Maryland Ebola Virus Disease Response Plan

Maryland Department of Health and Mental Hygiene

June 2016

CHANGING
Maryland
for the Better

Letter of Promulgation

In accordance with the powers vested in me, I hereby approve and promulgate the "Maryland Ebola Virus Disease Response Plan." This plan denotes the concept of operations and roles and responsibilities of State agencies with regard to an incident wherein multiple agencies would coordinate to support a Maryland response to Ebola Virus Disease.

Van T. Mitchell
Secretary
Maryland Department of Health and Mental Hygiene

6/13/16
Date

Howard Haft, M.D.
Deputy Secretary for Public Health Services
Maryland Department of Health and Mental Hygiene

6/1/16
Date

Sherry B. Adams, R.N.
Director, Office of Preparedness and Response
Maryland Department of Health and Mental Hygiene

5/27/2016
Date

Table of Contents

REVISIONS

Date	Revision Made	Page #	Name (printed)	Signature

Acronyms

ADOC	Alternate Departmental Operations Center
CDC	Centers for Disease Control and Prevention
DAM	Direct Active Monitoring
DBM	Department of Budget and Management
DGS	Department of General Services
DHMH	Department of Health and Mental Hygiene
DHR	Department of Human Resources
DOC	Departmental Operations Center
eMEDS	Electronic Maryland Emergency Medical Services Data System
EMS	Emergency Medical Services
EMSOP	Emergency Medical Services Operational Program
ESF	Emergency Support Function
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics
EVD	Ebola Virus Disease
HAI	Health care-associated infection
HHS	Department of Health and Human Services
HPP	Hospital Preparedness Program
HSEEP	Homeland Security Exercise and Evaluation Program
ICS	Incident Command System
IDEORB	Infectious Disease Epidemiology and Outbreak Response Bureau
LHD	Local Health Department
MDE	Maryland Department of the Environment
MEMA	Maryland Emergency Management Agency
MEPP	Maryland Emergency Preparedness Program
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MSP	Maryland State Police
NIMS	National Incident Management System
OP&R	DHMH Office of Preparedness and Response
PPE	Personal Protective Equipment
PUI	Person Under Investigation
SEOC	State Emergency Operations Center
SOP	Standard Operating Procedures

I. Introduction

Response Mission Statement: The Maryland Department of Health and Mental Hygiene (DHMH), with support from state and local partners, will conduct operations in a timely manner to identify, assess, and actively monitor individuals at-risk for Ebola Virus Disease (EVD), respond to suspected EVD cases, and prevent and/or contain EVD outbreaks to protect public health, mitigate the loss of life, and coordinate effective resource utilization in Maryland.

A. Purpose

The purpose of this framework is to identify primary and support functions and interagency/multi-jurisdictional coordination specific to EVD response and outbreak prevention in Maryland.

B. Scope

The scope of this plan is articulated in terms of state-level coordination to deliver the relevant capabilities regarding EVD response and outbreak prevention, in collaboration with or support of local government activities, and with private/nonprofit, regional, and/or federal partners.

C. Situation

Background: Ebola Virus Disease (EVD), previously known as Ebola hemorrhagic fever, is a rare disease with a high mortality rate caused by infection with one of several known Ebola virus strains. EVD can cause disease in humans and nonhuman primates (monkeys, gorillas, and chimpanzees). EVD is caused by infection with a virus of the family *Filoviridae*, genus *Ebolavirus*. There are five identified Ebola virus species, four of which are known to cause disease in humans: Ebola virus (*Zaire ebolavirus*); Sudan virus (*Sudan ebolavirus*); Taï Forest virus (*Taï Forest ebolavirus*, formerly *Côte d'Ivoire ebolavirus*); and Bundibugyo virus (*Bundibugyo ebolavirus*). The fifth, Reston virus (*Reston ebolavirus*), has caused disease in nonhuman primates, but not in humans. The natural reservoir host of Ebola virus remains unknown; however, on the basis of evidence and the nature of similar viruses, researchers believe the virus is animal-borne and bats are the most likely reservoir. Four of the five virus strains occur in an animal host native to Africa.

The 2014 EVD epidemic is the largest in history, affecting multiple countries in West Africa, including Guinea, Liberia, and Sierra Leone. As of February 2016, two imported cases, including one death, and two locally acquired cases in health care workers have been reported in the United States.[1]

EVD Transmission:

- Blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen) of a person who is sick with or has died from Ebola,
- Objects (like needles and syringes) that have been contaminated with body fluids from a person who is sick with Ebola or the body of a person who has died from Ebola,
- Infected fruit bats or primates (apes and monkeys), and
- Possibly from contact with semen from a man who has recovered from Ebola

[1]U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Ebola (Ebola Virus Disease), About Ebola Virus Disease, http://www.cdc.gov/vhf/ebola/about.html (last visited 12/10/15)

Clinical Characteristics of EVD:

- Fever
- Severe headache
- Muscle pain
- Weakness
- Fatigue
- Diarrhea
- Vomiting
- Abdominal (stomach) pain
- Unexplained hemorrhage (bleeding or bruising)

Symptoms may appear anywhere from 2 to 21 days after exposure to EVD, but the average is 8 to 10 days. Recovery from EVD depends on good supportive clinical care and the patient's immune response. People who recover from EVD infection develop antibodies lasting for at least 10 years.[2]

Current State of Health care System in Maryland to Respond to EVD: Five ports of entry to the U.S. have been established for travelers returning from Ebola-affected countries (JFK International, Newark Liberty International, Chicago O'Hare International, Hartsfield-Jackson International, and Washington Dulles International Airport). Maryland is a border state with Washington D.C. and has: the capacity to test for EVD (via the DHMH Laboratories Administration), several Centers for Disease Control and Prevention (CDC) assessed federal and state treatment facilities, and in coordination with CDC, the capacity to identify and monitor returning travelers.

EVD Treatment: No Food and Drug Administration approved vaccine or medicine (e.g., antiviral drug) is available for EVD.

Experimental vaccines and treatments for EVD are under development, but they have not yet been fully tested for safety or effectiveness.[3]

Symptoms of EVD and complications secondary to infection are treated as they appear. The following basic interventions, when used early, can significantly improve the chances of survival:

- Providing intravenous fluids and balancing electrolytes (body salts),
- Maintaining oxygen status and blood pressure, and
- Treating other infections if they occur.

EVD risk levels: The CDC has established four level of risk, based on epidemiological risk factors and likelihood of exposure (Annex A).[4]

- High risk
- Some risk
- Low (but not zero) risk
- No identifiable risk

---

[2]U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Ebola (Ebola Virus Disease), Signs and Symptoms, http://www.cdc.gov/vhf/ebola/symptoms/index.html (last visited 6/25/15)
[3]U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Ebola (Ebola Virus Disease), Treatment, http://www.cdc.gov/vhf/ebola/treatment/index.html (last visited 6/25/15)
[4] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Epidemiologic Risk Factors to Consider when Evaluating a Person for Exposure to Ebola Virushttp://www.cdc.gov/vhf/ebola/exposure/risk-factors-when-evaluating-person-for-exposure.html (last visited 6/25/15)

For this document, individuals at-risk meet one of CDC's identified risk levels—high, some, or low (but not zero) risk. Individuals at-risk do not exhibit signs and symptoms of EVD and are not ill. However, due to recent travel in Ebola-affected countries or exposure to a person with EVD, they must be monitored by health officials. Individuals who do exhibit signs and symptoms of EVD and have recent travel or exposure to a person with EVD, but have not been diagnosed with EVD, are deemed a person under investigation (PUI).

D. Facts and Assumptions

- EVD outbreak prevention and response will rely and build on existing DHMH and local health capacities and activities.
- EVD outbreak prevention and response falls within Emergency Support Function 8 (ESF-8) - Public Health and Medical Services, which provides the mechanism for coordinated assistance in response to a public health and medical disaster, potential or actual incidents requiring a coordinated response, and/or during a developing potential health and medical emergency.[5]
- DHMH has primary responsibility for the execution of courses of action relating to ESF-8 in Maryland.
- This plan supports the *State of Maryland Emergency Operations Plan ESF-8 - Public Health and Medical Services*, which supports the relevant Maryland Emergency Preparedness Program (MEPP) All-Hazards Operations Plans and MEPP Strategic Plan.
- DHMH will utilize the National Incident Management System (NIMS) and Incident Command System (ICS) to coordinate appropriate EVD outbreak prevention and response.
- This plan will be activated and deactivated based on CDC advice and posture and/or authority from DHMH Secretary or designee.
- The Governor of the State of Maryland has the authority to declare a State of Emergency and/or a Catastrophic Health Emergency, should circumstances warrant these actions.
- DHMH will coordinate the activities of other state agencies needed to achieve response objectives through the Maryland Emergency Management Agency (MEMA).
- The Maryland Emerging Infectious Disease Committee will advise DHMH on strategies to fulfill its mission and individual members will coordinate on guidance documents and provide subject matter expertise to the MEMA Planning Cell as needed and requested by DHMH.
- DHMH will support local level courses of action by local health departments (LHDs) relating to ESF-8.
- Additional support at the state or local level may come from private or non-governmental organizations; local government agencies will support LHDs.

[5]U.S. Department of Homeland Security, Federal Emergency Management Agency, Emergency Support Function #8 – Public Health and Medical Services Annex, http://www.fema.gov/media-library-data/20130726-1825-25045-8027/emergency_support_function_8_public_health___medical_services_annex_2008.pdf (last visited 3/19/15)

- Established procedures will be used for the acquisition of medical materiel, such as personal protective equipment (PPE), and Maryland Responds Medical Reserve Corps responders needed to support EVD response.
- Specific factors contributing to the ability of the State to conduct EVD response and outbreak prevention (i.e., specific factors the State relies on federal support to achieve) include:
    - CDC communication with DHMH regarding the number and risk status of travelers from Ebola-affected countries or individuals who have been in contact with those travelers
    - Development/deployment of medical countermeasures (e.g., vaccines and treatments) as they become available
    - Support by/coordination with other federal, state, local, and/or private agencies, such as the Office of the Assistant Secretary for Preparedness and Response and the CDC.
- Anticipated tipping point at which Maryland can no longer conduct optimal EVD response and outbreak prevention/containment includes the exhaustion of:
    - Incident management capacity
    - Adequately trained medical and public health personnel
    - Current supplies and/or medical materiel
    - Treatment facility space
    - Shelter facility space
- Data from this response will be evaluated throughout to ensure mission fidelity and institute improvement actions as needed
- Elements of this plan may be invoked if the Regional Ebola Treatment Center at Johns Hopkins Hospital is utilized for out-of-state care of patients with EVD

II. Concept of Operations

A. Preparedness:

The following actions will be taken to prepare for and conduct EVD case investigations, treatment of confirmed EVD cases, and, if necessary, containment of EVD outbreak.

- Health care Coordination--Health care facilities will establish facility and/or system-level clinical guidelines/protocols, stock appropriate type and amounts of PPE and other medical materiel, and establish agreements for sharing materiel as appropriate.
- Public Health Coordination--DHMH, in coordination with MEMA, will organize an ICS structure for EVD response and enhance public health operations, community communication and preparedness, and laboratory services in the following manner:
    - Incident Command System: The Secretary, DHMH or a designee will assume the role of Incident Commander of all ESF-8 activities. The DHMH Office of Preparedness and Response (OP&R) will coordinate these activities as directed by the Secretary, DHMH.

The Secretary, DHMH will provide subject matter expertise to the Governor of Maryland regarding clinical and public health guidelines/protocols and medical interventions.

- Epidemiology: The DHMH Infectious Disease Epidemiology and Outbreak Response Bureau (IDEORB) will establish procedures and protocols and will lead EVD case investigations and high quality EVD data collection, management, analysis, and reporting. IDEORB will provide guidance for infection prevention and control of EVD in both healthcare and community settings. This Bureau will also provide technical assistance and oversee EVD active and direct active monitoring and case investigation by LHDs. Additionally, this Bureau will be responsible for supervising and coordinating actions of hospitals and non-acute health care facilities to mitigate potential gaps in health care-associated infection (HAI) plans and protocols.

- Community communication and preparedness: The DHMH Office of Communications, in conjunction with OP&R and IDEORB, will establish and enact EVD communication strategies to educate the public and decision-makers. OP&R and IDEORB will provide guidance and technical assistance to LHDs and health care partners. OP&R, IDEORB, and/or LHDs will establish and enact EVD training and exercises with appropriate partners and EVD active/direct active monitoring protocols.

- Laboratory Services: The DHMH Laboratories Administration will establish and enact protocols and procedures to coordinate laboratory testing and electronic results reporting.

- Emergency Medical Services (EMS) Coordination -- The Maryland Institute for Emergency Medical Services (MIEMSS) will collaborate with DHMH, EMS providers, hospitals, and LHDs to provide guidance to the EMS providers, modify EMS treatment protocols and coordinate the transportation of EVD patients.

B. Identification/Assessment: Travelers from countries with widespread EVD transmission will be monitored in accordance with national guidance. Early identification and assessment of individuals at-risk of EVD exposure is essential to recognize, monitor, and treat EVD cases and thereby minimize spread of EVD to the Maryland population. *The Directive and Order of the Maryland Secretary of Health and Mental Hygiene to Report Ebola Case Information and To Take Measures to Prevent Transmission of Ebola* (Annex B) mandates all Maryland health care providers become familiar with the current CDC EVD case definition, follow current CDC infection prevention protocols to prevent person-to-person EVD transmission, and immediately notify LHDs of any suspected cases. All LHDs shall immediately notify DHMH of any suspected cases. Reports will be entered into the Maryland National Electronic Disease Surveillance System (NEDSS), Maryland's reportable disease surveillance system, in accordance with CDC and Council of State and Territorial Epidemiologists guidance. In addition, health data from Maryland emergency departments via the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) and the electronic Maryland EMS Data System (eMEDS) will be monitored for cases requiring further review. Testing of all suspected cases will be performed by the Maryland Public Health Laboratory using protocols and procedures appropriate for EVD. The *DHMH Ebola Notification Procedures* (Annex C) will be used to notify supporting partners for appropriate action.

Travelers with symptoms are directed to notify DHMH, who will then coordinate with health care facilities and other partners to arrange assessment and medical management. Should travelers contact EMS or if EMS providers encounters any individual meeting the criteria of a PUI for EVD, they are

required by protocol (Annex H) to immediately notify the intended receiving hospital and MIEMSS. MIEMSS will then contact DHMH to ensure the LHD is notified.

While patients with EVD or PUIs are in the hospital, rigorous protocols must be in place and practiced to prevent EVD transmission to health care workers and other patients. DHMH will maintain and expand upon the current Maryland Healthcare-Associated Infections Plan and collaborate with Maryland HAI Advisory Committee to ensure hospitals have access to infectious disease and HAI prevention expertise. DHMH will also maintain a directory with infectious disease and infection prevention contacts from all Maryland health care facilities to foster communication, collaboration, and data sharing among infectious disease units in these facilities with DHMH. EVD HAI prevention in all Maryland hospitals will be assessed by DHMH and technical assistance will be provided to address identified gaps.

C. Active and Direct Active Monitoring: Active monitoring will be instituted to assess individuals at low (but not zero) risk for the presence of fever or other EVD symptoms. DHMH will establish and maintain a monitoring center and other monitoring capacity with support from the CDC to ensure regular communication with these individuals and to ensure coordination with other jurisdictions as monitored individuals move in and out of Maryland.

In addition, direct active monitoring (DAM) will be instituted for other risk categories using in-person assessments or remote electronic visualization means by DHMH or LHDs upon DHMH request based on CDC guidance.[6] Should at-risk individuals be unresponsive or unable to complete active monitoring or DAM via telephone or other electronic means, LHDs will conduct home visits. Should DHMH determine the need for DAM cases to be sheltered at an alternate location, resources such as travel, food, means of communication, and waste management will be coordinated as described in later sections.

Active and direct active monitoring will be activated and deactivated based on CDC advice and posture and/or authority from DHMH Secretary or designee.

D. Emergency Medical Services: MIEMSS licenses commercial ambulance services and approves public safety Emergency Medical Services Operations Programs (EMSOPs).

- Public safety EMSOPs respond to calls to local 9-1-1 centers requesting EMS. Some of these programs have designated EVD transport teams, and all cooperate with local hazardous material teams and resources to ensure the safety of EMS personnel and the patients during transport to a hospital. Public safety EMSOPs also provide primary response for individuals under DAM who develop signs or symptoms of EVD and require care and transportation to a hospital. With the approval of MIEMSS, they may also act as secondary support to inter-facility transfer should an appropriate commercial ambulance service not be available.

- Commercial ambulance services generally provide inter-facility patient transfer between hospitals and other health care facilities. MIEMSS grants waivers to standard licensing requirements for those commercial ambulance services[7] applying to allow a variance from standard equipment and operational requirements by having specific plans for personnel protection, available equipment and supplies and appropriate follow-up of personnel. Commercial ambulance services holding contracted affiliations with Assessment or Treatment hospitals will serve as the primary resource

[6] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html#table-monitoring-movement (last visited 6/26/15)

[7] Maryland Instituted for Emergency Medical Services Systems, State Officeof Commercial Ambulance Licensing and Regulation; Equipment Waiver Application for Inter-Facility Transports of Confirmed Patients or Patients Under Investigation (PUI) for Ebola.Rev. 10/29/2014

to transport patients to those affiliated hospitals from other frontline or assessment hospitals. They may also be requested to assist public safety EMSOPs in transporting patients to hospitals from the community.

E. Hospitals and Regional Healthcare Preparedness Coalitions: Hospitals in Maryland are classified as frontline health care facilities, EVD assessment hospitals, or EVD treatment centers:

- Frontline health care facilities: these facilities are equipped for emergency care and should be prepared to promptly identify and isolate PUIs and promptly inform the hospital/facility infection control program and state and local public health agency according to CDC guidance for emergency departments. In general, EMS should transport stable PUIs to an Ebola assessment hospital, not to a frontline healthcare facility. However, frontline health care facilities are expected to be prepared to screen and isolate potential PUIs who do present to the facility and to provide care until patient transfer can be arranged and accomplished, which should occur within 12–24 hours of transport request. All frontline hospitals must have capabilities to support EMSOPs transporting PUIs to their facility to include an appropriate location for doffing of PPE, shower facilities for decontamination of EMS personnel, location on hospital property to decontaminate transport vehicles, and acceptance of waste from EMSOPs associated with the transport of these PUIs.

- Assessment hospitals: these hospitals are facilities prepared to receive and isolate PUIs and care for the patient until a diagnosis of EVD can be confirmed or ruled out and until discharge or transfer is completed. These hospitals must have the ability to coordinate EVD testing and provide appropriate care for up to 96 hours (i.e., have sufficient staff training, PPE, and isolation facilities appropriate for 4-5 days of patient care). All assessment hospitals must have the capabilities to support all EMSOPs transporting patients to them same as the frontline hospitals and have a formal arrangement with a waivered commercial ambulance service.[8] A list of current assessment hospitals may be found in Annex E.

- Treatment Centers: these centers are hospitals which have been assessed by CDC for EVD readiness and plan to care for and manage a patient with confirmed EVD for the duration of the patient's illness. Staff must be trained in and have practiced putting on and taking off (donning and doffing) PPE for EVD, as well as providing clinical care using PPE. At minimum, these hospitals need sufficient staff, PPE, and isolation facilities appropriate for at least 7 days of patient care. All treatment centers must have the capabilities to support all EMSOPs transporting patients to them, like the frontline hospitals, and have a formal arrangement with a waivered commercial ambulance service.[9] A list of current treatment centers may be found in Annex E.

- Regional Ebola Treatment Center (RETC): these centers meet the requirements of Ebola Treatment Centers listed above, but have enhanced capabilities to treat a patient with EVD. Johns Hopkins Hospital has been designated the RETC for HHS Region III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, or West Virginia).

[8] [8] Maryland Institute for Emergency Medical Services Systems, State Office of Commercial Ambulance Licensing and Regulation; Equipment Waiver Application for Inter-Facility Transports of Confirmed Patients or Patients Under Investigation (PUI) for Ebola. Rev. 10/29/2014

[9] Maryland Institute for Emergency Medical Services Systems, State Office of Commercial Ambulance Licensing and Regulation; Equipment Waiver Application for Inter-Facility Transports of Confirmed Patients or Patients Under Investigation (PUI) for Ebola. Rev. 10/29/2014

All hospital staff will maintain confidentiality of patient information for PUIs and individuals with EVD as per the Health Insurance Portability and Accountability Act (HIPAA).[10]

All assessment and treatment hospitals will be assessed by DHMH on the following CDC domains:

- Pre-Hospital Transport Plans, Emergency Management Services, Emergency Department Preparedness
- Staffing of Patient Care Team
- Patient Transport from Points(s) of Entry to Designated Ebola Treatment Area
- Patient Placement
- Personal Protective Equipment and Procedures for Donning and Doffing
- Monitoring Health Care Personnel and Managing Exposures
- Laboratory Safety
- Environmental Infection Control and Equipment Reprocessing
- Management of Waste
- Communications
- Management of the Deceased
- Special Populations

In addition to these criteria regarding PUIs, treatment hospitals will also meet these criteria for treating patients with EVD.

Regional Healthcare Preparedness coalitions, a collaborative network of health care organizations and their respective public and private sector response partners within defined Maryland regions,[11] consist of members from multiple disciplines, including health care, public health, emergency management, EMS, and behavioral health. These coalitions are responsible for regional planning and project management, inventory management (including medical materiel such as PPE), training and exercises, procurement and expenditure tracking, technical assistance, and emergency response and will provide appropriate resource support to hospitals and EMS assessing and/or treating patients suspected to have EVD to include the provision of appropriate PPE.

DHMH Hospital Preparedness Program (HPP) Regional Coordinators provide technical assistance to these coalitions and will facilitate EVD planning, training, exercises, assessment, and resource requests to improve operational readiness. In the case of EVD outbreak, Regional Healthcare Preparedness coalitions, with guidance from DHMH HPP Regional Coordinators, will be prepared to maintain situational awareness, facilitate information sharing, and allocate resources as needed.

In the event where demand on a health care system for examination of PUIs or treatment of patients with EVD exceeds local capacity and capability, the Maryland Public Health and Medical Surge Plan will be enacted to ensure timely and appropriate response.

F. Containment/Non-Pharmaceutical Intervention: Community containment measures may be necessary in EVD cases to prevent large scale outbreak of disease. The following protective strategies may be implemented by the State of Maryland as deemed necessary and appropriate by DHMH:

---

[10] U.S. Department of Health and Human Services, Office for Civil Rights, *Health Information Privacy, http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html (last visited 9/28/15)*

[11] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, Hospital Preparedness Program, *Healthcare Preparedness Capabilities, http://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf (last visited 3/19/15)*

- Controlled Movement: Individuals subject to controlled movement should not be allowed to travel by long-distance commercial conveyances (e.g., aircraft, ship, bus, train) without express prior approval from DHMH in accordance with CDC guidance. If travel is allowed, it should be by noncommercial conveyance such as private chartered flight or private vehicle and occur with arrangements for uninterrupted active monitoring.

- Isolation: Separation from the general population of an individual or group reasonably believed to be infected with EVD from those not infected to prevent spread of EVD may be warranted if an individual is reasonably believed to be infected (i.e., displays EVD signs and symptoms) and there is reason to believe an exposure occurred. Those in isolation will most likely be housed in an appropriate hospital setting.

- Quarantine: Quarantine of an individual or group reasonably believed to have been exposed to EVD, but not presenting EVD signs or symptoms from others not exposed, may be warranted to prevent the possible spread of EVD. Quarantine may take place in the individual's home, a DHMH facility capable of quarantine for 21 days, or another setting determined by DHMH. The individual or group may be restricted from public places (e.g., shopping centers, movie theaters), congregate settings, and workplaces throughout the 21-day period. An appropriate staffing support plan will developed by DHMH with advice from other state agencies as needed.

Isolation orders or quarantine orders will be drafted by the Office of the Attorney General (OAG) and will be approved by the DHMH Secretary or designee on a case-by-case basis upon request from a Maryland hospital, LHD or unit of the Department.

DHMH and/or LHDs will monitor medical needs of contained individuals and will request the following support from partner agencies as needed and described in the draft *Emerging Infectious Disease, Multi-Agency Resource Support Plan* (Annex F):

- MEMA will coordinate overall response as requested by DHMH and act as a liaison for federal government requests as needed.
- MIEMSS and appropriate hospitals or agencies will coordinate transport and medical care for contained individuals who have or develop signs or symptoms of EVD and require transport to the hospital. MIEMSS will also coordinate with EMSOPs or waivered commercial ambulance services to provide medical support for transportation of contained individuals who are not exhibiting signs and symptoms of EVD.
- The Maryland Department of Human Resources (DHR) and/or local designee will provide push packs, shelter, food, recreation, communication, and family support to contained individuals not already located in a hospital or DHMH facility. DHR will also provide guidance for children without guardians who need to be quarantine, or whose parents are quarantined.
- DHMH will coordinate with the Maryland Department of Housing and Community Development (DHCD) to provide appropriate lodging for quarantined individuals not already located in a hospital or a DHMH facility.
- The Maryland State Police (MSP) and/or local designee will provide security to protect the privacy and safety of contained individuals and transport teams.
- The Maryland Department of the Environment (MDE)will assist DHMH with guidance and technical assistance related to decontamination, cleaning, disinfection, disposal, and other waste management technical issues as requested.
- The Maryland Department of General Services (DGS) will procure needed resources as requested and appropriate.

- The Maryland Department of Budget and Management (DBM) will ensure fiscal resource management for responding state agencies.
- The Office of the Attorney General will provide legal consultation and representation for any issues arising from EVD operations, including non-compliance with containment measures and hospital holding policies to conduct necessary EVD assessment and/or treatment.

All staff having direct contact with contained individuals will adhere to guidance from DHMH to prevent the potential transmission of EVD.

Guidance relating to pet quarantine will be given by DHMH on a case-by-case basis as needed and appropriate.

G. Waste Management: Management of potential Ebola-contaminated wastes within health care settings has proven to be challenging, in part because of risk perception and in part because of documented risks. Waste management issues to be resolved include:

- Disposal of the considerable amount of waste generated even for patients who are not acutely ill, due to the large volume of PPE and rigorous infection prevention practices associated with care.
- Wastes generated in the care of suspect EVD infections are treated as Category A infectious wastes and have extensive handling and packaging requirements unless pre-treated on site.
- Due to the absence of accepting landfills, commercial waste management companies are currently forced to transport untreated suspected EVD waste to one commercial incinerator in Port Arthur, Texas.
- Disposal of urine and feces and disinfection protocols for treatment rooms after patient discharge are not yet standardized and vary considerably from facility to facility.

Waste contaminated (or suspected to be contaminated) with Ebola virus is considered a Category A infectious substance regulated as a hazardous material under the U.S. Department of Transportation Hazardous Materials Regulations (HMR; 49 CFR, Parts 171-180). Ebola-associated waste that has been appropriately incinerated, autoclaved, or otherwise inactivated is not infectious, does not pose a health risk, and is not considered to be regulated medical waste or a hazardous material under federal law.

Inactivation or incineration of Ebola-associated waste generated within a hospital system or delivered by EMS to a hospital in association with the care of transported patients may be subject to state, local, and OSHA regulations.

- On-site inactivation: Ebola-associated waste may be inactivated through the use of appropriate autoclaves.
- On-site incineration: Ebola-associated waste may be incinerated. The products of incineration (i.e., the ash) can be transported and disposed of in accordance with state and local regulations and standard protocols for hospital waste disposal.

DHMH and MDE will monitor national progress to resolve the complex EVD waste disposal issues that have made disposal of waste from hospitals both logistically complex and expensive and will provide guidance to partners as needed and available.

DHMH and DGS will develop specifications for model "just in time" procurement of decontamination services and management of wastes in pre-hospital (community) settings to ensure timely retention of these services.

H. Transportation: Several types of transportation needs are described below and relate to both EVD and routine (i.e., non-EVD) medical support for at-risk individuals:

- From home/shelter/health care facility to assessment/treatment hospital
- From frontline to assessment or assessment to treatment hospital
- From port of entry to shelter/home
- From port of entry to assessment/treatment hospital
- From assessment/treatment hospital to home/shelter
- From assessment/treatment hospital to RETC

For these needs, the *DHMH Ebola Notification Procedures* (Annex B), Patient Transport Algorithm (Annex D), and *Maryland Medical Protocol for EMS Provider – Emerging Infectious Disease Protocol* (Annex H) will be enacted. DHMH will be the ultimate authority for patient destination decisions; MIEMSS will be the authority coordinating with the appropriate EMSOPs or waivered Commercial Ambulance Services for transport of PUIs who need EMS transport to a hospital. MIEMSS will also coordinate and notify DHMH and MEMA of transport logistics. DHMH and MIEMSS will consult to determine if police escort is needed.

Patients may be transported from another HHS Region III state to the RETC; this transport may occur via ground or via air. Should this transport occur via air, the primary Airport of Debarkation shall be the Glen L. Martin State Airport. The Baltimore Washington International Thurgood Marshall Airport shall serve as the back-up Airport of Debarkation. The procedures and triggers for interstate transport of patients with EVD are described in the HHS Region III Ebola Virus Disease Regional Network Coordination and Response Plan.

DHMH will be responsible for the routine transportation of individuals at-risk with no signs or symptoms of EVD. MIEMSS will coordinate with the appropriate EMSOP for medical support as required with follow-on vehicles.

Should passenger vans or utility vehicles be required to transport individuals at-risk, equipment, or other items, such as luggage and personal items, DHMH will first secure an appropriate state owned vehicle, collaborating with DGS as necessary. Should a state owned vehicle not be available or appropriate, DHMH will then collaborate with DBM to secure an appropriate non-state owned vehicle.

I. Fatality management: The *DHMH Directive and Order of the Maryland Secretary of Health and Mental Hygiene for Cremation of Human Remains That Are Infected with Ebola* (Annex F) sets forth a protocol for handling the remains of individuals infected with EVD in Maryland. The State Anatomy Board will transfer the remains of all deceased individuals infected with EVD (except those from the National Institutes of Health). Hospitals will contact the State Anatomy Board in the event of a death of an individual infected with EVD, which will then transport the properly sealed remains from the hospital morgue to a State Anatomy Board facility. Remains will be handled by all appropriate partners in accordance with CDC guidance.[12]

Cremation is mandatory for any deceased individual infected with EVD, unless determined by the State Anatomy Board to be unsafe due to an implanted device. Once the body is cremated, the remains are no longer considered infectious and will be returned to the family of the deceased individual. Should a

[12] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Guidance for Safe Handling of Human Remains of Ebola Patients in U.S. Hospitals and Mortuaries. http://www.cdc.gov/vhf/ebola/health care-us/hospitals/handling-human-remains.html (last visited 9/21/15)

deceased individual infected with EVD have an implanted device and require burial, DHMH and the State Anatomy Board will coordinate with the Maryland Cemetery Oversight Board and the individual's family to determine the best burial location and interment method and transfer the deceased individual to that location for interment.

In the event of EVD outbreak, the *Maryland Department of Health and Mental Hygiene Mass Fatality Management Plan* would be activated. LHDs may also activate their local Mass Fatality Management plans.

J. Communication: Essential capabilities necessary to coordinate information/data sharing and provide appropriate information to affected individuals and stakeholders, including the public, are:

- Emergency Public Information and Warning: DHMH will develop, coordinate, and disseminate information, notifications, etc. to the public and incident management responders. In addition, DHMH will provide written guidance to affected individuals and their families to explain EVD symptoms, disease transmission prevention strategies, and general procedures during the quarantine process. Communications to the public and specifically to affected individuals and families will be inclusive of populations with limited English proficiency.

- Information sharing: DHMH or the Joint Information Center (if activated by MEMA) will coordinate to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among partners, including those in the field.

All communications with the public and media will follow the *DHMH Public Information Communications Plan for Public Health Emergencies.* DHMH will confirm a positive lab result and explain the investigation process only after confirmation of the lab result from CDC. DHMH will not discuss confidential data, preliminary results, or cases of patients who may be under initial consideration for EVD.

K. Operational Coordination: To coordinate during an EVD outbreak, DHMH and MEMA will consult to open the most appropriate location: the DHMH Departmental Operations Center (DOC), the DHMH Alternate Departmental Operations Center (ADOC), or the State Emergency Operations Center (SEOC).

Appropriate personnel, including members of the DHMH Emergency Management Team as requested, will staff the Operations Center. Supporting agencies may be requested to provide staff on an as-needed basis.

Should use of the RETC be required by another state, Maryland partners, including DHMH, MIEMSS, and MEMA will coordinate as per the HHS Region III Ebola Virus Disease Regional Network Coordination and Response Plan.

III. Roles and Responsibilities

DHMH has the primary responsibility for managing and coordinating an EVD response to monitor individuals, investigate suspected EVD cases, and prevent potential outbreak in Maryland with support from LHDs and technical assistance from key Federal agencies. The following State agencies will have the following support responsibilities for this mission:

State Agency Name	Primary Support Functions for EVD response

Maryland Emergency Management Agency	• Support DHMH response to accommodate contained individuals. • Coordinate the overall emergency planning, preparedness and response of all state agencies in a public health related emergency due to EVD outbreak. • The Director of the Maryland Emergency Management Agency shall serve as the State Coordinating Officer (SCO). • Maintain communication with DHMH regarding imminence or status of an EVD outbreak in Maryland. Coordinate the activation of the State Emergency Operations Plan in accordance with guidance from DHMH. • Supporting both local government and state agency emergency operations pre-outbreak planning. Ensure fire, public works and emergency management organizations complete emergency response plans, especially taking into account absenteeism, employee protective measures, and maintaining services. • Inform the Governor, the Superintendent of the Maryland State Police, Executive Council, and the Legislature, as appropriate, of emergency operations. • Facilitate the request for a presidential disaster declaration as appropriate. • Facilitate any Emergency Management Assistance Compact (EMAC) or Maryland Emergency Management Assistance Compact (MEMAC) requests • Support communications via an in-person or virtual Joint Information Center as appropriate.
Governor's Office of Homeland Security	• Coordinate with MEMA and DHMH to ensure timely situational updates regarding EVD outbreak, and provide these updates to the Governor's Office. • Monitor the progress of emergency preparedness planning and exercising in state agencies. • Liaison with the Federal Department of Homeland Security regarding the state's EVD outbreak preparedness.
Office of the Attorney General	• Provide legal advice and opinions in support of DHMH EVD operations to include preparing and reviewing proclamations and special regulations issued by the governor. • Represent the State on legal issues for isolation, quarantine, or other public health measures.
Office of the Judiciary	• Establish policies regarding justice system continuity during and after a public health related emergency. In particular, address modification of court schedules and operations (such as jury duty) to accommodate containment strategies. • Provide guidance regarding civil rights and statutory issues. • Ensure maintenance of civil and criminal court systems.
Comptroller of Maryland	• Coordinate and arrange for emergency funds to assist in purchasing resources needed for isolation or quarantined individuals and the overall EVD outbreak response effort. • Assist state and local governments with determining the value of losses sustained as a result of isolation or quarantine of individuals and EVD outbreak.
Department of Budget and Management	• Assist state agencies in identifying potential additional costs associated with supporting local agencies for isolation or quarantine of individuals and during EVD outbreak, and proposing strategies to request appropriation authority for such additional costs.
Department of Commerce	• Develop procedures to provide unemployment assistance to eligible individuals whose unemployment results from isolation, quarantine, or hospitalization due to EVD. • Provide an estimate of the immediate economic impact of a public health related emergency due to EVD outbreak, as requested by the Maryland Emergency Management Agency. Where possible and applicable, the Department shall provide estimated projections of long-range effects of each instance including: residents, businesses, and local, state, and federal agencies.

State Department of Education	• Coordinate with DHMH to develop a communication protocol between school systems and public health at the state and local level. • Coordinate with DHMH to develop protocols for closing and opening schools; canceling or suspending school activities; repurposing of school facilities, equipment, and vehicles; reassignment of non-school system employees (e.g., school nurses); screening of students and staff; and recommendations regarding prophylaxis, vaccines, and antivirals for staff and students. • Provide support and cooperation for mass vaccination of children and staff if required for mitigation in response to EVD outbreak
Department of the Environment	• Provide guidance to assist authorities to manage and dispose of medical waste from isolated, quarantined, or hospitalized individuals • Waive, modify or suspend enforcement of environmental rules if necessary.
Department of General Services	• Ensure information regarding service suspensions due to a public health related emergency due to EVD outbreak is provided to the public. • Identify any services, personnel, equipment, supplies, or buildings that could be useful resources to other departments, agencies, or organizations. • Establish procedures for giving organizations access and use of services, personnel, equipment, supplies, or buildings.
Department of Housing and Community Development	• Upon the declaration of a public health emergency due to EVD outbreak in Maryland, shall immediately inventory the availability of rental property suitable for housing isolated or quarantined individuals for a 21 day period. • Coordinate with DHMH to provide accommodations for quarantined individuals who do not have appropriate lodging.
Department of Human Resources	• Coordinate with appropriate partners to meet the childcare needs of isolated or quarantined individuals unable to care for their children. • Provide non-medical social services support, including food, toiletries, communication support, entertainment, family support, and mental health.
Maryland Institute for Emergency Medical Services System	• License all EMS providers and commercial ambulance services and coordinate the statewide EMS system • Monitor the operation of the statewide EMS System to identify suspected PUIs for EVD and conduct the appropriate notifications/activate resources outlined in this plan • Coordinate with EMSOPs to conduct all transportation and emergency medical services for PUIs/patients with EVD requiring ambulance transportation to a hospital. • Coordinate operational communications associated with PUIs as appropriate for the individual operations. • Provide guidance to EMSOPs, medical directors and individual EMS providers on the proper care and treatment of PUIs for EVD, personal protective practices associated with that care and transportation, and resources available for this response. • Modify Maryland Medical Protocols (Annex G) for EMS providers and COMAR Title 30 as required to ensure appropriate care and transportation of PUIs and the protection of personnel associated with that care and transportation • Inform EMSOPs and medical directors of status of public health emergency plans and when to activate associated EMS emergency operational plans. • Approve applications for Waiver to Licensing Requirements for Inter-facility Transfer for PUIs for Ebola to ensure the appropriate plans and procedures are adequate to meet waiver standards. • Collaborate with EMSOPs to identify resources required for response to PUIs for EVD
Maryland State	• Make field agents available to assist other state agencies with security for

Police	PUI/EVD patient or at-risk individual isolation or quarantine, when possible • Utilize state and local authorities to maintain civil order during a public health emergency due to EVD outbreak. • Coordinate law enforcement and assist with traffic control on effected interstate and state highways during a public health emergency due to EVD outbreak and during mass vaccination (mass prophylaxis if available.)
Department of Public Safety and Corrections	• Coordinate public health emergency plans for correctional facilities, particularly prophylaxis, vaccination, and antiviral plans. • Develop and implement control measures to prevent the introduction and spread of EVD within correctional facilities, to include policies and procedures for restricting visitors, encouraging staff absences, and isolation or quarantine.
Department of Juvenile Services	• Coordinate public health emergency plans for juvenile detention facilities, particularly prophylaxis, vaccination, and antiviral plans. • Develop and implement control measures to prevent the introduction and spread of EVD within juvenile detention facilities, to include policies and procedures for restricting visitors, encouraging staff absences, and isolation or quarantine.

IV. Logistics

DHMH, in conjunction with MEMA and with support from partners, shall oversee the deployment of resources described above using existing plans and protocols as appropriate. Should use of the Strategic National Stockpile be required, DHMH will coordinate with appropriate Federal entities using established processes.

V. Administration and Finance

Costs associated with this mission will be accounted for and documented according to established state and federal level procedures.

Should a State of Emergency be declared, legal authorities exist for reimbursement to counties or municipalities, mutual aid, and continuity of government operations.[13]

VI. Legal Authority

Legal authority for the above public health actions are listed below:

- Duty of physicians and hospitals to immediately report reportable infectious diseases: *Md. Health-General Article §§18-201 and 18-202*
- Isolation and quarantine: *Md. Health-General Article § 18-905*
- Cremation of human remains infected with EVD: *Md. Health-General Article §§ 2-104,18-102(b)(2), 18-903(a)(3), 18-902, and 18-903*
- Declaration of a State of Emergency: *Md. Public Safety §14-107*
- Declaration of a Catastrophic Health Emergency: *Md. Public Safety §14-3A-08*
- Coordination of Emergency Medical Services*: Education §. 13-501 through 13-515*
- EMS System authorities and operations: Code of Maryland Regulation Title 30.
- General Powers of Secretary to respond to infectious disease: *Health-General Article §18-102*

Local jurisdictions may have additional laws which may apply.

[13] http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS21929090304.pdf

VII. Plan Exercise/Maintenance

All DHMH plans are exercised in collaboration, where possible, with other local, state, and federal preparedness partners. The exercise type may vary from table-top, to functional, to full-scale. The exercise will bring statewide preparedness partners together representing several dimensions of a public health and medical response.

All DHMH exercises must be planned and evaluated following the guidelines of the Homeland Security Exercise and Evaluation Program (HSEEP). Exercise Evaluation Guides should be used when appropriate as they provide standards for assessing objectives through the execution of tasks and activities linked to each target capability. All Statewide exercises should strive to obtain buy-in from the appropriate jurisdictions/agencies, senior officials, and other local/state/federal preparedness partners. All exercises must also include a project management timeline, activity milestones, and an exercise planning team.

Through the Centers for Disease Control and Prevention Public Health Emergency Preparedness and Epidemiology and Laboratory Capacity for Infectious Diseases Cooperative Agreements and the Assistant Secretary for Preparedness and Response Hospital Preparedness Program, OP&R will provide training for staff and partners to carry out this plan.

This plan will be revisited on a biennial basis and updates will be incorporated as needed. After Action Reports and Improvement Plans from exercises or real incidents may identify the need for incremental updates of this plan.

VIII. Supporting Documents

Standard operating procedures or guides important for the conduction of this operation

- Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure
- Epidemiologic Risk Factors to Consider when Evaluating a Person for Exposure to Ebola Virus
- Interim Guidance for U.S. Hospital Preparedness for Patients Under Investigation (PUIs) or with Confirmed Ebola Virus Disease (EVD): A Framework for a Tiered Approach
- Guidance on Personal Protective Equipment To Be Used by Health care Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)

Annexes:

Annex A. Epidemiologic Risk Factors to Consider when Evaluating a Person for Exposure to Ebola Virus

The following epidemiologic risk factors should be considered when evaluating a person for Ebola virus disease (EVD), classifying contacts, or considering public health actions such as monitoring and movement restrictions based on exposure.

1. **High risk** includes any of the following:
   In any country
   - Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, and semen[1]) from a person with Ebola who has symptoms
   - Direct contact with a person with Ebola who has symptoms, or the person's body fluids, **while not wearing appropriate personal protective equipment (PPE)**
   - Laboratory processing of blood or body fluids from a person with Ebola who has symptoms **while not wearing appropriate PPE or without using standard biosafety precautions**
   - Providing direct care to a person showing symptoms of Ebola in a household setting

   In countries with widespread transmission or cases in urban settings with uncertain control measures
   - Direct contact with a dead body **while not wearing appropriate PPE.**
2. **Some risk** includes any of the following:
   In any country
   - Being in close contact[2] with a person with Ebola who has symptoms **while not wearing appropriate PPE** (for example, in households, health care facilities, or community settings)

   In countries with widespread transmission
   - Direct contact with a person with Ebola who has symptoms, or the person's body fluids, **while wearing appropriate PPE**
   - Being in the patient-care area of an Ebola treatment unit
   - Providing any direct patient care in non-Ebola health care settings
3. **Low (but not zero) risk** includes any of the following:
   In any country
   - Brief direct contact (such as shaking hands) with a person in the early stages of Ebola, **while not wearing appropriate PPE.** Early signs can include fever, fatigue, or headache.
   - Brief proximity with a person with Ebola who has symptoms (such as being in the same room, but not in close contact) **while not wearing appropriate PPE**
   - Laboratory processing of blood or body fluids from a person with Ebola who has symptoms **while wearing appropriate PPE and using standard biosafety precautions**
   - Traveling on an airplane with a person with Ebola who has symptoms and having had no identified *some* or *high* risk exposures

   In countries with widespread transmission, cases in urban settings with uncertain control measures, or former widespread transmission and current, established control measures
   - Having been in one of these countries and having had no known exposures

   In any country other than those with widespread transmission
   - Direct contact with a person with Ebola who has symptoms, or the person's body fluids, while wearing appropriate PPE
   - Being in the patient-care area of an Ebola treatment unit
4. **No identifiable risk** includes any of the following:
   - Laboratory processing of Ebola-containing specimens in a Biosafety Level 4 facility

- Any contact with a person who isn't showing symptoms of Ebola, even if the person had potential exposure to Ebola virus
- Contact with a person with Ebola before the person developed symptoms
- Any potential exposure to Ebola virus that occurred **more than 21 days previously**
- Having been in a country with Ebola cases, but **without** widespread transmission, cases in urban settings with uncertain control measures, or former widespread transmission and now established control measures, and not having had any other exposures
- Having stayed on or very close to an airplane or ship (for example, to inspect the outside of the ship or plane or to load or unload supplies) during the entire time that the airplane or ship was in a country with widespread transmission or a country with cases in urban settings with uncertain control measures, **and** having had no direct contact with anyone from the community
- Having had laboratory-confirmed Ebola and subsequently been determined by public health authorities to no longer be infectious (i.e., Ebola survivors)

[1] 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.
[2] Close contact is defined as being within approximately 3 feet (1 meter) of a person with Ebola while the person was symptomatic for a prolonged period of time **while not using appropriate PPE**.

Content source: Centers for Disease Control and Prevention

National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)

Division of Health care Quality Promotion (DHQP)

1600 Clifton Road Atlanta, GA 30329-4027 USA

800-CDC-INFO (800-232-4636), TTY: 888-232-6348

Annex B. The Directive and Order of the Maryland Secretary of Health and Mental Hygiene to Report Ebola Case Information and To Take Measures to Prevent Transmission of Ebola

Whereas the World Health Organization ("WHO") and Centers for Disease Control and Prevention ("CDC") have issued health advisories concerning the spread of an infectious and/or contagious condition known as Ebola Virus Disease ("EVD"), which is caused by Ebola Virus ("Ebola");

Whereas Ebola is capable of causing extensive loss of life or serious disability and is identified as a deadly agent as defined in § 18-901(c) of the Health-General Article of the Maryland Code;

Whereas prompt reporting of EVD cases and the proper use of infection control measures are required for effective control of Ebola;

Whereas EVD can at present be medically contained by the Department and appropriate health care providers; and

Whereas §§ 18-201 and 18-202 of the Health-General Article of the Maryland Code require physicians and hospitals to report immediately any case of certain conditions or infectious or contagious diseases designated by the Secretary as reportable;

Now, therefore, I, Joshua M. Sharfstein, Secretary of Health and Mental Hygiene, pursuant to §§ 2-104, 18-102, 18-103(a), 18-904 and 18-905 of the Health-General Article of the Maryland Code, finding it necessary for the control of communicable disease, for the maintenance of an effective disease surveillance system, and for the investigation of actual or potential exposures to Ebola, hereby order and direct as follows:

1. All health care providers and health care facilities, as those terms are defined in § 18-901 of the Health-General Article, shall:

    a. Become familiar with the current CDC case definition of EVD as set forth at the CDC Ebola website at http://www.cdc.gov/vhf/ebola/hcp/case-definition.html;

    b. Consult with the local health department for the jurisdiction in which the practitioner, provider, or facility is located for assistance with EVD case detection, classification, testing, and prevention, as necessary;

c. Submit immediate telephonic and written morbidity and other reports to the local health department for the jurisdiction in which the practitioner, provider, or facility is located, *see* Md. Code Ann., Health-Gen. §§ 18-201 and 18-202;

d. Follow the current CDC infection prevention protocols as posted on the CDC website and take such additional infection control measures as are necessary to prevent person-to-person transmission of EVD;

e. Educate and instruct a suspected EVD case on appropriate infection control measures to prevent transmission of Ebola to others;

f. Not release a suspected EVD case unless and until the immediate reporting requirements in section 1(c) of this Order have been completed and the local health department concurs with the release; and

g. Immediately notify by telephone the local health department for the jurisdiction in which the practitioner, provider, or facility is located of any suspected EVD case who, in the practitioner or provider's judgment, is unwilling or unable to comply with the instructions in section 1(e) of this Order for preventing transmission of Ebola to others;

2. All Local Health Departments shall:

a. Immediately notify the DHMH, Office of Infectious Disease Epidemiology, and Outbreak Response of any suspected EVD cases;

b. Determine, under CDC guidelines and in consultation with the DHMH Office of Infectious Disease Epidemiology and Outbreak Response, which persons might be contacts of a suspected EVD case;

c. Provide guidance to suspected EVD cases and contacts of suspected EVD cases in complying with instructions for preventing transmission of Ebola;

d. Notify the DHMH Office of Infectious Disease Epidemiology and Outbreak Response at 410-767-6700 immediately if, in the local health department's judgment, an individual suspected of having EVD fails to comply with instructions for preventing transmission of Ebola; and

e. Maintain the confidentiality of information collected in connection with this Order, as required by Title 4 and § 18-904(d) of the Health-General Article;

3. Any sheriff, deputy sheriff, or other law enforcement officer of the State or any subdivision shall assist with the enforcement of any portion of this directive and order if directed to do so, as anticipated in § 18-905(a)(3) of the Health-General Article.

THIS DIRECTIVE AND ORDER IS ISSUED UNDER MY HAND THIS 8 DAY OF OCTOBER, 2014, AND IS EFFECTIVE IMMEDIATELY.

Joshua M. Sharfstein, M.D.
Secretary of Health and Mental Hygiene

Annex C. DHMH Ebola Notification Procedures

Assessment and Confirmation of Ebola Cases

- Suspect cases are reported to DHMH or the local health department via hospital, EMS, or any other means.
- If reported to the local health department, the local health department will contact the DHMH Infectious Disease Epidemiology and Outbreak Response Bureau (IDEORB) at 410-767-6700 (daytime) and 410-795-7365 (after hours).
- If a suspect case is encountered directly by local EMS, EMS will contact the closest appropriate hospital receiving the patient and notify the Emergency Medical Resource Center (EMRC) prior to transporting the patient as per the Maryland Medical Protocols for EMS Providers. EMRC will notify the Maryland Institute for Emergency Medical Services Systems (MIEMSS) Administrator on Call who will notify the IDEORB (i.e., Epidemiologist on Call) and MIEMSS leadership.
- IDEORB will determine if suspected case requires further evaluation, and if so, will do the following:
    - If a patient is not in already at a hospital and might need transport by an ambulance, IDEORB will consult with the MIEMSS State EMS Medical Director to determine the appropriate means for transport. If EMS is required MIEMSS will contact the local EMS program to facilitate the transport. If the patient is to be transported to a designated assessment or treatment hospital, MIEMSS will coordinate with the waivered commercial ambulance service affiliated with the receiving hospital to complete that transport. Public safety EMSOPs may be utilized if a waivered commercial ambulance service is not available.
    - Any ambulance transporting a PUI for EVD will communicate through EMRC to the receiving hospital and the MIEMSS AOC to advise when they are leaving the sending hospital and inform them of their estimated time of arrival at the receiving hospital. They will again contact EMRC when the transport is complete.
    - IDEORB will alert the receiving hospital that the patient will be arriving to ensure that appropriate isolation and PPE is in place for evaluation of the patient.
    - IDEORB will follow up with the hospital on the initial assessment of the patient to determine whether or not the patient meets the CDC criteria to be considered a "person under investigation" (PUI) or otherwise merits additional consideration of Ebola infection and testing.
    - IDEORB will contact the CDC EOC to discuss the case.
    - IDEORB, in consultation with the Centers for Disease Control and Prevention (CDC), will determine whether the patient requires Ebola testing by DHMH Lab. If IDEORB determines that Ebola testing is needed, IDEORB will work with the hospital and CDC to ensure proper isolation and PPE are being employed pending the completion of the testing.
    - IDEORB will notify and work with the DHMH Laboratories Administration to ensure proper specimen collection, packaging, and transport to DHMH occurs.

DHMH Notification Process

- For a PUI:

1. Following the determination that an individual will be treated as a patient under investigation, the State Epidemiologist or IDEORB designee will notify:
    - Secretary
    - Deputy Secretary of Public Health Services
    - Lab Director
    - DHMH Public Information Officer (PIO)
    - Director of the DHMH Office of Preparedness and Response
    - Maryland Institute for Emergency Medical Services Systems (MIEMSS) State EMS Medical Director and Administrator on Call (AOC) via Emergency Medical Resource Center (EMRC).
    - Local Health Officer or designee

2. The Deputy Secretary or designee will alert the Governor's Office of Homeland Security and Director of Maryland Emergency Management Agency (MEMA) for situational awareness.

3. Following laboratory testing, the Lab Director will notify the following with the lab results:
    - Secretary
    - Deputy Secretary of Public Health Services
    - State Epidemiologist
    - DHMH Public Information Officer
    - Director of the DHMH Office of Preparedness and Response (OP&R)

4. The Deputy Secretary or designee will alert the Governor's Office of Homeland Security and Director of Maryland Emergency Management Agency of the lab results.

- For a Lab-Confirmed Case:

1. The Secretary or Deputy Secretary will immediately alert the following:
    - Governor
    - Governor's Office of Homeland Security
    - Director of Maryland Emergency Management Agency
    - DHMH General Counsel
    - State EMS Medical Director via EMRC

2. The Joint Information Center may be activated through MEMA to alert, respond, and educate the public about the event. However, the JIC should consider delaying any public information release if possible until the transport has been completed safely.

3. The DHMH OP&R will notify the Department of Human Resources (DHR) Office of Emergency Operations and place on standby for the potential need to quarantine contacts of the confirmed case (in the event that the home environment is inappropriate).

4. If transport is warranted, DHMH will determine the receiving hospital.

5. DHMH will contact EMRC to inform MIEMSS that a transfer has been ordered.

6. In collaboration with the sending facility, the designated receiving hospital and MIEMSS will contact the waivered ambulance company to order services for transfer.

7. Through consultation, DHMH and MIEMSS will determine if a police escort is needed.

8. If a police escort is needed, MIEMSS Administrator on Call will contact the Maryland Joint Operations Center (MJOC) to schedule a conference call to discuss the specifics of the request, including rendezvous points and times, means of communication, routes of travel, etc. The participants of the call shall include:
   a. The Emergency Medical Resource Center (EMRC) (To be contacted by MIEMSS AOC)
   b. The transporting ambulance company (To be contacted by MIEMSS AOC)
   c. Maryland State Police (Contact by MJOC only needs to be made with one official (in the following order):
      i. Sgt. Brett Canfield, MSP Motor Unit / 443-915-5592
      ii. F/Sgt. Rick Carroll, Special Operations Division / 443-764-4715
      iii. Lt. Dan Nelson, Special Operations Division / 443-496-0880
   d. Department of Health and Mental Hygiene (DHMH) personnel. Contact by MJOC only needs to be made with one official (in the following order):
      i. OP&R Emergency Operations Manager / 443-931-0025
      ii. OP&R Deputy Director/ 443-938-1855
      iii. OP&R Director / 443-865-6709
   e. Maryland Department of Transportation (MDOT) personnel. Contact by MJOC only needs to be made with one official (in the following order):
      i. Bud Frank / 410-446-1216
      ii. Mark Harris / 443-829-2147

9. MSP will be responsible for determining the level of law enforcement required to escort the ambulance transporting the patient. MSP will provide escort resources or coordinate allied agencies to conduct the escort.
   a. Law enforcement officials will escort the patient in a non-emergency manner, unless otherwise indicated by MSP command staff or dictated by the condition of the patient.
   b. Law enforcement escorts are primarily responsible for controlling access to the patient in the event of an emergency (e.g., traffic accident, crowd control). Escorting officers should not attempt to render aid to the Ebola patient unless proper PPE is worn.
   c. MSP will be responsible for coordinating with MDOT and any assisting agencies for the transfer of the infected patient.

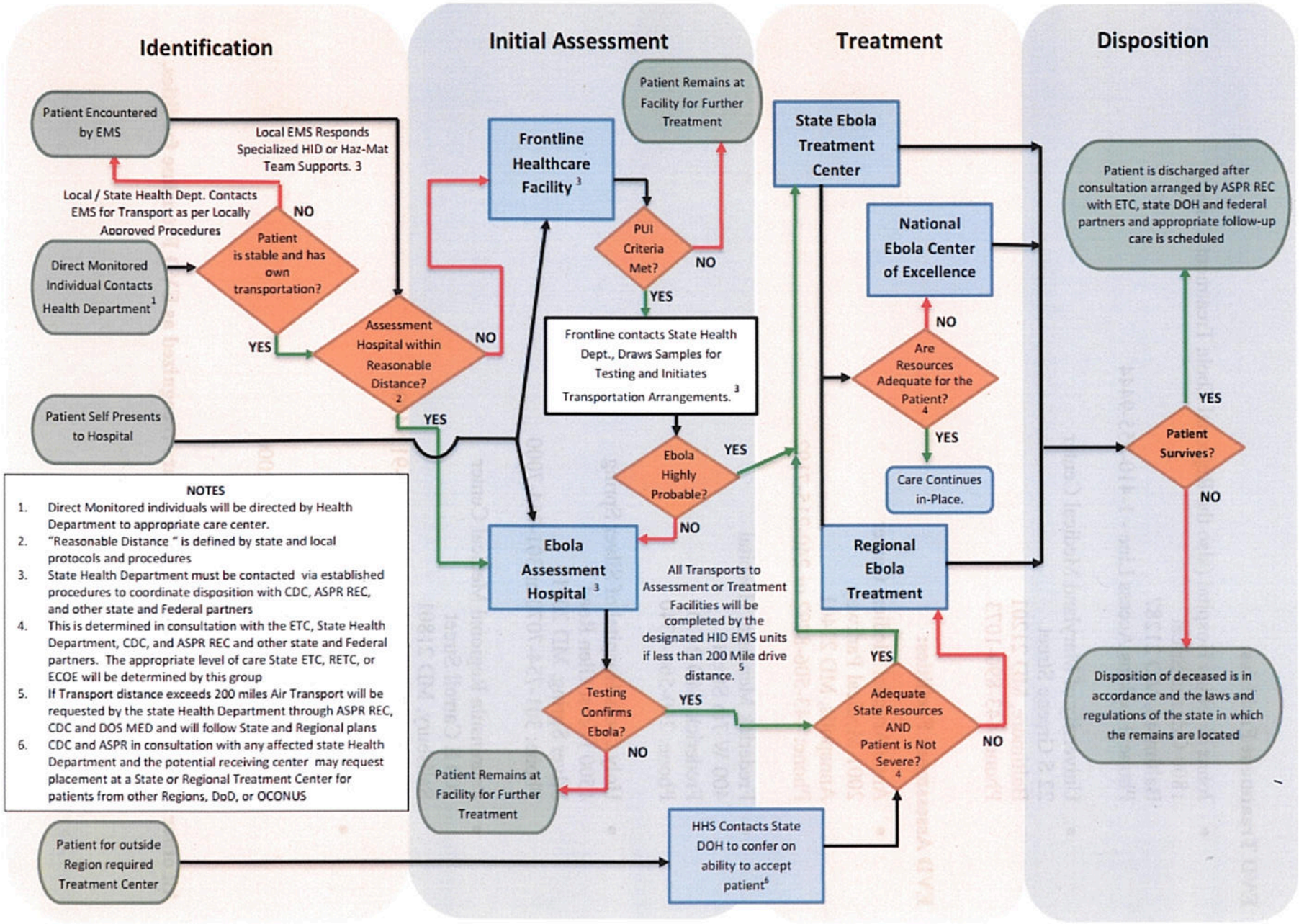
10. The ambulance company will contact EMRC to inform them of the request for transport. If MIEMSS was notified of the transfer by the ambulance company but not DHMH, MIEMSS will immediately contact DHMH to confirm transfer and determine whether a police escort is necessary.

11. The PUI will be transported to the designated hospital.

12. The ambulance company will decontaminate the unit, debrief, and notify MIEMSS of any concerns or potential exposure.

13. The DHMH Secretary will coordinate with MEMA to determine when or if it is appropriate to identify an Incident Commander and activate the SEOC.

Annex D. Patient Transport Algorithm



Annex E. List of Maryland Ebola Assessment and Treatment Hospitals

EVD Treatment Facilities:

- Johns Hopkins Hospital (also the Regional Ebola Treatment Center)
  1800 Orleans Street
  Baltimore, MD 21287
  Phone: Hopkins Access Line - 1-410-955-9444

- University of Maryland Medical Center
  22 S Greene Street
  Baltimore, MD 21201
  Phone: 443-890-1073

EVD Assessment Facilities:

- Anne Arundel Medical Center
  2001 Medical Parkway
  Annapolis, MD 21401
  Phone: 443-506-8892 or 240-215-7192

- Frederick Memorial Hospital
  400 W 7th Street
  Frederick, MD 21701
  Phone: 240-566-4340

- Holy Cross Hospital of Silver Spring
  1500 Forest Glen Road
  Silver Spring, MD 20910
  Phone: 301-754-7070 or 301-754-7000

- Penninsula Regional Medical Center
  100 E Carroll Street
  Salisbury, MD 21801
  Phone: 410-543-7530 ext. 0 or 410-912-4900

- Prince George's Hospital
  3001 Hospital Drive
  Cheverly, MD 20785
  Phone: 301-809-2020 or 301-618-2000

All other acute care hospitals in Maryland are recognized as EVD Frontline facilities.

Annex F. Draft Emerging Infectious Disease, Multi-Agency Resource Support Plan

Emerging Infectious Disease

Multi-Agency Resource Support Plan

I. Introduction

During the Ebola outbreak in Africa during 2014, the Governor's Office convened a task force of State agencies to address state plans for infection control and prevention in anticipation of the possibility of the outbreak impacting Maryland residents and visitors to the State. The task force was divided into subcommittees to address related preparedness and planning activities. *The Multi-Agency Resource Support Plan* is the result of the work done by the Isolation and Quarantine subcommittee. The plan lays the foundation for a coordinated response between multiple state agencies to support people who are: providing health monitoring to the health department, are restricted to their homes, or are restricted from public gatherings and transportation in order to limit the likelihood of disease transmission in Maryland.

Effective implementation of methods to prevent disease transmission requires a clear understanding of the roles and legal authorities of public health staff at local, state, and federal levels and cooperation and collaboration with traditional and non-traditional partners.

The Maryland Department of Health and Mental Hygiene (DHMH) is the lead agency for Health and Medical response at the state level. All preparedness and response activities at the state level related to public health will be approved by DHMH, and may evolve based on the most current information available.

This document was created in coordination with and language from:

- Maryland State Response Operations Plan - Emergency Support Function 8 (Health and Medical Services)
- Maryland Department of Health and Mental Hygiene Emergency Support Function 8: Emerging Infectious Disease plan
- Maryland Department of Health and Mental Hygiene: Isolation and Quarantine Guidelines, Revised Draft Version July, 2009
- Mass Care and Shelter Strategy: State of Maryland ESF-6 Protocol
- Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS)
- Isolation and Response Toolkit, Seattle and King County

II. Purpose of the Plan

The purpose of this plan is to provide guidance for how DHMH and state and local partner agencies can coordinate efforts to support the medical community and the resource needs of affected individuals during an emerging outbreak, specifically:

- Providing a template to create a relevant response plan for a specific outbreak and to clarify expectations of available resources from each agency
- Identifying the authorities, roles, and responsibilities of State and partner organizations when restrictive measures to limit outbreak exposure are taken
- Describing procedures to support small or large scale events, both voluntary and involuntary
- Describing how communications and coordination will occur among DHMH, local, and state entities during an event

- Describing specific procedures for supporting persons who need to shelter in place
- Describing procedures for identifying a facility for persons who cannot stay at their homes or who do not have a suitable home environment during a period of restricted measures
- Identifying methods for providing caretakers for people in need during periods when they are requested to restrict movement (isolation, quarantine, or restricted activities)
- Providing guidance for community-based residential facilities and detention centers.

III. Scope of the Multi-Agency Resource Support Plan

This plan applies to emerging major and life threatening communicable disease events in the State of Maryland requiring intervention by government agencies to provide support and services for people who are asked to restrict their activities and movement for the purpose of preventing disease transmission, including periods of active monitoring, quarantine, or isolation.

While isolation and quarantine are techniques used in the everyday management of infectious disease, this plan does not apply to:

- Tuberculosis Program Control
- Prevention and control of sexually transmitted diseases, or
- Routine operation of Communicable Disease and Epidemiology

This plan can be applied to an individual or group who is mandatorily or voluntarily placed under active monitoring, restricted activities, quarantine or isolation.

This plan will be triggered by DHMH.

The Plan is designed to work in cooperation with the Maryland State Response Operations Plan - Emergency Support Function 8 (Health and Medical Services) and with any policies or procedures put in place by the Maryland Department of Health and Mental Hygiene Emergency Support Function 8: Emerging Infectious Disease plan, and does not supplant any policies or guidance currently in use by DHMH, or ESF 8 authorized agencies, or common sense of leadership.

This plan focuses on roles, responsibilities and activities of multi-agency response partners.
The plan will be coordinated with other preparedness plans and activities of local, state, and federal partners.

This plan applies to:

- DHMH and partner agencies mentioned herein.
- Any persons living in or visiting Maryland requiring assistance as a result of requested or imposed travel or shelter in place restrictions during a qualifying response event.

This plan does not apply to quarantines of geographical areas.

This plan was developed in coordination with multi-agency response partners such as Maryland Emergency Management Agency (MEMA), the Department of Human Resources (DHR), the Office of the Attorney General (OAG), Maryland State Police (MSP), and others. This plan will be maintained by DHMH. DHMH will review the plan every two years and update as necessary. Updates may be made sooner based on exercises or actual events.

IV. Planning Assumptions

Development of the Response Support Plan assumes the following:

- People who display symptoms of a deadly communicable disease will typically be isolated within a healthcare facility, and the hospitals/DHMH will have complete authority over all plans, SOPs, and services for these isolated patients.
- People residing in or visiting Maryland may be asked to restrict their movements and their public exposure, or to isolate or quarantine as one of several tools used to reduce the spread of communicable diseases. There will not typically be accommodations provided for quarantined individuals in a traditional health care setting.
- To stay safe and healthy during these periods, these affected individuals will need resources that their restrictions may prevent them from accessing.
- It is in the best interest of our communities to provide services and have certain resources available to keep affected individuals and families comfortable and healthy, both for their safety, and to limit the likelihood they would break their restrictions for reasons that are otherwise preventable.
- It is advisable that people remain in the household where they are currently living during an isolation or quarantine period (similar to shelter in place), unless this location is inappropriate.
- There may be circumstances when an individual or family will not have an appropriate location to stay during this period, such as:
    - Visitors to the state
    - People living in dense housing, such as:
        - Apartment buildings
        - College dormitories
        - Residential Treatment Centers
    - Foster Care Children

- There may be circumstances when an individual belonging to a vulnerable population (minor, elderly, or otherwise vulnerable) will not have an appropriate person to care for them during restrictive or quarantine periods, such as:
    - Foster Children
    - Children whose parents are in isolation
    - People who are reliant on home health care prior being placed under isolation, quarantine, or travel restrictions

- Planning efforts must incorporate and address the unique needs and circumstances of vulnerable populations including the homeless, limited English proficiency populations, and persons with special medical needs.
- All policies and procedures assuring the security of protected health information (PHI) apply. Policies and procedures recognize that DHMH may make necessary disclosures to protect public health when it is acting as the Public Health Authority.
- Large scale events will require the participation of many public health resources as well as coordination with multiple community, healthcare, and first responder agencies for a successful response.
- Health officials will focus on gaining voluntary compliance from ill or exposed persons and implementing the least restrictive means possible to reduce the spread of infection.

V. Definitions

Active health monitoring, quarantine and isolation are three of a number of measures used to stop or slow the spread of communicable disease and may be applied to individuals and groups on a voluntary or involuntary basis.

- **Health Monitoring:** Is when a person or people who may have been exposed to a disease take certain measures to limit their exposure to others and observe and regularly report on their state of health to a public health authority. Persons who are being monitored are required to check in frequently and report on the presence or absence of certain indicators (e.g., temperature) which may signal exposure. Health monitoring is performed either until the period of incubation has passed and it is clear the subject is not contagious, or until the subject develops definite symptoms of the disease. The period of health monitoring

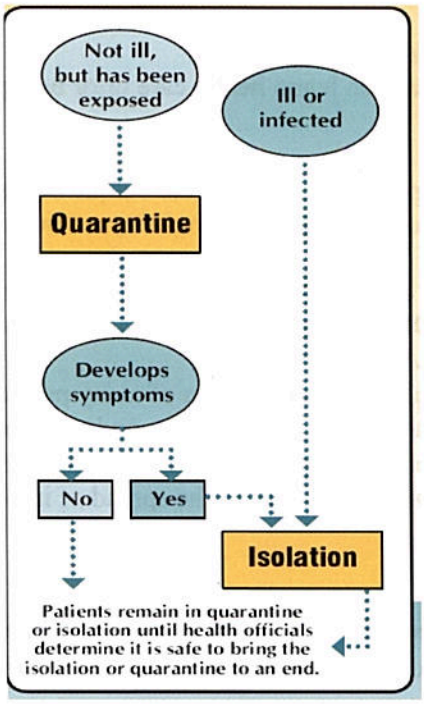
will vary with the incubation period of the disease. Health monitoring may be considered 'Active' based on the regular engagement of the local health department, or other professional medical staff. Health monitoring can be used independently or used during the time people are under isolation or quarantine.

- **Quarantine:** Based on the definition used in COMAR 10.59.01.02 B(6), "quarantine" means the separation or restriction of movement of an individual who, though not ill, has been exposed to an infectious agent, to prevent the spread of infectious illness that may be transmitted to other individuals before illness develops or is recognized. It is the restriction of the movement of individuals who may have been exposed to an infectious agent, but who are not yet sick. The purpose of quarantine is to prevent the transmission of disease to persons who were not exposed to the disease and who are not yet infected.

- **Isolation:** As defined in COMAR 10.59.01.02 B(5), "isolation" means the separation or restriction of movement of an individual who is ill and has an infectious illness or who is ill and suspected of having an infectious illness from those who are not ill or infected for the purpose of stopping the spread of the infectious illness. Isolation reduces the opportunities for contact between the ill individual and well individuals. It is the standard procedure used in hospitals to keep ill patients away from healthy staff and others. Ill persons may be isolated in hospitals, at home, or in a community-based facility, depending on their specific medical needs.

For the purposes of this plan, these three actions are collectively referred to as restrictive measures.

Restrictive measures are standard practices in public health and raise legal, social, financial, and logistical challenges. When restrictive measures are imposed, they must be designed not only to prevent disease transmission in the community but also to ensure prompt delivery of medical care and support to exposed persons and to protect individual civil liberties.



From the DHMH Isolation and Quarantine Guidelines

VI. Concept of Operations

A. General Guidance

1. DHMH will be the lead agency in determining when a current or potential outbreak reaches sufficient status to warrant additional monitoring or response. DHMH will coordinate and communicate with the local health departments and medical response systems to provide guidance and polices for restricting movement of individuals.
2. DHMH has internal plans and policies in place which address:
    - Implementation of restrictive measures, including mandatory isolation or quarantine
    - Issuance of restrictive measure requests and orders
    - Communication to people being asked to participate in restrictive measures
    - Coordination of restrictive measures enforcement

3. At the onset of a potential outbreak, DHMH will notify MEMA, which will in turn notify all necessary agencies and assess their readiness.
4. DHMH and all response partners will operate under the National Incident Management System (NIMS)/Incident Command System (ICS) throughout the duration of the event response.
5. DHMH may coordinate with MEMA to activate a preparedness planning period, or an Emergency Operations Center (EOC) to coordinate state-wide health and medical response during an outbreak situation.
6. Local jurisdictions may activate their local preparedness planning mechanisms, or their EOCs during an outbreak to coordinate consequence response.
7. DHMH and partner agencies will respond under the auspices of the State Response Operations Plan, Emergency Support Function 8 (Health and Medical Services).
8. DHR will be the lead agency (on behalf of DHMH) responsible with coordinating non-medical services and resources for people who are under quarantine or have other imposed restrictions which require service coordination.
9. DHMH will coordinate with local health departments to provide health screening and monitoring.
10. DHMH will provide DHR with contact information for anyone needing services, and DHR will perform an intake and assessment of needs. DHR will acquire resources and coordinate delivery of supplies, with the assistance of DHR's ESF 6 partner agencies and the local LDSS offices.
11. This plan is scalable, and can also be used to assist larger facilities, should this type of quarantine be necessary.
12. DHMH will provide facility support appropriate for isolation and quarantine activities (should the home environment be inappropriate) and determine when the facilities are ready to open. DHMH will coordinate with MEMA, DHR, and DHCD if assistance is needed.
13. This plan can be applied to support people in isolation or quarantine.
14. During illnesses where isolation or quarantine measures are used, response agencies will look to DHMH to provide situationally-specific guidance on:
    - Criteria for determining what measures are required
    - Monitoring or quarantine period required
    - Recommended Personal Protective Equipment (PPE) for caregivers
    - Recommended limitations for affected individuals
    - Infection prevention techniques when multiple people are sheltering in place at one location

15. At a minimum, people under restrictive measures must have access to:
    - Electricity
    - Hot and cold potable (fit to drink) water
    - Hand-washing facilities
    - Toilets
    - Temperature control
    - Telephone access

- Means for discarding trash and waste
- Food
- Medical supplies
- Medications
- Medical care, including psychological care.

B. Determination of Need for Activating Response Measures

1. The Secretary of DHMH or designee will determine when restrictive measures are an appropriate strategy to control a communicable disease outbreak, and what measures are appropriate for specific populations.
2. The Secretary of DHMH or designee will serve as Incident Commander and will also coordinate with MEMA to decide if EOC activation is appropriate and if so, which EOC.
3. DHMH, in coordination with DHR and MEMA, will determine when it is appropriate to trigger services provided for in this plan, including the Quarantine Response plan.

C. Initiation of Voluntary vs. Mandatory Quarantines

DHMH has internal guidelines to determine the necessary voluntary or mandatory restrictive measures.

1. Typically, voluntary compliance is requested first. DHMH, the Local Health Officer (LHO), or appropriate representative will make reasonable efforts to obtain voluntary compliance with restrictive measures.
2. An individual's cooperation with restrictive measures will usually be assumed in good faith unless there is evidence to the contrary. Depending on the event, information collected by DHMH or the LHO during monitoring may be used as evidence of non-cooperation.
3. The LHO, or appropriate representative, will alert DHMH to situations where a person or group indicates unwillingness to comply.
4. The LHO may provide a recommendation to DHMH regarding initiation of involuntary detention.
5. The Secretary of DHMH, or designee, can issue an order for a mandatory quarantine or isolation.
6. If an individual or group is under mandatory quarantine, DHMH, MEMA, and DHCD will resolve issues related to locations for persons under quarantine.
7. Police may provide monitoring to persons involuntarily detained. Security may also be provided for the protection of the person(s) under restrictive measures.
8. Support services (e.g. feeding, supplies) will be provided using the protocols applicable to persons who under isolation or quarantine. Modified protocols may be necessary if the location for detention is a correctional facility or other secure residential facility.

D. Release from Restrictive Measures

1. The Secretary of DHMH, or designee, will determine the release an individual or group from restrictive measures based on the following:

   a. The individual or group is no longer suspected to be infected with, exposed to, or contaminated with a communicable disease or infecting agent; or
   b. The individual or group is no longer deemed to pose a serious and imminent risk to the health and safety of others if released from restrictive measures.

2. If release of a detained person (involuntary isolation or quarantine) is authorized before the expiration of a detention order, the DHMH legal team will coordinate with the activities necessary to accomplish release.

E. Demobilization

The Secretary of DHMH or designee will deactivate response activities for a specific communicable disease when restrictive measures are no longer necessary as a strategy to control the outbreak.

F. Communications with the Public

Coordination of messaging to the general public and healthcare partners will be led by DHMH. This may be accomplished by establishing a virtual Joint Information Center to include public information officers from the health departments of the affected jurisdictions, other state agencies, and health care systems as appropriate. The JIC will ensure consistent public messaging regarding the criteria, justification, role, duration and support for individuals or groups under restrictive measures to generate and maintain public trust.

VII. Responsibilities related to Multi-Agency Coordination

A. DHMH will be responsible for the following activities:

1. Evaluating the public health threat and its potential consequences based on established criteria, and determining restrictive measures are necessary in any given outbreak situation.
2. Providing leadership and appropriate representation for planning activities in support of response efforts.
3. Providing interpretation of federal guidance related to relevant planning for partner agencies, when relevant to providing appropriate services.
4. Determining when statewide guidance is necessary for response.
5. Providing planning guidance for response partners, including:
    - Recommended length of restrictive measures
    - Appropriate facilities for those on restrictive measures
    - Guidance for opening communal facilities
    - Health Monitoring schedule and methodology
    - Appropriate tracking methods for persons on restrictive measures needing services (similar to patient tracking)
    - Education on enforcement methods being used during an event
6. Evaluating local response operations to ensure consistency and inform improvement actions for service delivery.
7. Informing DHR when individuals enter into restrictive measures, and providing contact information for those persons.
8. Delivering an information packet to the individual placed under restrictive measures and providing appropriate instructions and training, if needed, regarding the packet contents, Public Health expectations, and infection control measures.
9. Assisting with coordinating care for supply and service requests for medically fragile, vulnerable population groups, and other unique situations.
10. Contacting identified individuals to evaluate the suitability of their residence for isolation or quarantine.
11. In partnership with DHR, determining if the needs assessment can be implemented using a telephone questionnaire or if an in-person assessment is necessary (See Annex A).
12. Coordinating messaging with DHR related to healthy living guidance for the individuals during periods of restrictive movement.
13. If an individual is a patient in a hospital or other communal living environment, making contact with both the facility staff and the patient to ensure proper care and appropriate infection control measures are practiced.

LHOs or designees will be responsible for the following activities:

1. Implementing health surveillance and quarantine services that comply with clinical protocols and federal, state, regional and local regulations, laws and guidelines.
2. Verifying the individual is at a specified location and monitoring their health status.
3. Providing (through DHMH) any appropriate information to DHR to support the basic needs of individuals including but not limited to food, clothing, shelter, medical care, communication with family members,

legal counsel and others, if needed. Utilizing the *Resource Support Plan for People Sheltering In Place* (Annex A) when needs cannot be addressed locally.

4. If an individual requiring restrictive measures is a patient in a hospital or other communal living environment, making contact with facility staff as well as the patient to ensure proper care and appropriate infection control measures are practiced, if indicated.
5. Conducting surveillance for those under active monitoring.
6. Recording information gathered during check-in calls on a standardized form and entering information into a database.
7. Responding to irregularities such as changes in health status and failure to respond for those under active health monitoring (e.g., requesting law enforcement or Public Health staff drive by; making contact with the patient's health care provider, personal contacts or employer, etc.).
8. Providing requested reporting to DHMH daily.

B. MEMA will be responsible for the following activities:

1. Assisting with coordinating care for supply and service requests for medically fragile, vulnerable population groups, and other unique situations.
2. Coordinating multi-agency assistance requested from DHMH.

C. Law Enforcement agencies will be responsible for the following activities:

1. Assisting with delivery of Mandatory Quarantine orders, if needed.
2. Providing escort for individuals requiring transportation for purposes of involuntary isolation or quarantine, if needed.
3. Executing arrest warrants related to involuntary isolation and quarantine cases.

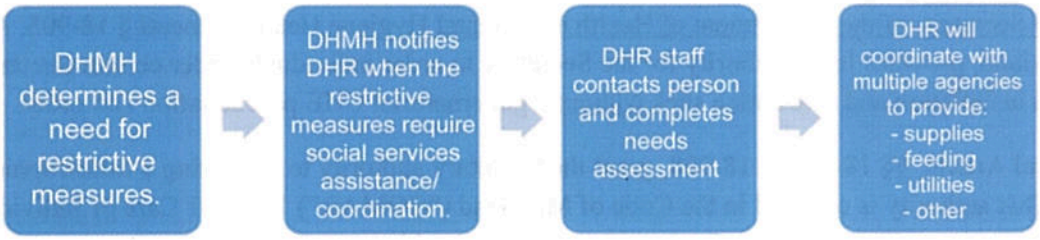
D. The Attorney General's office will be responsible for the following activities:

1. Representing Public Health in any petition or appeal hearings required to carry out involuntary isolation or quarantine of individuals.
2. Coordinating with Public Health and Local Law Enforcement to serve notice necessary to achieve mandatory isolation or quarantine.

E. DHR, in partnership with the State ESF 6 Team, will be responsible for the following activities:

1. Coordinating activities to provide supplies and resources on an emergency basis.
2. Determining which, if any, services are needed to facilitate communication between the person and local authorities, family members or other appropriate agencies/groups and providing these services, as necessary.
3. Coordinating with local community-based organizations, and public and private stakeholders to ensure the ongoing provision of basic utilities (water, electricity, garbage collection, and heating or air-conditioning) to residences where persons under isolation or quarantine are sheltering.
4. Coordinating access to communication services for individuals who are isolated or restricted to their homes or other community setting, if needed.
5. Providing access to mental health and other psychological support, in coordination with DHMH.
6. Arranging resources for childcare or elder care, as needed, and in coordination with DHMH, if required.
7. Coordinating with local social service providers to provide faith-based services and social amenities, as available (e.g. television, radio, Internet access, and reading materials).
8. Documenting all requests for assistance from patients on a standardized form, including the nature and specific type of assistance requested, and the date and time the request was made.
9. Following up with referral agencies on requests for assistance.
10. Providing access for partner agencies to the CERTS database, to track services and finances.

Flow of Events



VIII. Authorities

This section is quoted from the DHMH Isolation and Quarantine Guidelines, Revised Draft Version July, 2009. It is included for the purpose of providing response agencies with context and expectations relevant to service delivery.

Legal Authority for Isolation and Quarantine

Md. Code Ann., Pubic Safety ("Public Safety"), Title 14, Subtitle 3A, Governor's Health Emergency Powers, provide the Governor of Maryland with the legal authority to address a catastrophic health emergency (CHE). Under Public Safety § 14-3A-01(b), a catastrophic health emergency is defined as "a situation in which extensive loss of life or serious disability is threatened imminently because of exposure to a deadly agent." A deadly agent is defined in Public Safety § 14-3A-01(c) as one of a wide range of biological, chemical, or radiological items that could potentially cause extensive loss of life or serious disability.

Powers of the Governor

Public Safety §§ 14-3A-01 to 14-3A-08 grants the Governor authority to act with health emergency powers. The Governor can declare a catastrophic health emergency, issue a proclamation and issue orders under the proclamation.

The Governor has the power to declare a catastrophic health emergency under Public Safety § 14-3A-02. If the Governor determines that a catastrophic health emergency exists, then the Governor will issue a proclamation. Public Safety §14-3A-02(a). The proclamation will include: the nature of the catastrophic health emergency, the areas threatened and the conditions that led to the catastrophic health emergency or the conditions that made possible the termination of the emergency. Public Safety § 14-3A-02 (b) (1)-(3). The proclamation will last for 30 days after the issuance and is renewable by the Governor for successive 30-day periods during the catastrophic health emergency. Public Safety § 14-3A-02 (c) (2)-(3). The Governor will rescind the issued proclamation when the Governor determines that the catastrophic health emergency no longer exists. Public Safety § 14-3A-02 (c) (1).

During the proclamation the Governor can order:

- A health care provider to participate in disease surveillance, treatment and suppression efforts and to comply with the directives of the Secretary or other designated official. Public Safety §14-3A-03(c).
- An evacuation, closing, or decontamination of any facility. Public Safety14-3A-03(d) (1).
- Individuals to remain indoors or refrain from congregating if necessary and reasonable to save lives or prevent exposure to a deadly agent. Public Safety §14-3A-03(d) (2).

Additionally, the Governor can issue orders to the Secretary of the Department of Health and Mental Hygiene ("Secretary") or other designated official under Public Health § 14-3A-03.

Powers of the Secretary of the Department of Health and Mental Hygiene Health-General § 18-905, Annotated Code of Maryland, provides legal authority for the Secretary to order individuals under certain circumstances to go to and remain in isolation and quarantine sites without a gubernatorial CHE proclamation and order.

Health-General Article, §§ 18-901 to 18-908, grant the Secretary authority to act during a catastrophic health emergency. This authority is codified in the Code of Maryland ("COMAR") 10.59.01 Care of Individuals Isolated or Quarantined Due to a Deadly Agent. During a catastrophic health emergency, the Secretary can also receive orders from the Governor under Public Safety § 14-3A-03.

After the Governor issues a proclamation, the Governor may also issue orders to the Secretary or other designated official under Public Safety §14-3A-03 (b)-(d) granting the power to:

- seize immediately anything needed to respond to the medical consequences of the catastrophic health emergency work collaboratively with health care providers.
- control, restrict, or regulate the use, sale, dispensing, distribution, or transportation of anything needed to respond to the consequences of the catastrophic health emergency.
- require individuals to submit to medical examination or testing.
- require individuals to submit to vaccination or medical treatment unless the vaccination or treatment will cause serious harm to the individual.
- establish places of treatment, isolation and quarantine.
- require individuals to go to and remain in places or isolation or quarantine until they no longer pose a risk of transmitting the condition or disease to the public.

The Secretary, or other designated official, has the authority under Public Safety § 14-3A-05 to issue a directive for isolation and quarantine. The content of the directive given to an individual or group of individuals placed in isolation or quarantine shall include the following, according to Public Safety § 14-3A-05(b):

- the identity of the individual or group of individuals that are subject to isolation or quarantine.
- the premises that are subject to isolation or quarantine.
- the date and time when the isolation or quarantine starts.
- the suspected deadly agent causing the outbreak or disease if known.
- the justification for the isolation or quarantine.
- the availability of a hearing to contest the directive.

The directive shall be in writing and given to the individual or group of individuals before the directive takes place. Public Safety § 14-3A-05 (b) (2). If a written directive is impractical, then the Secretary, or other designated official, shall use the best possible means available to ensure that the affected individual(s) are fully informed of the directive. Public Safety § 14-3A-05(b) (3).

The Secretary, or other designated, official also has the authority under Health-General § 18-902(1)-(3) to:

- continuously evaluate and modify existing disease surveillance procedures in order to detect a catastrophic health emergency.
- investigate actual or potential exposures to a deadly agent.

treat, prevent, or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent.

Below are relevant COMAR regarding the government's role in isolation and quarantine.

10.59.01.03

.03 Standards For Isolation and Quarantine.

A. As set forth in Health-General Article, §18-905, Annotated Code of Maryland, in investigating actual or potential exposures to a deadly agent, the Secretary may order isolation or quarantine of an individual or a group of individuals, including those individuals who refuse to be vaccinated, medically examined, treated, or tested.

B. An individual who does not comply with an isolation or quarantine order of the Secretary is guilty of a misdemeanor and on conviction is subject to a fine and imprisonment pursuant to Health-General Article, §18-907(a), Annotated Code of Maryland.

C. If the Secretary issues an order in compliance with Health-General Article, §18-905(b), Annotated Code of Maryland, the Secretary may order an individual into isolation or quarantine at:

(1) A health care facility;
(2) The individual's home; or
(3) A non-health care facility.

D. Place of Quarantine or Isolation other than the Individual's Home.

(1) If the Secretary has determined that it is necessary to issue an isolation or quarantine order for an individual to a facility other than the individual's home, the health officer, in consultation with other public health professionals, shall recommend to the Secretary a suitable place for isolation or quarantine.
(2) The health officer shall base the recommendation for a place for isolation or quarantine on the following:
(a) The seriousness of the disease;
(b) The route or routes of transmission of the disease;
(c) The contagiousness of the disease;
(d) Precedents in the practice of public health;
(e) The behavior, neurological development and condition, and physical condition of the individual being isolated or quarantined; and
(f) The access to needed support services at the site.

E. The health officer, with assistance from local emergency management services, law enforcement personnel, or both, as needed, shall arrange for and provide, if needed, transportation for an individual to be isolated or quarantined.

F. The health officer, with assistance from the local law enforcement agency as needed, shall monitor an isolated or quarantined individual by phone call, home visit, or other means, to ensure that the isolated or quarantined individual stays in the designated facility at all times during the period of isolation or quarantine, except in an emergency such as fire, natural disaster, or evacuation of the area by a county, State, or federal agency for any other reason.

G. If evacuation from the site occurs in an emergency, an isolated or quarantined individual shall notify the health officer immediately by a phone call or any other means possible and follow instructions given by the health officer.

H. Unless not available in the community due to a general state of emergency, the health officer, the administrator of a health care facility, or an individual in charge of an isolation or quarantine facility set forth in Regulation .07B of this chapter, with assistance from staff at local health care facilities, local law enforcement agencies, local social service agencies, local county agencies, or other agencies, shall ensure that an isolation or quarantine facility has, at a minimum:

(1) Electricity;
(2) Hot and cold potable (fit to drink) water;

(3) Hand-washing facilities;
(4) Toilets;
(5) Heat;
(6) Telephone access; and
(7) Means for discarding trash and waste.

I. If an isolated or quarantined individual is in a health care facility, the administrator of the health care facility, and otherwise the health officer, with assistance from staff at local health care facilities, local law enforcement agencies, local social service agencies, local county agencies, or other agencies, shall ensure that an individual in isolation or quarantine has access to, at a minimum:
(1) Food;
(2) Medical supplies;
(3) Medications; and
(4) Medical care, including psychological care.

J. To the extent feasible, the health officer shall provide information to an isolated or quarantined individual, without compromising the health of the isolated or quarantined individual or the people caring for the isolated or quarantined individual, by:
(1) Assessing the language needs of the isolated or quarantined individual;
(2) Translating both oral and written communications and documentation; and
(3) Monitoring to assure that the isolated or quarantined individual is not treated in a discriminatory manner.

K. If an isolated or quarantined individual is in a health care facility, the administrator of the health care facility, and otherwise the health officer, shall, to the extent feasible:
(1) Determine whether the individual has any cultural or religious beliefs that would interfere with medical care during quarantine or isolation; and
(2) Make arrangements to accommodate these beliefs, without compromising the health of:
(a) The isolated or quarantined individual; or
(b) The people caring for the isolated or quarantined individual.

L. An individual in isolation or quarantine shall:
(1) Follow all written and verbal instructions provided by the Department and the local health department;
(2) Notify and receive approval from the local health officer in advance of relocation to a new isolation or quarantine site, except in an emergency such as fire, natural disaster, or evacuation of the area by a county, State, or federal agency for any other reason; and
(3) Notify the health officer immediately upon relocation to a new location, in the event of an emergency such as fire, natural disaster, or evacuation of the area by a county, State, or federal agency for any other reason.

M. An individual in isolation or quarantine may not leave the isolation or quarantine site without notification of the health officer, except in an emergency such as fire, natural disaster, or evacuation of the area by a county, State, or federal agency for any other reason.

N. Parent or Guardian of an Isolated or Quarantined Minor.
(1) If the Secretary orders a minor into isolation or quarantine, the minor's parent or guardian may accompany the minor into isolation or quarantine.
(2) If the Secretary orders a minor into isolation or quarantine and the minor's parent or guardian is unavailable, the minor shall be isolated or quarantined in a facility where adequate care and supervision are available for the minor.
(3) The health officer shall follow the requirements of §I of this regulation in regard to the parent or guardian.

O. The health officer, in consultation with local health care providers, shall:

(1) Recommend to the Secretary when an individual can be released from isolation or quarantine; and
(2) Notify the individual who is isolated or quarantined of the date and time of release from isolation or quarantine, as decided by the Secretary.

10.59.01.06

.06 Isolation and Quarantine in an Individual's Home.

A. The Secretary, with assistance from staff at a local health department, local health care facilities, local law enforcement agencies, local social service agencies, or any other local county agencies as needed, may isolate or quarantine in the individual's home an individual who does not require hospitalization or other highly skilled medical care.

B. The health officer shall:

(1) Ensure that appropriate supplies, such as surgical masks, gloves, thermometers, and hand hygiene material, are available to an isolated or quarantined individual; and
(2) Depending on the kind of illness of an isolated individual or the suspected illness of a quarantined individual, recommend to the Secretary that the Secretary issue further quarantine orders to ensure that other members of the house are quarantined either at the house as set forth in this regulation or at a non-health care facility as set forth in Regulation .07 of this chapter and are provided, at a minimum, with the following:

(a) Written or oral information, or both, about the:

(i) Infection for which the individual is being isolated or quarantined; and
(ii) Precautionary measures the individuals living in the house should exercise while staying in the house where the individual is being isolated or quarantined;

(b) Supplies, such as surgical masks, hand hygiene material, thermometers, and gloves, if appropriate;
(c) The local health department phone number; and
(d) Other information and supplies determined by the health officer as necessary.

C. The health officer, in collaboration with local health care practitioners, shall ensure the monitoring of the health of an isolated or quarantined individual, as needed.

10.59.01.07

.07 Isolation and Quarantine in Non-health Care Facilities Not Individuals' Homes.

A. The Secretary may order an individual, who cannot be accommodated in either a health care facility or the individual's home, into isolation or quarantine in one of the sites listed under §B of this regulation.

B. A health officer may recommend to the Secretary the following sites for isolation and quarantine:

(1) A school;
(2) A hotel;
(3) A motel;
(4) A dormitory; or
(5) Another site determined to be appropriate by the local health officer because the site meets the minimum standards for isolation or quarantine as set forth in Regulation .03H of this chapter.

Specific legal citations which might be used to write a quarantine order are:

- MD Code Ann. Health-General Article §2-104
- MD Code Ann. Health-General Article §18-102
- MD Code Ann. Health-General Article §18-103
- MD Code Ann. Health-General Article §18-104
- MD Code Ann. Health-General Article §18-901(c)
- MD Code Ann. Health-General Article §18-904

- MD Code Ann. Health-General Article §18-905
- MD Code Ann. Health-General Article §18-906
- MD Code Ann. Health-General Article §18-906(b)(2)
- MD Code Ann. Public Safety Article §14-3A-01(c)
- MD Rule 15-1103

Annex A: Resource Support Plan for People Sheltering in Place

Lead: The Maryland Department of Human Resources

A. **Home-Based Support**

Concept of Operations:

Intake, Delivery, Supplies and Services

DHR, Office of Emergency Operations (DHR-OEO) will take the lead on coordinating supplies for those in quarantine at the request of DHMH, or a local jurisdiction. An individual plan will be made for each family, based on their needs and the region where they live.

Notification and Intake

DHR-OEO staff will be notified that a family or individual is being recommended to be restricted to their homes by DHMH (or authorized agent).

DHR-OEO staff will contact the individual or family and perform a telephone interview to determine what resources the family will need, and to provide contact information for follow-up requests (Interview Questionnaire - Attachment A). DHR-OEO staff will be restricted to discussing resource requests. Any questions on the limitations of the restrictions, or health related questions will be referred back to the Health Department.

A waiver allowing coordination between multiple agencies on behalf of an individual will be used. (Attachment B)

Supply Plan: Pick-up, Payment and Delivery

1. DHR-OEO staff will coordinate with the appropriate partner agencies and make an individual plan for the pick-up, payment, and delivery of the supplies for each family.

2. DHR-OEO staff will track purchases and deliveries using the Community Emergency Response Tracking Database (CERTS). Agencies participating in the plan will have access to the database, and can also receive the individual requests for resources and deliveries from DHR-OEO staff (including pick-up addresses and contacts for supplies).

3. Pick-up and payment plans for supplies will vary based on the specific resource requested, the capability of the person receiving the resources to pay.

4. Supplies will be delivered as necessary, probably weekly, but possibly more frequently if hot meals are included with the supplies. Frequent deliveries may also decrease the feelings of isolation for those in quarantine.

5. Unless the situation demands otherwise (or other specific guidance is available), supplies will be dropped off in a disposable box, or a shopping bag with a weight limit not exceeding 25 lbs. per package. People delivering supplies should call those who are under the quarantine to notify them of the several hour

window of time when they will be arriving with supplies. The supplies should be placed at an agreed upon location. The deliverer should then return to a safe distance and notify the individual or family by phone that the supplies have arrived.

6. Supplies being delivered to those under quarantine will be picked up from the appropriate location and transported to the home by the appropriate representative from the local health department who is providing health monitoring, or their designated representative, evaluated on a case-by-case basis, based on the safest situationally specific plan.

Safety During Supply Delivery

Under no circumstances should someone making a supply delivery put themselves at risk of contracting the disease or come in contact with the person for whom they are delivering supplies unless specific guidance is available from DHMH. DHMH will provide guidance on how to prevent transmission. The person who delivers goods will also note any developing concerns, such as accumulation of waste or dog feces that could lead to health or safety issues.

Feeding

Feeding plans will be individualized, and based on the resources available to the individual or group in quarantine. It is anticipated that most people will be able to provide for their own feeding needs. If they cannot, DHR-OEO staff will convene the State Feeding Task Force to create a feeding plan. Plans may include:

- Snacks may be requested from the Maryland Food Bank, and delivered in bulk twice during the restrictive period, based on the needs of the individual or family.
- Four MREs, or suitable shelf-stable equivalent, per person, will also be dropped within the first day of the restrictive period, in case of any unforeseeable disruption of the feeding plan. MREs or their equivalent, can be provided by the local jurisdiction, or are available from DHR-OEO.
- If families can make their own food, families will provide grocery lists to their supply contact. Payment will be made by the families, when possible. If the family is not able to pay for the groceries, DHR-OEO will determine if the individual or family is eligible for the Supplemental Nutrition Assistance Program (or similar). If the individual or family is not eligible, DHR-OEO will work within our ESF6 network to create method for funding the food purchase.
- If an individual or family cannot make food during the quarantine, an arrangement will be made with the best local option to provide appropriate hot meals based on the unique diets of the family (Salvation Army, Meals on Wheels, Department of Corrections, local hospital).

Toiletries and Non-prescription Medications

Those in isolation or quarantine will receive an initial supply drop of items necessary for healthy survival. The initial supply push pack will include items similar to:

- Toilet Paper
- Toothpaste
- Tissues
- Disinfectant
- Paper towels
- Liquid Pump Soap
- Laundry detergent
- Garbage bags
- Snacks
- First Aid Kit
- Non-permeable disposable gloves (for those preparing food, and cleaning the bathroom)
- Age appropriate, assorted games and diversions (e.g. deck of cards, books, DVDs, board games)

- Available fliers appropriate for infection prevention and approved by DHMH (hand-washing flier, body-fluid clean-up flier used in sheltering, indoor exercise advice)
- Pet, infant supplies, and over-the-counter medications - if appropriate based on family composition

Additional similar supplies can be requested by the client by calling their DHR-OEO contact person, who will arrange for the purchase of the supplies (feminine hygiene supplies, adult diapers, prophylactics, etc). The DHR-OEO staff will work with the person delivering supplies to arrange for pick-up and delivery of supplies.

Prescription Medications

Prescription Medications will be replaced through typical Maryland sheltering protocol. Typically, the individual will work with their doctor, insurance company and pharmacy to have the medicine prepared by the pharmacy. The pick-up will be arranged by the OEO by the appropriate delivery method being used for other supplies.

Service Animal and Pets Protocol

Additional supplies will be provided to a family with a cat, dog or other animal that produces substances which need to been cleaned up. Individuals or families in this situation will be provided with additional gloves, bags, disinfectant, and face masks to clean up after the pets. Supplies for persons under quarantine with animals will include paper instruction on the appropriate method for cleaning up fluids or other matter produced by the animal.

Specific guidance will be available on a case-by-case basis, from the Maryland Department of Agriculture.

School

The Maryland State Department of Education has a Pandemic Influenza Continuity of Operations Plan Annex which provides guidance on how the agency would assist students remotely. For quarantine situations, the primary concern will always be the health and safety of children, closely followed with the instruction of the children.

Should a student be identified as being contagious or coming in contact with a person identified with any infectious disease, local medical protocols are already in place. Treating physicians will notify the local health department of the diagnosis; the local health department will notify the local superintendent or the appropriate central office staff, providing guidance on the best course of action to take immediately. The local superintendent will notify the State Superintendent of Schools of the event and the actions taken, including but not limited to their communication protocol to parents and their community.

If it is determined that the student will be quarantined, the local school system will provide the student or students with instructional materials that can be accessed either electronically or by mail. Provisions will be made to make-up any work that was missed during the period of quarantine. The Maryland State Department of Education staff will be available to assist the local school system with guidance, supports and any other assistance they may require.

DHR-OEO staff will attempt to accommodate any requests an individual has to coordinate with colleges, universities or schools that are not licensed through MSDE to continue education during the quarantine or active monitoring period.

Employment

DHR-OEO staff and LDSS staff can provide assistance by producing and delivering documentation explaining the quarantine to employers (if it is not already provided and delivered by the local health department) and verifying that the affected person(s) is/are under isolation or quarantine.

If an employee has an option of working from home during isolation or quarantine, DHR-OEO can work with the individual (and potentially the employer) to assist with acquiring and delivering appropriate supplies.

DHR will report to partner agencies (MEMA and DLLR) when consideration should be given for providing Unemployment Insurance.

Bills and Utilities

If, for any reason, there is a threat of utilities being turned off due to unpaid bills, DHR-OEO will coordinate with the Public Service Commission to ensure adequate services. If necessary, additional coordination with local programs, including faith-based partners, will be provided for utility assistance. If no options exist to pay outstanding utility bills, DHR-OEO may consider payment of the portion of a utility bill incurred during the quarantine, in order to maintain safe and stable utility supply and climate conditions in the household.

Mental Health

DHMH or DHR-OEO staff will request disaster Mental Health volunteers from the DHMH Maryland Responds system to provide mental health support by telephone to anyone under quarantine. The initial request will be for a daily phone call to each individual. The Licensed Mental Health Professional can make the determination of the appropriate call frequency for each individual after his/her professional assessment is completed. Following the individual's release from restrictions, or in the event that an infection is identified within the household, a new mental health treatment plan will be requested.

Additional Services

Additional services, typically available for mass care, remain available for those in isolation or quarantine (telephone translation, assistive communication devices, and medical equipment.) Whenever possible, laptop computers, cellular telephones, and other supplies appropriate for making someone comfortable during a quarantine will be supplied.

Supply Decontamination

If any borrowed or rented supplies are used, they will be decontaminated as per usual methods if no infections are present at the end of the restricted period. If any infections are identified, supply decontamination advice will be requested from DHMH.

B. Location Support

Special concerns are needed to address quarantine for people who have no local residence that is appropriate for isolation or quarantine. Such individuals could include students, tourists, commuters, and others. When the Secretary has determined that it is necessary to issue an order for isolation or quarantine of an individual to a facility other than the individual's home, the health officer shall, in consultation with other public health professionals, recommend to the Secretary, a suitable place for isolation or quarantine. COMAR 10.59.01.03D(1). The health officer shall base the recommendation for a place for isolation or quarantine on the following, under COMAR 10.59.01.03D(2):

- The seriousness of the disease;
- The route or routes of transmission of the disease;
- The contagiousness of the disease;
- Precedents in the practice of public health;
- The behavior, neurological development and condition, and physical condition of the individual being isolated or quarantined; and

- The access to needed support services at the site.

In the event that an individual does not have an appropriate household in which to stay during periods of restricted activities, it is expected that DHMH will find a suitable location, or request the assistance of MEMA and DHCD to find an appropriate facility to use. Together, the agencies will

1. DHMH and DCHD will determine the needs the facility should address.
2. Identify any state or local facilities that may be available.
3. Identify any private facilities that may be available.
4. Work with internal leadership to identify what options they would support.
5. Determine the long-term impact and liability of the options.
6. Determine a payment plan.
7. Determine how to provide necessary services at the location.
8. Determine how to restore the site after the quarantine.

In the event that a family member is identified as having an infection, the household would need to be decontaminated as soon as possible. DHMH or the Local Health Department (with assistance as necessary) will determine a suitable facility for other residents of the house during decontamination.

C. Providing Caregivers for People in Quarantine

Children

In the event that a child without an appropriate guardian needs to be isolated or quarantined, the child will need to stay at a facility provided by DHMH until a guardian is identified. If an appropriate guardian cannot be identified, the child will need to stay at an appropriate facility, provided by or through coordination by DHMH, throughout the duration of the monitoring period.

Youth in the foster care system (in-state and out-of-state placements) will stay with their identified placement provider and follow the same protocols put in place for children residing with their birth families. This protocol is identified in COOP planning, and providers are aware of the plan.

Medically Vulnerable Adults

In the event that an adult cannot safely isolate or quarantine alone, DHMH will find an appropriate facility where the individual's specific needs can be met.

D. Extension of Support

At the request of the patient care team, or family members of a patient being held in isolation or quarantine, any services that are provided for in the Resource Support Plan could be provided for someone in isolation or quarantine, or for someone on less restrictive active monitoring.

E. Guidance for Community Based Residential Facilities

1. All community residential care facilities are encouraged to continue COOP planning activities, which includes the potential for shelter-in-place/quarantine.
2. Specific guidance for COOP planning, and infection control is available from DHMH, and contained within the Maryland Department of Health and Mental Hygiene Emergency Support Function 8: Pandemic Influenza Response Annex.
3. Any additional supply requests can be sent to the State agency under which the facility is licensed. If the agency cannot accommodate the request, the agency can request support through MEMA.

4. During steady state operations, facilities should have guidelines to ensure there is documentation of the dates times, names and contact information for everyone who visits your facility, including staff shifts (actual, not assigned), vendors and visitors. Facilities should have 24 hour contact information for all vendors that provide services and supplies to the facilities.

Annex G. DHMH Directive and Order of the Maryland Secretary of Health and Mental Hygiene for Cremation of Human Remains That Are Infected with Ebola

Whereas the World Health Organization ("WHO") and Centers for Disease Control and Prevention ("CDC") have issued health advisories concerning the spread of an infectious and/or contagious condition known as Ebola Virus Disease ("EVD"), which is caused by Ebola Virus ("Ebola");

Whereas Ebola is capable of causing extensive loss of life or serious disability and is identified as a deadly agent as defined in § 18-901(c) of the Health-General Article of the Maryland Code;

Whereas the CDC has issued Guidance for Safe Handling of Human Remains of Ebola Patients in U. S. Hospitals and Mortuaries;

Whereas the human remains of an individual who was infected with Ebola at the time of death may be infectious and be capable of transmitting Ebola;

Whereas Title 5, Subtitle 5 of the Health-General Article of the Maryland Code sets forth certain provisions related to the cremation or other disposition of human remains, including a requirement for identification of a body prior to cremation, *see* Md. Code Ann., Health-Gen. § 5-502(b); a time restriction on cremation, *see* Md. Code Ann., Health-Gen. § 5-503; the identification of an individual's right to decide in writing on the disposition of the individual's body after death, *see* Md. Code Ann., Health-Gen. §§ 5-509(a) and 5-512(b); and an identification of the right of certain other persons to determine the manner of final disposition of a body after death, in the absence of written instructions from the decedent, *see* Md. Code Ann., Health-Gen. § 5-509(c);

Whereas compliance with the provisions of Title 5, Subtitle 5 of the Health-General Article of the Maryland Code related to cremation, would increase the risk of transmission of Ebola from human remains of an individual who was infected with Ebola at the time of death;

Whereas, based upon current knowledge, cremated remains of a deceased individual who was infected with Ebola at the time of death are no longer infectious and do not pose a threat to health or safety;

Whereas cremation, as defined in § 5-508 of the Health-General Article of the Maryland Code, is the safest method of disposing of the human remains of an individual who was infected with Ebola at the time of death; and

Whereas the State Anatomy Board ("the Board"), as established by § 5-402 of the Health-General Article of the Maryland Code, has the expertise and available facilities to safely handle and dispose of the remains of an individual who was infected with Ebola at the time of death;

Now, therefore, I, Van T. Mitchell, Secretary of Health and Mental Hygiene, pursuant to §§ 2-104, 18-102(b)(2), 18-903(a)(3), 18-902, and 18-903 of the Health-General Article of the Maryland Code, finding it necessary for the control of communicable disease, hereby order and direct as follows:

1. Notwithstanding any provision of law to the contrary, cremation is required for any deceased individual present in the State of Maryland who was infected with Ebola at the time of death, unless cremation is determined by the Board to be unsafe due to an implanted medical device.

2. All health care facilities, as that term is defined in § 18-901 of the Health-General Article, shall:

    a. Become familiar with the current CDC Guidance for Safe Handling of Human Remains of Ebola Patients in U.S. Hospitals and Mortuaries as set forth on the CDC website at http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html;

    b. Comply with all relevant requirements in the CDC Guidance for Safe Handling of Human Remains of Ebola Patients in U.S. Hospitals and Mortuaries and the protocols established by the Board that are attached hereto as Exhibit A;

    c. Immediately notify by telephone the local health department for the jurisdiction in which the facility is located and the Director of the State Anatomy Board of any death of a patient infected with Ebola at the facility;

    d. Provide the Board with any information that the Board deems necessary to expedite the removal and transfer of the decent to the Board's facilities and alert the Board if the body has a medical device implanted; and

    e. Notify the decedent's next of kin or emergency contact person of the death and that the remains are being transferred from the hospital morgue facility to the Board for proper storage.

3. Notwithstanding any other provisions of law, including Title 5, Subtitle 5 of the Health-General Article , the State Anatomy Board shall:

   a. Provide an immediate response to any health care facility that contacts the Board to report a death at the facility of a patient infected with Ebola;

   b. In a manner that is consistent with the CDC Guidance for Safe Handling of Human Remains of Ebola Patients in U.S. Hospitals and Mortuaries and the protocols established by the Board that are attached hereto as Exhibit A, secure, transport, and store human remains of a deceased individual who was infected with Ebola at the time of death, until cremation of the remains or other disposition of the remains if the Board determines that cremation is unsafe due to an implanted medical device;

   c. Authorize cremation of the remains and perform final disposition of the body; and

   d. Release cremated remains to the next of kin of the deceased patient.

THIS DIRECTIVE AND ORDER IS ISSUED UNDER MY HAND THIS 13 DAY OF MARCH, 2015, AND IS EFFECTIVE IMMEDIATELY.

Van T. Mitchell
Secretary of Health and Mental Hygiene

Annex H. Maryland Medical Protocol for EMS Providers – Emerging Infectious Disease Protocol

Presented and passed as amended in September.

ZZ. EMERGING INFECTIOUS DISEASE (EID)

1. Initiate General Patient Care.

2. Presentation

An Emerging Infectious Disease is an infectious disease whose incidence in humans has increased in the past 2 decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include

- New infections resulting from changes or evolution of existing organisms
- Known infections spreading to new geographic areas or populations
- Previously unrecognized infections appearing in areas undergoing ecologic transformation
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.

The most recent example is Ebola Viral Disease (EVD). EIDs that meet this protocol will be posted on MIEMSS webpage under the Infectious Disease Tab. Seasonal influenza is not considered an EID but some of the same principles of infection control may apply to the more common infectious diseases.

a) Signs And Symptoms

Signs and Symptoms of an EID are based on **specific case definitions** for the disease:

- EBOLA case definition includes:
  Travel history or exposure **and** a set of signs and symptoms that are included in the case definition which has evolved over time.

- Other future EID diseases may vary in their Signs and Symptoms which could include
  - Respiratory congestion
  - Sneezing/Coughing
  - Nausea/Vomiting
  - Skin Rashes, Hives or "poxs"
  - Swollen lymph nodes
  - General malaise
  - Loss of appetite
  - Hemorrhage from mucosal membranes
  - Descending neurological deficits

b) Case Definition

As EIDs become more prevalent the Center for Disease Control (CDC) typically publishes a description of each disease which are used to include or exclude a Patient Under Investigation (PUI) for specific testing, treatment and specific isolation or quarantine measures. MIEMSS will post these case definitions on the MIEMSS website and provide specific guidance on the identification, treatment and appropriate transport of these patients and the appropriate use of PPE.

c) Modes of transmission

- Direct Transmission
  In direct transmission, an infectious agent is transferred from a reservoir to a susceptible host by direct contact or droplet spread.

Presented and passed as amended in September.

i. **Direct contact** occurs through skin-to-skin contact, kissing, and sexual intercourse. Direct contact also refers to contact with soil or vegetation harboring infectious organisms.
ii. **Droplet spread** refers to spray with relatively large, short-range aerosols produced by sneezing, coughing, or even talking. Droplet spread is classified as direct because transmission is by direct spray over a few feet, before the droplets fall to the ground.

- Indirect transmission

Indirect transmission refers to the transfer of an infectious agent from a reservoir to a host by suspended air particles, inanimate objects (vehicles), or animate intermediaries (vectors).

i. **Airborne transmission** occurs when infectious agents are carried by dust or droplet nuclei suspended in air. Airborne dust includes material that has settled on surfaces and become re-suspended by air currents as well as infectious particles blown from the soil by the wind. In contrast to droplets that fall to the ground within a few feet, droplet nuclei may remain suspended in the air for long periods of time and may be blown over great distances
ii. **Vehicles** that may indirectly transmit an infectious agent include food, water, biologic products (blood), and fomites (inanimate objects such as handkerchiefs, bedding, or surgical scalpels).
iii. **Vectors** such as mosquitoes, fleas, and ticks may carry an infectious agent through purely mechanical means or may support growth or changes in the agent.

3. Treatment

a) If the presence of an EID at a scene is known prior to entering, don the appropriate PPE and limit entry into the scene to essential personnel only. If an EID is discovered during assessment, immediately don the appropriate PPE, clear scene of non-essential personnel and initiate the recommended decontamination procedures.

b) Initiate General Patient Care.

c) Treat the patient according to the signs and symptoms presented and according to the MIEMSS guidance for the specific EID. Procedures that increase risk of distributing fluids or secretions should be limited to those absolutely necessary to maintain life and provide the patient with a reasonable level of comfort.

d) Contain any bodily fluids or respiratory excretions prior to transporting the patient. A SURGICAL mask may be placed on the patient to limit respiratory droplet aerosolization.

ALERT

N-95 SHOULD **NEVER** BE PLACED ON A PATIENT AS THEY RESTRICT THE EXCHANGE OF RESPIRATORY GASES AND TYPICALLY HAVE A ONE-WAY EXPIRATORY VALVE THAT ALLOWS DROPLETS TO BE AEROSOLIZED UPON EXPIRATION DEFEATING THE PURPOSE OF PLACING A MASK ON THE PATIENT.

e) Transport the patient to the appropriate hospital
Hospitals have been categorized into three levels based on their capabilities to asses and treat PUIs for designated EIDs. MIEMSS will publish a list of Designated EIDs on the MIEMSS website (Currently only Ebola)

Presented and passed as amended in September.

v. Refusal of transport

If a PUI for a designated EID refuses care or transport the EMS provider should remove him/herself from the immediate presence of the patient and contact the local health department through their dispatch center or locally defined procedures and provide as much of the following information about the patient that is available.

1. Full name
2. Age
3. Gender
4. Home address
5. Contact phone numbers
6. Current location
7. Recent travel history
8. Signs and symptoms being displayed
9. Recent contact history with Ebola patients

The EMS provider should expect to be involved in a discussion of the situation with Health Department and Law Enforcement officials and if a quarantine/isolation order is issued, should be prepared to assist Law Enforcement in carrying out that order.

f) Treat the patient according to the signs and symptoms presented and according to the MIEMSS guidance for the specific EID. Limit invasive procedures and any that increase risk of distributing fluids or secretions to those absolutely necessary to maintain life and provide the patient with a reasonable level of comfort.

g) Pediatric patients under the age of 15 discovered at the home or in a non-healthcare environment should be transported to a Treatment Hospital that is also a pediatric trauma center if transport times are not longer than 45 minutes greater than transport to the nearest Frontline Hospital ED. If transport times are longer than 45 minutes greater than transport to the nearest Frontline Hospital ED, the patient should be taken to an Assessment Hospital (if within 45 minute transport time) or the closest Frontline Hospital.