

North Carolina Healthcare Preparedness Response and Recovery Program News

“Everyday Pediatric Readiness for Extraordinary Events: Lessons Learned from the Commonwealth of the Northern Mariana Islands”

“Everyday Pediatric Readiness for Extraordinary Events: Lessons Learned from the Commonwealth of the Northern Mariana Islands” hosted by the Emergency Medical Services for Children Program (EMSC) on April 22, 2014. An impressive line-up of speakers will address the following learning objectives:

- Describe the disaster preparedness culture and socioeconomic impact of disasters in rural and insular settings;
- List opportunities and challenges for local, state and federal response prior to, during, and after a disaster; and
- Discuss strategies for engaging local community leaders in the planning and coordination of disaster training and exercises that include children.

Date: Tuesday, April 22, 4:00-5:30pm Eastern

Log on at <https://hrsa.connectsolutions.com/everyday1/>

Please contact Dr. Cynthia Hansen at Cynthia.hansen@hhs.gov for additional information.

A Quick Guide: FEMA Reimbursement for Acute Care Hospitals

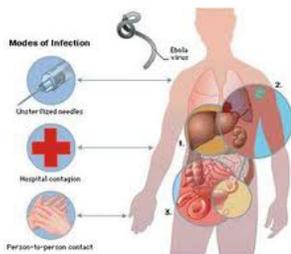
A Quick Guide: FEMA Reimbursement for Acute Care Hospitals



This document *provides* an overview of FEMA’s reimbursement process and outlines the tasks and corresponding timelines that must be met by acute care hospitals to successfully apply to FEMA for reimbursement of disaster related expenses incurred as a result of the event. The guide provides information on FEMA’s policies and the application process for reimbursement and provides a common understanding of the program policies as they relate to hospitals. This document is only intended as a guide and not an official source; the information contained herein should be verified with FEMA PA program representatives and state officials.

This product was developed in part through Health and Human Services Hospital Preparedness Program funding to the State of Connecticut grant number 2013-1001. http://www.ynhhs.org/emergency/pdfs/FEMA-ACH_ReimbursementGuide.pdf

Frequently Asked Questions (FAQs) for Health Care Providers about Ebola Virus Disease



Given the current outbreak of Ebola Hemorrhagic Fever in Guinea and Liberia, the HPP wanted to disseminate the attached (FAQs) and Answers for Health Care Providers about Ebola Virus Disease. As you know, Ebola outbreaks in some African nations are not uncommon; however, the cases are occurring in capitol and populated regions, raising the risk of transmission to other areas of the world. Please disseminate this to your healthcare coalitions and/or healthcare facilities, as

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you deem necessary. More information about the current outbreak can be found at: <http://www.cdc.gov/vhf/ebola/outbreaks/guinea/>

HPP would again like to thank Drs. Daniel Lucey, John Hick, and Dan Hanfling for developing this document as courtesy information for healthcare providers and all in the preparedness community. This information does not constitute clinical guidance or policy, and facilities may modify this document as required to reflect their specific needs and circumstances. HHS, ASPR/HPP and the authors bear no responsibility for the use of this information by a healthcare provider or facility.

Please contact Dr. Daniel Lucey (DRL23@Georgetown.edu) for any factual or contextual errors in this FAQ.

1. Why is Ebola Virus Disease so concerning?

Ebola is a filovirus that can be transmitted by contact with infected body fluids, has no recognized treatment other than supportive care, and has a very high mortality rate (60-90%). Of note, less than 50% of patients have hemorrhage, especially early in the illness. Healthcare providers in Africa sometimes become infected because of exposure to the patient prior to diagnosis, or the inability to protect themselves through appropriate polices and personal protective equipment.

2. How extensive is the Ebola outbreak in Guinea and Liberia?

Compared with the other Ebola outbreaks in Africa since 1976, this outbreak is more geographically widespread involving 6 districts (five rural) and 20 patients in one major city (Conakry, the capital of Guinea). See color map of outbreak zones at: <http://www.afro.who.int/en/clusters-a-programmes/dpc/epidemic-a-pandemic-alert-and-response/outbreak-news/4087-ebola-virus-disease-west-africa-7-april-2014.html>. As of 7 April, a cumulative total of 151 clinically compatible cases, including 95 deaths had officially been reported from Guinea. 14 of the cases including 8 deaths are health workers (11 are laboratory confirmed cases). Medical observation is continuing for 535 contacts. Liberia has reported a cumulative total of 5 laboratory confirmed cases and 16 suspected and probable cases of Ebola virus disease (EVD), including 10 deaths. Three cases have occurred in health-care workers, all of whom have died. See updates on the WHO website at: <http://www.who.int/csr/don/en/>

3. What is the strain of Ebola causing this outbreak?

Zaire strain (98% match), the most lethal strain of Ebola. (approximately 60% of patients in the current outbreak and higher in prior Zaire strain outbreaks in Africa) There is little or no clinical experience with Ebola patients being treated in modern ICUs, thus mortality here may be lower.

4. What is the incubation period?

From 2-21 days after exposure. CDC states that 8-10 days is most common

5. Is the virus contagious before illness onset?

No. It is contagious only after illness onset (e.g., fever)

6. How is the virus transmitted from person-to-person?

By contact with infected body fluids, especially blood (including via needles) but also urine, vomitus, stool, and soiled linen. Patients in Africa often have had exposures to several such body fluids. Thus, it is sometimes difficult to be certain how infection occurred.

7. What should we look for in a suspect case in the USA?

- (1) Travel from Guinea or Liberia outbreak areas within 21 days of illness onset.

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(2) Contact with suspected or confirmed Ebola Virus Disease (EVD) patient within 21 days of illness onset.

8. What are the symptoms and signs to look for?

The CDC Ebola fact sheet lists 2 sets of signs & symptoms:

- (1) Symptoms “typically include: Fever, headache, vomiting, stomach pain, and lack of appetite”.
- (2) “Some patients may experience: A rash, red eyes, hiccups, cough, sore throat, chest pain, difficulty breathing, difficulty swallowing, bleeding inside and outside the body.”

9. What patient should I suspect of having Ebola virus (& initiate reporting to local public health)*?

Patients with a travel and/or exposure history AND a clinical presentation consistent with the above CDC description.*When more specific CDC or local Health Department guidance is given, then it should be adopted.

Note CDC document for airlines: “Interim Guidance about Ebola Virus Infection for Airline Flight Crews, Cargo and Cleaning Personnel, and Personnel Interacting with Arriving Passengers” <http://www.cdc.gov/vhf/abroad/airline-workers.html>

10. During this outbreak have any suspected patients been reported in North America?

One patient traveling to Canada was reported March 25th to have tested negative for Ebola virus. One patient traveling from West Africa was hospitalized March 31 in Minneapolis and reported to be infected with Lassa fever virus (not Ebola). Statistically, the risk of a traveler to the USA having Ebola virus is very low. The risk of a traveler being suspected of having Ebola in the differential diagnosis is higher, however, and warrants enhanced Ebola preparedness.

11. Is there an FDA-licensed prophylaxis, or a treatment?

No, only investigational ones (none of which include efficacy data in humans to our knowledge)

12. What initial actions should be taken, and what personal protective equipment should be worn?

1. Immediately place any suspected patient into an isolation room. Until the disease process is defined, an airborne isolation (AIIR) room is recommended. Patients with respiratory symptoms should wear a simple mask.
2. Adopt strict contact precautions and pay particular attention to safe doffing, or removal of PPE. Use of a simple mask and face shield is appropriate although providers may opt for N95 mask until the pathogen is confirmed.
3. Contact Infection Prevention and Control and Infectious Disease on-call immediately and assure that the local/state health department is involved as well for appropriate sample acquisition and tracking
4. Minimize the number of caregivers and invasive procedures to decrease exposure opportunities.
5. Assure special precautions for handling laboratory samples and for personnel performing testing (including notification of lab personnel, special labeling, handling, and containers, etc.)

Note that once Ebola is confirmed, infection control precautions move to strict contact precautions and private, but not respiratory isolation rooms. See the current online CDC “Prevention” guidance for Ebola <http://www.cdc.gov/vhf/ebola/prevention/index.html> for further information on PPE, disinfection / sterilization of equipment and spaces, and isolation procedures.

Also, see the detailed 4-page most recent (2005) CDC information on “Infection Control Precautions” and PPE contained in the document titled “Interim Guidance for Managing patients with Suspected Viral Hemorrhagic Fever in U.S. Hospitals” at: <http://www.cdc.gov/vhf/ebola/vhf-interim-guidance.pdf> This guidance includes more detailed information on infection prevention and control as well as laboratory handling and addresses special circumstances and options for PPE.

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ASPR Division of At-Risk Individuals, Behavioral Health and Community Resilience (ABC)



The Division for At-Risk, Behavioral Health & Community Resilience (ABC) provides subject matter expertise, education, and coordination to internal and external partners to ensure that the functional needs of at-risk individuals and behavioral health issues are integrated in the public health and medical emergency preparedness, response, and recovery activities of the nation to facilitate and promote community resilience and national health security. There are a number of tools developed by this Division to assist.

For more details and access to the information sheets: <http://www.phe.gov/Preparedness/planning/abc/Pages/default.aspx>

ASPR Releases Evidence-Based Planning Guidance for Decontamination of Patients

First responders, medical providers, and public health officials need guidance based on scientific evidence on decontaminating patients in ways that improve health outcomes in order to respond effectively to an event that involves the release of hazardous chemicals. The nation's first draft guidance is now available for comment.

<http://www.phe.gov/ASPRBlog/Lists/Posts/Post.aspx?ID=87>

INSTITUTE OF MEDICINE Crisis Standards of Care: A Toolkit for Indicators and Triggers

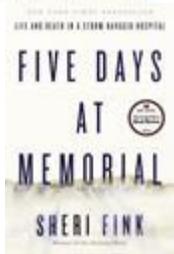
The IOM's reports on crisis standards of care contain key concepts, guidance, and practical resources to help actors across the emergency response system develop plans for crisis standards of care and response to a catastrophic disaster. The resources in report may be used by federal, state, and local governments; public health agencies; emergency medical services; emergency management and public safety agencies; hospitals; and out-of-hospital health care organizations and agencies. This report examines indicators and triggers that guide the implementation of crisis standards of care and provides a discussion toolkit to help stakeholders establish indicators and triggers for their own communities. - See more at: <http://www.iom.edu/Reports/2013/Crisis-Standards-of-Care-A-Toolkit-for-Indicators-and-Triggers.aspx#sthash.5aqcaZnH.dpuf>

Preparedness, Response, and Recovery Considerations for Children and Families

Although children represent nearly 25 percent of the U.S. population, current state and local disaster preparedness plans often do not include specific considerations for children and families. The preparedness and resilience of communities related to children will require a systems framework for disaster preparedness across traditional and non-traditional medical and public health stakeholders, including community organizations, schools, and other partners in municipal planning. This report examines resilience strategies that lead to successful recovery in children after a disaster and discusses current approaches and interventions to improve recovery in children. To see the report on the workshop with planning recommendations: http://books.nap.edu/catalog.php?record_id=18550



Keynote Speaker: Sheri Fink, MD



Over 1400 attendees at the Preparedness Summit got to hear keynote speaker Sheri Fink, MD describe events that took place at Memorial Hospital in New Orleans during Katrina and relate that to events that transpired at Bellevue Hospital in NYC after Superstorm Sandy. Her book Five Days at Memorial is a must read for preparedness planners.

http://www.nytimes.com/2013/09/04/books/five-days-at-memorial-by-sheri-fink.html?_r=0

First Responder Support Tools (FiRST)



FiRST provides First Responders, EM, and government officials easy access to map-based IED stand-off distances and HazMat evacuation areas. This app is available on Windows C, Android and iOS platforms. Find out more at: www.ara.com/products/first
