended Training

**“Advanced Professional Development Series” (APDS):**

Required Courses: (All Required Courses have to be completed)

1. EOC Management & Operations FEMA	(G-275)	SEMA and/or
2. ICS/EOC Interface	(G-191)	“
3. Rapid Assessment Workshop	(G-250.7)	“
4. Recovery from Disaster (Local Gov’t Role)	(G-270.4)	“
5. Mitigation Planning Workshop (Local Govt’s)	(G-318)	“

Elective Courses: (Choose Any 5)

1. Donations Mgmt. Workshop FEMA	(G-288)	SEMA and/or
2. Multi-Hazard Emergency Plng. (for schools)	(G-362)	“
3. Emergency Plng. & Special Needs Populations FEMA	(G-197)	SEMA and/or
4. Debris Mgmt.	(G-202)	“
5. Mass Fatalities	(G-386)	“
6. Exercise Program Manager	(G-137)	“
7. Flood Fight Operations	(G-361)	“
8. Emerg. Mgmt. Ops. (for Local Gov’t)	(G-110)	“
9. Homeland Security Plng. (for Local Gov’t)	(G-408)	“
10. Community Mass Care Mgmt.	(G-108)	“
11. Evacuation & Re-Entry Plng.	(G-358)	“
12. Basic PIO	(G-290)	“
13. Hazardous Weather & Flood Preparedness	(G-271)	“
14. Warning Coordination	(G-272)	“

Ten (10) Courses have to be complete. Again, like the PDS Series, you will receive a certificate

of completion for each course completed and a final certificate showing that you completed the “Advanced Professional Development Series” (APDS). When you have completed the series, requests for the Certificate of Completion must be sent first to SEMA for agency verification. They will forward all of the paperwork to FEMA / Emergency Management Institute (EMI) who will in turn send the Certificate back to SEMA for the State Directors signature and they will forward to student.

## ANNEX – D

### PHASE-4: “ADDITIONAL” RECOMMENDED COURSES

Additional “Recommended” Courses offered through FEMA (on-line) and/or the Missouri State Emergency Management Agency (SEMA) or the Department of Health and Senior Services (DHSS) throughout various areas of the state:

FEMA ON-LINE COURSES: (...Not in any particular order...)

1. IS-703 “NIMS Resource Management”
2. IS-271 “Anticipating Hazardous Weather & Community Risk”
3. IS-22 “Are You Ready? An In-Depth Guide to Citizen Preparedness”
4. IS-26 “Guide to Points of Distribution”
5. IS-100HC “Introduction to ICS for Health Care”
6. IS-120a “An Introduction to Exercises”
7. IS-130 “Exercise Evaluation and Improvement Planning”
8. IS-139 “Exercise Design”
9. IS-197EM “Special Needs Plng. Considerations for Emergency Mgmt.”
10. IS-197SP “Special Needs Plng. Considerations (Service & Support Providers)”
11. IS-288 “The Role of Voluntary Agencies in Emergency Mgmt.”
12. IS-346 “An Orientation to HazMat for Medical Personnel”
13. IS-546 “Continuity of Operations (COOP) Awareness”
14. IS-547 “Introduction to Continuity of Operations (COOP)”
15. IS-701 “NIMS Multi-Agency Coordination Systems”
16. IS-702 “NIMS Public Information Systems”
17. IS-706 “NIMS Intra-State Mutual Aid, an Introduction”
18. IS-775 “EOC Management & Operations”
19. IS-814 “Emergency Support Function (ESF #14) – Long Term Recovery”

There are many other FEMA course offerings – they add new courses all of the time; they also revise many courses to keep them current. Visit: <http://www.training.fema.gov>.

**SEMA COURSES OFFERED – ( THROUGHT THE STATE OF MISSOURI):**

(.....some have been identified in previous sections listed above.....)

- |                   |   |          |
|-------------------|---|----------|
| 1.G-290<br>days]  | “Basic Public Information Officer” (classroom)                    | [2.5     |
| 2.G-108<br>days]  | “Community Mass Care Management” (classroom)                      | [2       |
| 3.G-240           | “Leadership & Influence’ (classroom)                              | [1 day]  |
| 4.G-241           | “Decision Making & Problem Solving” (classroom)                   | [1 day]  |
| 5.G-244           | “Developing & Managing Volunteers” (classroom)                    | [1 day]  |
| 6.G-242           | “Effective Communications” (classroom)                            | [1 day]  |
| 7.G-197<br>days]  | “Emerg. Plng. for Special Needs Populations” (classroom)          | [2.5     |
| 8.G-235           | “Emergency Planning” (classroom)                                  | [2 days] |
| 9.G-358<br>days]  | “Evacuation & Re-Entry Planning” (classroom)                      | [1.5     |
| 10.<br>[2 days]   | G-125 “Exercise Design & Evaluation” (classroom)                  |          |
| 11.<br>[3 days]   | AWR-201 “Intro to SNS & Mass Prophylaxis” (classroom)             |          |
| 12.<br>[2.5 days] | G-240 “Mass Fatalities & Incident Response” (classroom)           |          |
| 13.<br>[2 days]   | MO-7 “Medical Considerations” (classroom)                         |          |
| 14.<br>[2 days]   | G-230 “Principles of Emergency Management” (classroom)            |          |
| 15.<br>[2 days]   | MGT-318 “Public Info in WMD/Terrorism Incidents” (classroom)      |          |
| 16.<br>[2 days]   | G-276 “Resource Management” (classroom)                           |          |
| 17.<br>[2 days]   | MGT-312 “Senior Officials Workshop: All Hazards Prep” (classroom) |          |
| 18.<br>[2 days]   | G-270.4 “Recovery from Disaster: Local Gov’t Role” (classroom)    |          |

19.

**APPENDIX – E**  
**SITES WHERE TRAINING and ONLINE TRAINING ARE**  
**OFFERED**

The following sites (listed below) offer on-line training that may be required to be complete by health department personnel (in some cases), and/or may be utilized as a means of accomplishing training by health department personnel:

United States Department of Health and Human Services (DHHS):  
<http://www.hhs.gov/emergency/index.shtml> (follow the various links)

Emergency Management Institute – FEMA Independent Study (IS) Program:  
<http://training.fema.gov> (follow the various links for ICS/NIMS courses, other IS courses, etc.)

Missouri State Emergency Management Agency (SEMA): <http://training.dps.mo.gov>  
(all SEMA classes are classroom delivered in various areas around the state).

Public Health Foundation: <http://www.phf.org> or <https://www.train.org>

University of Albany (New York) School of Public Health: <http://www.ualbanycph.org>  
(e-Learning Center/ Center for Public Health Preparedness).

Yale New Haven Health Center for Emergency Preparedness and Disaster Response  
(Online Education and Training): <http://ynhhs.emergencyeducation.org>

Center for Disease Control and Prevention (CDC) [Public Health Training Network (PHTN)]: <http://www2a.cdc.gov/PHTN/sites.asp> also:  
<http://emergency.cdc.gov/training> (both of these sites also link you to other training sites).

The Northwest Center for Public Health Practice: (you can get CE's through this site for a small fee). [http://www.nwcpheo.org/training/courses-exercises/index\\_html](http://www.nwcpheo.org/training/courses-exercises/index_html)

University of Minnesota School of Public Health (Center for Public Health Preparedness): <http://cpheo.sph.umn.edu/umncphp/phet/home.html>

St. Louis University (SLU) Heartland Centers:  
<http://heartlandcenters.learnpublichealth.com>

Texas Engineering Extension Service (TEEX) [Texas A&M University System]:  
<http://teexweb.tamu.edu> (follow the various links)

Humane Society of the United States [Humane Society University]:  
<http://www.humanesocietyu.org> (follow the links).

National Center for Biomedical Research and Training (HCBRT) – [eLearning]  
Louisiana State University (LSU): <http://www.ncbrt.lsu.edu/eLearn./Default.aspx>  
(follow the links).



Missouri Department of Health and Senior Services (DHSS): [ESSENCE and MOHSAIC]  
<http://www.dhss.mo.gov/ESSENCE/Training.html>  
[http://www.dhss.mo.gov/MOHSAIC\\_Training.html](http://www.dhss.mo.gov/MOHSAIC_Training.html)