



2014

**State of New Hampshire
Ebola Response Plan**

12/22/14

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Terms and Definitions

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

BEMS: Bureau of Emergency Medical Services

BIDC: Bureau of Infectious Disease Control

CDC: Centers for Disease Control and Prevention

Close Contact

- a) Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment for standard, droplet, and contact precautions
- b) Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended PPE

Confirmed Case: Positive polymerase chain reaction (PCR) lab test results from the CDC

Contact Tracing: Conducted by infectious disease Epidemiology team and CDC team; finding everyone who comes in direct contact with an infectious Ebola patient

DES: Department of Environmental Services

DHHS: Department of Health and Human Services

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

DoD: Department of Defense

DOJ: Department of Justice

DOS: Department of Safety

DPHS: Division of Public Health Services

DRC: Disaster Response Coordinator

EMS: Emergency Management System

ESF: Emergency Support Function

EUA: Emergency Use Authorization

EVD: Ebola Virus Disease

HAN: Health Alert Network

HazMat: Hazardous Materials

HSEM: Homeland Security & Emergency Management

IMT: Incident Management Team

Isolation: Symptomatic; and in isolated setting in a medical setting or in a home setting

JIC: Joint Information Center

Low/Negligible Risk: The rationale for the use of this term by DPHS is that the exposures listed under “Low” risk represent a negligible risk for EVD, and so from a messaging standpoint, DPHS prefers the term negligible.

LRN: Laboratory Response Network

NHSP: New Hampshire Division of State Police

PCR: Polymerase Chain Reaction

PIO: Public Information Office

PPE: Personal Protective Equipment

PSAP: Public Safety Answering Point (9-1-1)

Quarantine (Confinement): Non-symptomatic; exposed to the disease: confined for the duration of the incubation period which is 21 days for Ebola.

SEOP: State Emergency Operations Plan

SME: Subject matter expert

Suspect Case: A person under investigation for Ebola who has signs and symptoms that may be consistent with Ebola AND has traveled to Ebola-affected country(ies) within 21 days.

UC: Unified Command

VOAD: Voluntary Organizations Active in Disaster

WebEOC: Web Emergency Operations Center: An online tool used for information sharing and resource request tracking during emergencies, disasters, significant events and daily operations.

Subject

Ebola is a virus that has worldwide consequences. Confirmed or suspected cases of Ebola virus disease (EVD) present special requirements for disease surveillance, public communications, allocation of medical resources, and expansion of human services.

Background

The 2013-2014 Ebola epidemic is the largest in history, affecting multiple countries in West Africa. There has been one patient who acquired infection in Liberia and developed disease in the United States (US), and his care was associated with spread to two healthcare workers. The Centers for Disease Control and Prevention (CDC) and partners are taking precautions to prevent the further spread and importation of Ebola within the US. However, there remains a risk that persons exposed to Ebola may travel from the affected countries to the US.

1. The likelihood of contracting Ebola is extremely low unless a person has direct unprotected exposure to the body fluids (i.e., blood, urine, saliva, feces, vomit, sweat, breast milk, and semen) of a person with Ebola, or has direct handling of bats or nonhuman primates from areas where Ebola is endemic.
2. Initial signs and symptoms of Ebola include fever, chills, muscle aches, and weakness, progressing to diarrhea, nausea, vomiting, and abdominal pain. Other symptoms such as chest pain, shortness of breath, maculopapular rash, headache, or confusion may also develop. Abnormal bleeding, shock, and multi-organ failure can also occur as later complications. Symptoms can develop anywhere from 2 to 21 days after exposure.
3. Ebola should be considered in anyone with fever or other compatible symptoms who has traveled to, or lived in, an area where Ebola transmission is occurring. Patients with Ebola infection are not contagious until they are symptomatic; patients without symptoms are not contagious. To prevent the spread of Ebola, precautions need to be taken to avoid exposure of blood or body fluids from an infected patient with non-intact skin or mucous membranes (of the eyes, nose, or mouth), or through percutaneous (puncture of the skin) exposure from contaminated needles or other sharp objects.

All New Hampshire (NH) healthcare facilities and healthcare providers must be able to promptly identify and isolate any patient presenting with signs and symptoms consistent with Ebola who also has a consistent travel history. All acute care hospitals need to have the capability to identify, isolate, and inform the Division of Public Health Services (DPHS) of a suspect case of Ebola in order to manage a suspect case. Coordination among NH e9-1-1, the emergency management system (EMS), healthcare facilities, and the public health system is critical when responding to cases with suspected Ebola. Each EMS system should include an EMS medical director to provide appropriate medical supervision.

Purpose

The intent of the Ebola Response Annex to the NH State Emergency Operations Plan (SEOP) is to provide general guidance to municipal, State, and Federal governments and all stakeholders in the preparation of plans specific to an Ebola response. The specific purposes of this document are as follows:

1. Protect life and property
2. Minimize exposure particularly in the following sectors:
 - a. Healthcare providers and facilities
 - b. Faith-based and non-governmental organizations—due to missionary/humanitarian efforts in affected countries
 - c. Ports, airports
 - d. First responders and other emergency medical personnel
 - e. Schools, particularly those of higher learning, as students and faculty may be from, or study in, West Africa
3. Conduct active medical and public health vigilance to identify and isolate symptomatic cases
4. Identify consequence management steps for confirmed case(s) and their contacts
 - a. Pathway 1: Symptomatic patients who enter the healthcare system
 - b. Pathway 2: Asymptomatic household contacts who may be quarantined in their home(s)
5. Support a rapid, effective, and coordinated response
6. Collect and disseminate accurate incident and public information to inform decision making, dispel rumors, and promote public awareness and understanding

Assumptions

1. Local governments have the primary responsibility to provide initial emergency response and EMS within their jurisdictions.
2. State government may provide and/or augment emergency response services that exceed the capabilities of local governments as per the SEOP.
3. In the response to a confirmed case of Ebola in NH, the Governor or the Commissioner of NH Department of Health and Human Services (DHHS) will activate the SEOP under the direction of the Director of Homeland Security & Emergency Management (HSEM).
4. The State Emergency Operations Center (SEOC) will be activated to the appropriate level.
5. Unified Command (UC) will assemble immediately to set response actions in motion.
6. Joint Information Center (JIC) will be activated and operated in accordance with the State JIC Plan.
7. Municipal conference calls will be conducted to obtain and provide information and guidance. HSEM will maintain continual contact with affected State and local response agencies and healthcare providers ensuring an immediate and coordinated response.

8. DPHS will activate the DPHS Incident Management Team (IMT) and assume the lead role in the response.
9. DPHS will issue Health Alert Network (HAN) messages and conduct clinician conference calls.
10. WebEOC will facilitate immediate support requested by and/or for local and State agencies.
11. The Governor will issue a Public Health Emergency Incident declaration in the event of a confirmed case.
12. State and local public health departments will help to coordinate care and management of Ebola patients, in close partnership with the CDC and the Department of Defense (DoD) as needed.
13. The likelihood of one Ebola case is low; the plan does not characterize Ebola response as a mass fatality incident.
14. The United States Coast Guard will provide information on any ship or crew with suspected illness or hazardous condition that is coming into, or attempting to come into, the Port of Portsmouth.
15. The Canada Border Services Agency routinely assesses people arriving in Canada for signs of illness. Travelers arriving from the affected countries are referred to the Public Health Agency of Canada Quarantine Officer for a screening. As of 10/31/2014, officials in Canada will not process new visa applications or continue processing for people who were in the affected countries within 3 months prior to the application being received.

Concept of Operations

Key Stakeholders

- Local Emergency Management Directors
- Local EMS
- e911
- Local Fire Service
- Local law enforcement agencies
- Local Health Departments
- Local Funeral Homes
- Local healthcare facilities and healthcare personnel providing care for the Ebola patient
- Faith-based or humanitarian organizations
- Media
- Department of Health and Human Services
 - Division of Public Health Services
 - Emergency Services Unit
 - Public Health Networks
 - Public Information Office
- Department of Safety
 - Division of Homeland Security & Emergency Management
 - Division of Fire Standards and Training and Emergency Medical Services
 - Division of Fire Safety
 - Division of State Police
 - Division of Emergency Services and Communications
- Department of Education
- Department of Environmental Services
- Department of Justice
 - Office of the Chief Medical Examiner
 - Office of the Attorney General
- State and Federal (Health and Human Services/CDC) Emergency Support Function (ESF) 6/8 partners
- U.S. Centers for Disease Control and Prevention

Phase 1: Identification and Investigation of Suspect Ebola Cases

- Healthcare providers at a local healthcare facility, EMS providers, or e9-1-1 telecommunications identify a suspect Ebola patient based on presenting signs and symptoms with a consistent travel history to an affected country with active Ebola virus disease (EVD) transmission. Suspect cases may also be identified by Public Health staff during daily monitoring of persons potentially exposed to Ebola (travelers returning from Ebola-affected countries or others with contact to an Ebola case).
- The healthcare provider immediately isolates the patient, provides them with a mask in a single room, and immediately reports the suspect case to the NH DHHS Division of Public Health Services (DPHS), Bureau of Infectious Disease Control (BIDC), at 603-271-4496 or after hours at 603-271-5300. The healthcare provider should not have direct contact with the suspect EVD patient without appropriate personal protective equipment (PPE).
- DPHS will determine if the suspect patient should be tested for EVD using the conditions below:
 1. DPHS determines whether the suspect case requires Ebola testing at a CDC-certified Laboratory Response Network (LRN) Lab. If DPHS determines that testing is warranted based on risk factors and signs/symptoms of illness, then the individual is immediately identified as a suspect case of Ebola. Patient will then be maintained in isolation with necessary PPE, and patient will be transported to a local or designated hospital for further evaluation, testing, and management (if not already there).
 2. The hospital will collect and properly package a blood sample for transport to an LRN lab certified in Ebola testing, with additional samples sent to the CDC. DPHS will coordinate this transport.
 3. Test results can take up to 24 hours to be reported.
 4. Lab results will be sent to DPHS.
 5. DPHS will then share the results with the healthcare provider and hospital. These notification procedures are shown later in this document.
 6. Because the EVD test can be negative during the early symptomatic period, if the first test result from a suspect case has been symptomatic for less than 72 hours is negative, a second Ebola blood test is required ≥ 72 hours after the onset of symptoms.
 7. The suspect case who has been symptomatic will remain in isolation with all healthcare workers using appropriate PPE while awaiting test results.

Phase 2: Notification Process for a Suspect Case of Ebola

- The State Director of Public Health/State Epidemiologist will immediately alert and activate the DHHS Incident Command Center and the DPHS Incident Management Team, HSEM, and Manchester and Nashua Health Department Directors.
- DPHS will notify the healthcare facility and healthcare provider caring for a suspect Ebola patient and will consult to coordinate care and management.
- DPHS will alert the CDC Emergency Operations Center to request additional assistance and resources.
- HSEM will immediately inform the Governor and ESF partners.
- DPHS will alert all Subject Matter Experts (SMEs) and Public Health Regions.
- A Joint Information Center (JIC) will be activated through the SEOC to:
 1. Coordinate information to be released among state PIOs, Governor's office, and federal partners.
 2. Develop press releases.
 3. Develop consistent risk communication that can be used by partners including other State PIOs and local officials
 4. Disseminate appropriate information to the public and news media
 5. Monitor and use social media
 6. Update appropriate website(s) and WebEOC
 7. Coordinate media inquiries and manage media on scene
 8. Coordinate press conferences
- Healthcare and emergency response partners will be alerted through the HAN.

Phase 3: Response

Response for a Suspect Case

The patient will remain in the hospital facility under isolation, and healthcare personnel will wear appropriate PPE.

- Hospital will manage care and be responsible for patient's waste, etc. (see Appendix 5 Guidance on Infectious Waste).
- Facility transfer may occur depending upon the patient's clinical status and hospital resources. A decision on this will be made in consultation with DPHS.
- Any persons/contacts who are not ill but were potentially exposed to the suspect Ebola patient while s/he was symptomatic will be monitored by DPHS, Manchester Health Department, and Nashua Health Department staff in their respective jurisdiction for 21 days following their last possible exposure. (See Appendix I Interim Policy Summary for Isolation of Suspect Ebola Patients and Quarantine of Persons Potentially Exposed to Ebola Virus, November 10, 2014).

Response for a Confirmed Case

- If a patient is confirmed to have infection with Ebola, further investigation and response is required for all contacts, including pets. This includes evaluation of healthcare personnel who may have cared for the patient during the infectious period of EVD and investigation into airline or other travel contacts if appropriate. CDC will assist DPHS with the case investigation and contact tracing. Risk categories are outlined below and adapted from CDC guidance dated October 28, 2014.

Response for High-Risk Contacts to a Confirmed Case of Ebola

- High-risk contacts are determined by DPHS with assistance from the CDC.
- High-risk contacts are defined as:
 - Percutaneous (i.e., needle stick) or mucous membrane exposure to blood or body fluids of a confirmed Ebola case.
 - Direct skin contact with, or exposure to blood or body fluids of, a confirmed Ebola case without appropriate PPE
 - Processing blood or body fluids of a confirmed Ebola case without appropriate PPE or standard biosafety precautions.
 - Direct contact with a dead body without appropriate PPE in a country where an Ebola outbreak is occurring.
 - Immediate household contact who provided care to a confirmed Ebola case while person was symptomatic.
- All high-risk contacts require mandatory quarantine with direct active monitoring for symptoms.
- Immediate household contacts will be provided essential provisions for 21 days after last exposure to the confirmed case.

Response for Contacts with Some Risk to a Confirmed Case of Ebola

- Some risk is defined as:
 - Direct contact with a confirmed Ebola case while using appropriate PPE in country with widespread Ebola transmission.
 - Brief direct contact (i.e., shaking hands) with a confirmed Ebola case early in disease without appropriate PPE.
 - Other close household contacts to a confirmed Ebola case (within 3 feet) while not wearing appropriate PPE.
- All contacts with some risk will be voluntarily quarantined with direct active monitoring for symptoms.
- Immediate household contacts may be provided essential provisions for 21 days post last exposure to the confirmed case.

Response for Low/Negligible Risk Contacts to a Confirmed Ebola Case

- Low/Negligible risk persons who do not require quarantine but will undergo DIRECT ACTIVE monitoring for symptoms include the following:
 - Direct contact with confirmed Ebola case while using appropriate PPE in country without widespread Ebola transmission (i.e., US-based healthcare workers).
 - Travel on an aircraft with a confirmed Ebola case (sitting within 3 feet or had direct contact with a confirmed Ebola case).
- Low/Negligible risk persons who do not require quarantine and will under ACTIVE monitoring for symptoms include the following:
 - Brief indirect contact (i.e., being in same room) with confirmed Ebola case without appropriate PPE.
 - Returning travelers from Ebola-affected countries with no specific exposure risk.
 - Travelers on an aircraft not sitting within 3 feet and not had direct contact with a confirmed Ebola case.
 - Monitoring by ESF 8 DHHS ICC of all contacts is described in Appendix 1.
 - Changes may occur on a case-by-case basis and as determined by DPHS in consultation with CDC.

Management of Household Environment and Contacts for Confirmed Ebola Case

- Special cleaning and disinfection will be needed when homes are contaminated with blood or body fluids from a person with confirmed Ebola. Consultation with DHHS/DPHS and CDC will take place if a confirmed case is diagnosed. Recommendations for the cleaning of household environment will be made based upon the most current CDC guidance.
- DHHS/ESF 8 will work in collaboration with Department of Environmental Services (DES) to identify professional cleaning contractors if needed. A professional cleaning contractor may be preferred to ensure safe and proper handling, packaging, and disposal of any items contaminated with blood or other body fluids and to ensure the health and safety of responders.
- For persons being monitored who have no symptoms, cleaning and laundering can be done as usual. No special cleaning or disinfection is needed unless that person develops symptoms and visibly contaminates an area with blood or other body fluids.
- DHHS/DPHS will coordinate management of contacts as described in the ESF 8 section.

Link for CDC's Ebola web-based PPE training: <http://www.cdc.gov/vhf/ebola/hcp/index.html>

Direction and Control

In the response to a confirmed case of Ebola in New Hampshire, the Governor will activate the State's Emergency Operations Plan (SEOP). Response to Ebola will be conducted in accordance the policies and procedures outlined in the SEOP, which is an all-hazards plan.

Organization/Assignments of Responsibilities by Emergency Support Function

These are a few examples of ESF responsibilities that may be pertinent for Ebola response; see the SEOP for a complete list of all responsibilities.

ESF 1 Transportation

- Prepares to assist local and state officials with traffic management
- Coordinates with public transportation services
- Keeps transportation corridors open for cases with massive quarantine requirements or illnesses within the workforce

ESF 4 Firefighting

- Provides local Fire Departments with situational awareness
- Provides local Fire Departments with best practices and protective measures
- Coordinates and provides assistance in response and mitigation

ESF 5 Emergency Management

- Unified Command will convene HSEM
- Activates State EOC to appropriate level
- Conducts municipal and regional conference calls to obtain and provide information
- Initiates WebEOC situational reporting and resource requesting from State, municipal and private sector agencies

Department of Safety

- Establishes activity code for tracking expenses
- Issues memorandum(s) to State agencies to track expenditures and report same into WebEOC

ESF 6 Mass Care & Sheltering

DHHS/DPHS

American Red Cross

- Provides comfort kits to quarantined persons
- Coordinates with Voluntary Organization Active in Disasters (VOAD) partners on a feeding plan
- Provides funding for prescription medications and medical equipment
- Coordinates with partner agencies to assist with support of quarantined families in order to handle non-Ebola medical needs

Workforce Commission

- Provides mass feeding support through established contracts (minimum 500 people to activate contracts)

Department of Education (DoE) (See Appendix 4, "Guidelines for School Administrators," for

additional school information.)

Determines continuity of education of quarantined school children

- Disseminates all Ebola educational information to the following, as needed:
 - Public Schools, Child Care Centers, Private Schools, Charter Schools, Colleges and Universities

ESF 7 Resource Support

- Ensures necessary contracts are in place

ESF 8 Health & Medical

DHHS/DPHS

- Acts as overall medical lead for all Ebola suspect and confirmed cases
- Monitors quarantined persons in coordination with Manchester and Nashua Health Departments
- Identifies needed provisions for persons under quarantine and coordinates with appropriate ESF
- Educates Hospitals and pre-hospital providers regarding treatment protocols, PPE levels, and handling of remains through development and dissemination of clinical guidance
- DPHS Bureau of Infectious Disease Control
 - Will notify federal and state agencies and healthcare providers of confirmed cases of Ebola
 - Conduct epidemiological investigation and initiate contact tracing with confirmation of a case
 - Determine and inform restricted level of movement for contacts based upon risk factors
 - Identify contaminated items and provide consultation for on scene decontamination in coordination with CDC, DHHS and DES
 - Conduct notifications and share situational updates to appropriate federal, state, regional and local partners
- Activates the Disaster Behavioral Health Response Team
- Bureau of EMS provides proper direction and level of PPE for responders to potential Ebola-related 911 calls
 - Educates pre-hospital providers on decontamination and current infection control procedures
 - Provides guidance on “just-in-time” training

ESF 10 HazMat

- Coordinates and disseminates Ebola guidance and information for regional HazMat teams
- Provides on-site command and control for all decontamination and remediation
- Removes or assists with all persons from contaminated sites as directed by DPHS
- Provides SMEs on decontamination procedures

ESF 11 Agriculture & Natural Resources

- Provides resource support to ESF 6 and 8
- Sheltering, transportation and care of pets of hospitalized or quarantined contacts will be conducted in facilities using methods approved by the State Veterinarian

ESF 13 Law Enforcement

Division of State Police

- Provides public safety utilizing law enforcement assets
- Provides escorts for transportation as needed on a case by case basis
- Department of Justice
- Supports ESFs with quarantine and isolation orders

ESF 14 Volunteer and Donations Management

- Coordinates volunteer groups to meet the needs of the incident

ESF 15 Public Information

- Coordinates with the Governor's Office and key Departments in the development and dissemination of information
- Establishes Joint Information Center (JIC)

Administration and Finance

- State agencies will track all related emergency expenses with supporting documentation
- State agencies will absorb all cost for their statutory and ESF responsibilities and seek supplemental budget and funding as needed

Appendix 1: Interim Policy Summary for Isolation of Suspect Ebola Patients and Quarantine of Persons Potentially Exposed to Ebola Virus, November 10, 2014

The purpose of isolation and quarantine is to control the spread of infectious diseases. Both are common practices in public health, and both aim to prevent the exposure of well persons to infected or potentially infected persons. Both may be undertaken voluntarily or compelled by authorities if necessary. This document provides a framework for isolation and quarantine decisions in New Hampshire for Ebola virus disease (EVD), however, modifications may occur on a case-by-case basis and the policy will be updated as the situation evolves.

Voluntary Isolation

Isolation is the separation of persons who are ill. Persons will be placed in isolation at a hospital if they have possible symptoms of EVD and have been potentially exposed to Ebola virus through travel or contact with an EVD case. Local officials will be notified.

Public Health Monitoring and Voluntary Quarantine

Quarantine is the separation and restriction of persons who, while not ill, may have been exposed to an infectious agent and therefore may become infectious. Quarantine can include a range of disease control strategies that may be used individually or in combination, including: short-term, voluntary home confinement; restrictions on travel by those who may have been exposed; and restrictions on passage into and out of a geographic area.

Persons who are not ill but were potentially exposed to Ebola virus will be monitored by public health authorities for 21 days following their last possible exposure. Public health monitoring will be based on residency of the person and will be performed by the NH Department of Health and Human Services, Division of Public Health Services (DPHS) and the cities of Manchester and Nashua Health Departments, who have authority for communicable disease control in New Hampshire.

Public health monitoring activities are divided into four categories:

Exposure Category	Quarantined at Home	Prohibited from Public Transport	Notification to Local Officials	Symptom Monitoring	Public Health Daily Check-In
High [†] Risk Exposure	YES [§] (mandatory)	YES	YES	YES	YES (direct active)
Some [‡] Risk Exposure	YES [§] (voluntary)	YES	YES	YES	YES (direct active)
Low/Negligible [*] Risk Exposure (close airline contacts [¥] and US-based healthcare workers)	NO ^{&®}	NO	NO	YES	YES (direct active)
Low/Negligible [*] Risk Exposure (all others)	NO ^{&®}	NO	NO	YES	YES (active)

[§] Non-congregate public activities for persons in quarantine may be approved on a case-by-cases if a 3-foot distance from others is maintained (e.g., jogging outside, etc.).[&] Attendance at large public gatherings and use of public transportation is discouraged. All travel outside of NH requires public health consultation and approval.

[®] The person will maintain a log of all activities for the 21 day time period, including a list of any close contacts.

[¥] Close airline contacts are those sitting within 3 feet of the symptomatic EVD case.

Direct Active: Check-in in-person or using visual virtual technology

Active: Check-in by phone call unless home visit or virtual technology is necessary on case-by-case basis

The federal government will notify DPHS of all travelers returning from Ebola-affected countries upon arrival in the US. Healthcare providers, other public health agencies, employers, and the public may also report returning travelers to DPHS at 603-271-4496 (after hours 603-271- 5300).

The assigned public health agency will make contact with the returning traveler to assess exposure history and assign the person to the appropriate public health monitoring category. The public health official will provide instructions to the traveler over the phone and will send a letter with instructions in writing. Persons with High or Some Risk exposures will be asked to sign a voluntary quarantine agreement.

The assigned public health agency will contact (in person or via phone depending on risk of exposure) potentially exposed persons every day to assess for symptoms, collect measured temperatures, and ensure the person is following all instructions.

For New Hampshire healthcare workers providing care to an Ebola patient in New Hampshire, DPHS will work closely with the hospital to identify all healthcare workers who had contact with the patient. Healthcare workers will be instructed on symptom monitoring. DPHS will work with the hospital to establish direct active symptom monitoring of the healthcare workers.

Exposure Definitions

Adapted with modification from CDC guidance dated November 28, 2014, available at:

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

[†]High-Risk Exposures:

1. Percutaneous or mucous membrane exposure to body fluids of symptomatic EVD patient
2. Direct contact with body fluids of symptomatic EVD patient without appropriate PPE
3. Processing body fluids of symptomatic EVD patient without appropriate PPE or standard biosafety precautions
4. Direct contact with dead body without appropriate PPE in country with widespread Ebola transmission
5. Immediate household contact who provided care to EVD case while person was symptomatic

[‡]Some Risk Exposures:

1. Direct contact with symptomatic EVD case while using appropriate PPE in country with widespread Ebola transmission
2. Brief direct contact (e.g., shaking hands) with symptomatic EVD case early in disease without appropriate PPE
3. Other close household contacts to symptomatic EVD case (within 3 feet) while not wearing appropriate PPE

^{*}Low/Negligible Risk Exposures:

1. Returning travelers from Ebola-affected countries with no specific exposures to virus
2. Brief indirect contact (e.g., being in same room) with symptomatic EVD case without appropriate PPE
3. Direct contact with symptomatic EVD case while using appropriate PPE in country without widespread Ebola transmission
4. Travel on an aircraft with a symptomatic EVD case (those sitting within 3 feet of the patient will have direct active monitoring and others will have active monitoring unless an individual had direct contact with the person)

Rationale for Exposure Definitions

The public health monitoring activities described in this document are based on the CDC *Interim Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure* dated October 28, 2014. DPHS officials have reviewed and carefully considered these guidelines carefully in developing the New Hampshire plan. In a few instances, DPHS has elected to deviate from the CDC guidance.

The specific items and associated rationale are described as follows:

1. Brief unprotected direct contact with an EVD case early in disease was moved from “Low” risk exposure to a “Some” risk exposure. The rationale for this change is that any direct contact with a symptomatic EVD case, regardless of the timing of onset of illness in relation to that contact, is higher risk for EVD than Low/Negligible.
2. Low risk exposure is described as “Low/Negligible” risk in this document. The rationale for this change is that the exposures listed under “Low” risk represent a negligible risk for EVD, and so from a messaging standpoint, DPHS prefers the term negligible.
3. In the CDC guidelines, movement restrictions for persons in the “Some” risk category are made case by case. In New Hampshire, DPHS will ask all persons in this risk category to voluntarily quarantine. The rationale for this policy is that persons in the “Some” risk category, while not at high risk, still have had direct contact with a symptomatic EVD patient without proper PPE. Risk is not negligible and so for the purposes of closer monitoring and to prevent risk to the public, we are asking the persons in the “Some” risk category to voluntarily quarantine themselves. If these persons refuse voluntary quarantine, no legal action will be taken unless there is imminent danger to the public, but DPHS will continue direct active monitoring on a daily basis and request that the person stays out of public places. They will also be restricted from public transportation.

Mandatory Isolation and Quarantine in New Hampshire

The Department of Health and Human Services has the legal authority in New Hampshire to issue mandatory orders of isolation and quarantine. The legal authority and processes for issuing and enforcing these orders under RSA 141-C are set forth in RSA 141-C:9,II; RSA 141-C:11; and RSA 141-C:12.

Legal orders will be pursued for all persons with suspect EVD who refuse voluntary isolation. If a suspect EVD case has not yet sought care for his or her illness and refuses to do so, a public health order will be served by a public health official and law enforcement may be called upon to assist with serving the order if needed. The person will be transported to a hospital via ambulance for medical evaluation.

Legal orders will also be pursued for all persons with “High-risk” exposures to EVD who refuse voluntary quarantine. The order will be served by a public health official, and law enforcement may be called upon to assist with serving the order if needed. If necessary, legal orders will also be pursued if a potentially exposed person does not comply with Direct Active or Active symptom monitoring.

Appendix 2: Guidance for Safe Handling of Human Remains of Ebola Patients in New Hampshire Hospitals and Mortuaries

State plans for addressing the handling of human remains of Ebola patients are to follow CDC Guidance, last updated December 15, 2014, available at:

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

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

- Only personnel trained in handling infected human remains, and wearing PPE, should touch, or move, any Ebola-infected remains.
- Handling of human remains should be kept to a minimum.
- Autopsies on patients who die of Ebola should be **avoided**. If an autopsy is necessary, DPHS and CDC should be consulted regarding additional precautions.

Definitions for Terms Used in this Guidance

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

Hermetically sealed casket: A casket that is airtight and secured against the escape of microorganisms. A casket will be considered hermetically sealed if accompanied by valid documentation that it has been hermetically sealed AND, on visual inspection, the seal appears not to have been broken.

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

Personal Protective Equipment for Postmortem Care Personnel

Personal protective equipment (PPE): Prior to contact with body, postmortem care personnel must wear PPE.

Putting on, wearing, removing, and disposing of protective equipment: PPE should be in place BEFORE contact with the body, worn during the process of collection and placement in body bags, and should be removed immediately after and discarded appropriately (see Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus at <http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html>).

Use caution when removing PPE as to avoid contaminating the wearer. Hand hygiene (washing your hands thoroughly with soap and water or using an alcohol-based hand rub) should be performed immediately following the removal of PPE. If hands are visibly soiled, use soap and water.

Postmortem Preparation

Preparation of the Body

At the site of death, the body should be wrapped in a plastic shroud. Wrapping of the body should be done in a way that prevents contamination of the outside of the shroud. Change your gown or gloves if they become heavily contaminated with blood or body fluids. Leave any intravenous lines or endotracheal tubes that may be present in place. Avoid washing or cleaning the body. After wrapping, the body should be immediately placed in a leak-proof plastic bag not less than 150 μm thick and zippered closed. The bagged body should then be placed in another leak-proof plastic bag not less than 150 μm thick and zippered closed before being transported to the morgue.

Surface Decontamination

Prior to transport to the morgue, perform surface decontamination of the corpse-containing body bags by removing visible soil on outer bag surfaces with Environmental Protection Agency (EPA)-registered disinfectants, which can kill a wide range of viruses. Follow the product's label instructions. The visible soil has been removed, reapply the disinfectant to the entire bag surface and allow to air dry. Following the removal of the body, the patient room should be cleaned and disinfected. Reusable equipment should be cleaned and disinfected according to standard procedures.

Individuals Driving or Riding in a Vehicle Carrying Human Remains

PPE is not required for individuals driving or riding in a vehicle carrying human remains, provided that drivers or riders will not be handling the remains of a suspected or confirmed case of Ebola, and the remains are safely contained and the body bag is disinfected as described above.

Mortuary Care

- Do not perform embalming. The risks of occupational exposure to Ebola virus while embalming outweighs its advantages; therefore, bodies infected with Ebola virus should not be embalmed.
- Do not open the body bags.
- Do not remove remains from the body bags. Bagged bodies should be placed directly into a hermetically sealed casket.

- Mortuary care personnel should wear PPE listed above (surgical scrub suit, surgical cap, impervious gown with full sleeve coverage, eye protection (i.e., face shield, goggles), facemask, shoe covers, and double surgical gloves) when handling the bagged remains.
- In the event of leakage of fluids from the body bag, thoroughly clean and decontaminate areas of the environment with EPA-registered disinfectants which can kill a broad range of viruses in accordance with label instructions. Reusable equipment should be cleaned and disinfected according to standard procedures.

Disposition of Remains

- Remains should be cremated or buried promptly in a hermetically sealed casket.
- Once the bagged body is placed in the sealed casket, no additional cleaning is needed unless leakage has occurred.
- No PPE is needed when handling the cremated remains or the hermetically sealed closed casket.

Transportation of Human Remains

- Transportation of remains that contain Ebola virus should be minimized to the extent possible.
- All transportation, including local transport, for example, for mortuary care or burial, should be coordinated with relevant local and state authorities in advance.
- Interstate transport should be coordinated with CDC by calling the EOC at 770-488-7100. The mode of transportation (i.e., airline or ground transport), must be considered carefully, taking into account distance and the most expeditious route.
- Ebola virus is a Category A infectious substance regulated by the US DOT's Hazardous Materials Regulations (HMRs) (HMR, 49 Code of Federal Regulations Parts 171-180), available here, last updated December 18, 2014, at <http://www.ecfr.gov/cgi-bin/text-idx?SID=aa86a290affda932646134b319299151&tpl=/ecfrbrowse/Title49/49CISubchapC.tpl>
- The DoT-issued guidance that human remains contaminated with a Category A infectious substance are accepted from the HMR, available at: <http://phmsa.dot.gov/portal/site/PHMSA/>
- Transportation of remains that contain Ebola virus outside the US would need to comply with the regulations of the country of destination, and should be coordinated in advance with relevant authorities.

References

CDC. Medical Examiners, Coroners, and Biologic Terrorism A Guidebook for Surveillance and Case Management. MMWR 2004;53(RR08);1-27, available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5308a1.htm>

Appendix 3: Recommendations for Pets in New Hampshire

As stated by CDC, “At this time, there have been no reports of dogs or cats becoming sick with Ebola or of being able to spread Ebola to people or other animals. Even in areas in Africa where Ebola is present, there have been no reports of dogs and cats becoming sick with Ebola. There is limited evidence that dogs become infected with Ebola virus, but there is no evidence that they develop disease.”

Out of an abundance of caution, the State of New Hampshire recommends adherence to the *Interim Guidance for Dog and Cat Quarantine after Exposure to a Human with Confirmed Ebola Virus Disease*, initially released November 10, 2014; available at:

<http://www.cdc.gov/vhf/ebola/pdf/dog-cat-quarantine.pdf>

Note that there is no current location in New Hampshire or people who can or will manage the animals as outlined in the plan. Regional discussions about where to handle animals are ongoing.

The Plan’s *Background* section states, “Patients with Ebola infection are not contagious until they are symptomatic; patients without symptoms are not contagious.” It is strongly recommended that any person who will be monitored for illness but who has not yet developed clinical symptoms should board all of their household pets for the duration of their own monitoring period. This would prevent the need to quarantine dogs and cats.

For questions and answers about Ebola and pets, see links available at:

<http://www.cdc.gov/vhf/ebola/transmission/qas-pets.html>

<https://www.avma.org/KB/Resources/Reference/Pages/Ebola-virus.aspx>

Appendix 4: Guidelines for School Administrators

The local superintendent may dismiss any or all schools due to emergency situations, including any actual or imminent threat to public health or safety which may result in loss of life, disease, or injury; an actual or imminent threat of natural disaster, chase occurring, or catastrophe which may result in loss of life, injury or damage to property; and, when an emergency situation has been declared by the governor, the state health officer, or the governing authority of the school (General Authority - Code of Administrative Rules ED 302.02.3(m)).

It is recommended that a student who has been quarantined by order of state or local health officers following prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, and is temporarily unable to attend school, be provided any missed assignments, homework, or other instructional services in core academic subjects in the home, hospital environment, or temporary shelter to which he has been assigned. The principal, with assistance from the local superintendent, should collaborate with state and local health officers and emergency response personnel to ensure the timely delivery or transmission of such materials to the student. It is recommended that materials be provided at least once for every five days of school missed.

Bureau of Infectious Disease Control

The NH DoE will work cooperatively with DHHS for the prevention, control, and containment of communicable diseases in public and non-public schools and shall assist in the dissemination of information relative to communicable diseases to all school governing authorities, including but not limited to, information relative to imminent threats to public health or safety which may result in loss of life or disease.

Students are expected to be in compliance with the required immunization schedule.

1. In accordance with RSA 141-C:20-a,* No child shall be admitted or enrolled in any school, public or private, unless the following is demonstrated:
 - a. Immunization against certain diseases. These diseases shall include, but not be limited to, diphtheria, mumps, pertussis, poliomyelitis, rubella, rubeola, and tetanus. The Commissioner of the New Hampshire Department of Health and Human Services shall adopt rules relative to other diseases which require immunization.
 - b. Partial immunization relative to the age of the child as specified in rules adopted by the Commissioner of the Department of Health and Human Services; or,
 - c. Exemption under RSA 141-C:20-c.
2. School personnel will cooperate with public health personnel in completing and coordinating all immunization data, waivers and exclusions, in accordance with RSA 141-C:20-b.

The superintendent may exclude a student, in accordance with RSA 193:1.I(c)**, from school when reliable evidence or information from a public health officer or physician confirms him/her of having a communicable disease or infestation that is known to be spread by any form of casual contact and is considered a health threat to the school population. Such a student may be excluded unless the state or local public health officers determine the condition is no longer considered contagious.

*RSA 141-C <http://www.gencourt.state.nh.us/rsa/html/x/141-c/141-c-mrg.htm>

**RSA 193:1 <http://www.gencourt.state.nh.us/rsa/html/xv/193/193-1.htm>

Appendix 5: Guidance for Infectious Waste

Ebola-Containing Infectious Waste

Infectious Waste: NH Regulatory Authority

Infectious waste is regulated by the New Hampshire Department of Environmental Services (“DES”) under RSA 149-M and its implementing regulations Env-Sw 100-2100, specifically Part Env-Sw 904, Infectious Waste (link to Env-Sw 900):

<http://des.nh.gov/organization/commissioner/legal/rulemaking/documents/env-sw900-adptd-pstd.pdf>

Packaging

In addition to the packaging requirements of Env-Sw 904, DES recommends that all Ebola infectious waste be stored in packaging identified by DOT as acceptable for the transport of Category A infectious substances (link to US DOT packaging guidance:

http://phmsa.dot.gov/pv_obj_cache/pv_obj_id_E7AFD0A1C5DBDDE54BCAAA0A80F9D6898FF50400/filename/suspected_ebola_patient_packaging_guidance_final.pdf_

Storage

In addition to the storage requirements of Env-Sw 904, the packaged waste containers should be stored separately from other regulated medical waste, in an isolated area with limited access.

Transportation

The transportation of infectious waste is regulated by the US DOT hazardous materials regulations as provided in 49 CFR 171-180. All waste generated from a suspected/confirmed Ebola patient is a Category A infectious substance, as defined in 49 CFR Part 173.134(1)(i).

79 FR 64646, October 30, 2014; Federal Register Notice: Safety Advisory Packaging and Handling Ebola Virus Contaminated Infectious Waste for Transportation to Disposal Sites, available at: http://www.gpo.gov/fdsys/pkg/FR-2014-10-30/pdf/2014-25778.pdf_

Disposal

NH DES is recommending that Ebola infectious waste be transported off-site, in accordance with US DOT requirements, for disposal at an authorized incineration facility. Any entity wishing to inactivate Ebola infectious waste via other means, such as in on-site autoclaves or via chemical inactivation, should consult with DES before attempting to render the waste “non-infectious.” NH DES contact information: Robert Bishop, Waste Management Specialist, 603-661-6623 or via email Robert.Bishop@des.nh.gov.

Untreated Sewage

Guidance for workers handling untreated sewage from individuals with Ebola updated November 20, 2014: <http://www.cdc.gov/vhf/ebola/prevention/handling-sewage.html>

Appendix 6: Interim Guidance for Emergency Medical Services Systems for Management of Patients with Known or Suspected Ebola Virus Disease in New Hampshire

Ebola Response Guidance for Emergency Medical Services – NH Interim Guidelines updated as of 11/3/14. Link to guidelines <http://www.dhhs.state.nh.us/dphs/cdcs/ebola/clinicians.htm>

Identify Patients, Protect Yourself, Respond Safely

DPHS and NH Bureau of EMS recognize the critical role of NH EMS providers and services for response to a possible Ebola virus disease (EVD) patient. Because Federal guidance is evolving, this document should be considered as interim NH guidance. One aspect that will never change, however, is that our providers and healthcare workers must be protected. Your first priority must be to ensure that you and your team are properly equipped and trained.

Personal Protective Equipment (PPE) Recommendations

EMS providers coming into contact with a suspect EVD patient should wear, at a minimum, the following disposable PPE to ensure no skin is showing:

- Fluid resistant or impermeable gown
- Two pairs of nitrile gloves with extended cuffs
- Fluid-resistant or impermeable boot covers that extend to mid-calf (fluid-resistant or impermeable shoe covers can be used instead if used in combination with a suit with integrated socks)
- Surgical hood that covers the head and extends to shoulders
- Full face shield (goggles are no longer recommended)
- National Institute of Occupational Safety and Health (NIOSH)-certified fit-tested N95 mask (surgical mask is no longer recommended)

Additional PPE can also include:

- Impermeable suit with shoe covers. The suit should NOT include a hood. If a suit with hood is used, the hood should be rolled up and stuffed inside the collar to minimize steps while doffing the PPE.
- NIOSH-certified powered air purifying respirator (PAPR) with a full face shield and headpiece. If a reusable helmet or headpiece is used, the PAPR must be covered with an additional disposable surgical hood that extends to the shoulders and is compatible with the selected PAPR.
- A fluid-resistant or impermeable apron that will protect providers from gross contamination and allow for easier contamination removal.

Initial Screening and Suspect Case Identification

- Upon arrival on scene, the EMS provider should assess each patient for a travel history to Guinea, Liberia, or Sierra Leone and symptoms of EVD.
- Remain at least 3 feet away to acquire the travel history before any physical contact with the patient.
- If patient meets criteria for suspect EVD, the EMS provider should leave the physical location of the patient until he/she can put on the appropriate PPE (see above).
- Instruct the patient to isolate himself/herself from others on scene (including family).
- Proceed carefully to ensure all personnel safety precautions and appropriate notifications are made.
 - Consult with Medical Control regarding the patient.
 - Notify DPHS at 603-271-4496 (after hours 603-271-5300).
- Don appropriate PPE. If available, change into scrubs before donning PPE in order to prevent any disposal of personal clothing or uniforms.
- If recommended PPE is not available on scene:
 - First responders should NOT make contact with the patient regardless of the clinical situation.
 - Wait for arrival of ambulance and EMS personnel with appropriate PPE. If jurisdictional ambulance service does not have appropriate PPE, request mutual aid.
 - If mutual aid agency similarly lacks appropriate PPE, request PPE from the hospital or other resource and arrange for supplies to be transported to the scene.
 - Further guidance and assistance can be given by medical control and DPHS.
- Limit contact with the patient and the patient's environment to essential providers only. Only those providers who will be transporting the patient to the hospital should have contact with the patient, and any other first responders on scene should avoid all contact. However, if the patient's condition necessitates care prior to ambulance arrival, AND the first responders have appropriate PPE, the minimum number of first responders should make contact with the patient.
- All first responders who don PPE and make contact with the patient on scene will need to go with the ambulance to the receiving hospital so that PPE can be properly doffed and disposed of. PPE should NOT be doffed in the field (see below for further guidance on doffing PPE).
- Document all personnel who are on scene or involved in the transport of the patient. In the event the patient is confirmed to have EVD, DPHS will monitor all personnel who were on scene for 21 days.

Medical Care

- Medical equipment used on EVD patients should be disposable whenever possible.
- Avoid any use of needles and other sharps. IVs should not be started unless the patient is in emergent need of volume replacement or IV medications and this care cannot be delayed until arrival at the emergency department (ED).
- Avoid aerosol-generating procedures such as nebulized medications, continuous positive airway pressure (CPAP), intubation, and suctioning.
- Avoid pre-hospital resuscitation procedures such as endotracheal intubation; open suctioning of airways, and cardiopulmonary resuscitation.
- If a suspected EVD patient is in cardiac arrest, follow established protocols for initiation and termination of resuscitation efforts in the field (3.2A Cardiac Arrest and 8.15 Special Resuscitation Situations). EMS providers should consider not initiating resuscitation efforts, as the physical environment may not be safe and successful resuscitation is unlikely.
- EMS providers should contact medical control before transporting a suspected EVD infected patient to the hospital.

Transport

- Transport should be performed in an ambulance with appropriate preparations for suspect EVD patient.
 - Limit equipment exposure to an EVD patient. Make a plan to remove any equipment that will not be used during transport and is in the immediate patient care area such as cardiac monitors. Coordinate with the BEMS
 - While not necessary, some EMS agencies may elect to perform additional ambulance precautions such as lining the patient compartment with plastic sheeting.
- The transporting EMS unit must be adequately staffed (recommended staffing is one driver and two patient care providers). If not, consider mutual aid.
- Transport in an ambulance with an isolated driver compartment is preferred. If the driver compartment can be isolated from the patient compartment, the ambulance driver should NOT have patient contact and should NOT don PPE. No special decontamination of the driver compartment is necessary.
 - If an ambulance with isolated driver compartment is not available, plastic sheeting can be used to separate the driver compartment from the rest of the ambulance.
- Place a surgical mask on the patient during transport.
- Transport patient to a local hospital per normal EMS protocol. Notify NH DPHS prior to transport.

- At receiving hospital, patient care should be transferred to hospital personnel with appropriate PPE preferably in ambulance bay/ambulance receiving area to limit EMS personnel from walking through the hospital in potentially contaminated PPE.

Decontamination

- Following transport of a suspect or confirmed EVD patient, appropriate environmental cleaning of the ambulance and medical equipment is critical.
- Decontamination of the ambulance and doffing of PPE should occur in a controlled environment at the receiving hospital in accordance with CDC guidance and hospital protocol.
- Personnel performing decontamination must wear appropriate EVD PPE as described above.
- All linens and non-fluid-impermeable pillows or mattresses, medical waste and any other materials that secretions from the suspect patient may have contaminated should be placed in leak-proof containment and discarded at the destination hospital according to the hospital's protocols for managing waste from suspect EVD patients.
- Standard environmental cleaning with EPA-registered, hospital-approved disinfectant is effective for non-critical patient care equipment and environmental surfaces. The EPA-registered hospital disinfectant should have a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) and be used in accordance with the manufacturer's instructions.
- All non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's and EMS unit policies.
- Patient-care surfaces (including stretchers, railings, medical equipment control panels, and adjacent flooring, walls and work surfaces) are likely to become contaminated and should be cleaned and disinfected after transport.
- A blood spill or spill of other body fluid or substance (e.g., feces or vomit) should be managed through removal of bulk spill matter, cleaning the site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient.
- PPE should be doffed using a second trained observer to guide the person doffing the PPE through specific removal and decontamination steps per CDC guidance:
 - Written guidance, as of October 20, 2014:
<http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>
 - Video demonstration, as of October 29, 2014:
<http://www.medscape.com/viewarticle/833907>
- The trained observer and assistant should also wear the following minimum PPE to assist with removal of specific components of PPE:

- Fluid-resistant or impermeable gown
- Full face shield
- Two pairs of nitrile gloves with extended cuffs
- Fluid-resistant or impermeable shoe covers
- Once PPE has been doffed, EMS personnel should shower and change garments at the hospital. All removed uniforms or garments should be laundered.
- PPE breaches: If a break in PPE occurs during patient care, decontamination, or PPE removal, the provider should stop working and immediately wash the affected skin surfaces with soap and water. Mucous membranes (e.g., conjunctiva) should be irrigated with copious amounts of water or eyewash solution.
- Persons with percutaneous exposures to blood or body fluids (e.g., needle stick) should immediately contact occupational health and his or her supervisor for assessment and access to post exposure management services for all appropriate pathogens (e.g., HIV, Hepatitis C, etc.).
- An asymptomatic healthcare provider who had an exposure should receive medical evaluation and follow-up care including symptom monitoring for 21 days. Any potential PPE or infection control breach should be reported to NH DPHS at 603-271-4496 (after hours 603-271-5300).

Interim guidance for EMS is available 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>