Region IV Ebola Virus Disease Coordination and Transportation Plan

Region IV ESF8 Unified Planning Coalition

July 2016
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Promulgation Statement

ON BEHALF of THE STATES
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee

HHS Region IV Ebola Virus Disease Coordination and Transportation Plan
PROMULGATION

Infectious diseases, such as Ebola Virus Disease, threaten the public health and medical welfare of the Nation. One of the primary roles of government is to provide for the public health and medical welfare of its citizens. Per the National Response Framework, state governments depend on their public health and medical agencies to engage in mitigation, preparedness, response, and recovery actions to safeguard citizens during disaster and emergency public health incidents.

The HHS Region IV Ebola Virus Disease Coordination and Transportation Plan provides a framework for the safe transport of confirmed Ebola patients to the appropriate Regional Ebola Treatment Facility. It addresses the roles and responsibilities of the Authorized Public Health and Healthcare Coordinating Agencies and provides a link to local, state, federal, and private organizations and resources to address transportation and treatment of patients in Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

The HHS Region IV Ebola Virus Disease Coordination and Transportation Plan facilitates consistent response with current state Ebola CONOPs and describes coordination relationships with other levels of government. The plan will continue to evolve from lessons learned from future infectious disease response experiences, ongoing planning efforts, training and exercise activities, and federal guidance.

Therefore, in recognition of the public health and medical responsibilities of the governments of the eight states of HHS Region IV and with the authority vested in the State Health Officers of HHS Region IV, we hereby promulgate the HHS Region IV Ebola Virus Disease Coordination and Transportation Plan.

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State Health Officer, State of South Carolina

John J. Dreyzehner, MD, MPH
State Health Officer, State of Tennessee
Approval and Implementation

The management authority for actions during an Ebola Virus Disease response is done through the execution of the affected states’ Ebola CONOPs. The implementation of this plan is executed by the affected State’s Authorized Public Health and Healthcare Agency and the Georgia Department of Public Health. This plan outlines the direction, control, and coordination protocols required for implementation.

The HHS Region IV Ebola Virus Disease Coordination and Transportation Plan delegates the State Health Officials’ authority to specific individuals in the event that he or she is unavailable. The designated deputy for chain of succession in a major infectious disease incident is as follows:

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This document establishes an HHS Region IV Ebola Virus Disease Coordination and Transportation Plan. The HHS REGION IV STATES adopt the PLAN

Approved by:

Thomas M. Miller, MD, MPH, FACOG, Acting State Health Officer, Alabama Department of Public Health
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This document establishes an HHS Region IV Ebola Virus Disease Coordination and Transportation Plan. The HHS REGION IV STATES adopt the PLAN

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Dr. Celeste Phillip, MD, MPH, State Surgeon General & Secretary of Health, Florida Department of Health
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This document establishes an HHS Region IV Ebola Virus Disease Coordination and Transportation Plan. The HHS REGION IV STATES adopt the PLAN

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This document establishes an HHS Region IV Ebola Virus Disease Coordination and Transportation Plan. The HHS REGION IV STATES adopt the PLAN

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This document establishes an HHS Region IV Ebola Virus Disease Coordination and Transportation Plan. The HHS REGION IV STATES adopt the PLAN

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This document establishes an HHS Region IV Ebola Virus Disease Coordination and Transportation Plan. The HHS REGION IV STATES adopt the PLAN.

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I. Purpose, Scope, Situation, and Assumptions

A. Purpose

To inform local, state, and federal governments; relevant agencies and organizations; and other stakeholders of the preparedness and response plans specific to an Ebola Virus Disease, or Ebola-like disease, in HHS Region IV.

This plan outlines the regional network for the safe transport of patients with Ebola Virus Disease (EVD) and possibly other types of infectious disease. This includes the communication and transportation protocols required for the rapid transport of confirmed Ebola cases to the Regional Ebola Treatment Facility (RETF) at Emory University Hospital, Atlanta, GA or other designated treatment center.

B. Scope

This plan applies to all participating departments and agencies of the jurisdictions contained within the geographical boundaries of the eight states of HHS Region IV. These states include: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. The Region IV Infectious Disease Network primary participants are the state public health departments that oversee infectious disease protocols for the healthcare facilities that may encounter patients with EVD or another infectious disease that may need treatment at a facility that provides specialized care in the treatment of Ebola Virus Disease. The primary Ebola treatment facility for HHS Region IV is located at Emory University Hospital (EUH) in Atlanta, GA, which houses the Serious Communicable Diseases Unit (SCDU).

C. Situation Overview

1. Description of Ebola Virus Disease

EVD is an infectious disease caused by the Ebola virus. Symptoms may appear from 2 to 21 days after exposure and include fever, headache, joint and muscle aches, weakness, diarrhea, vomiting, stomach pain, and abnormal bleeding.

2. Transmission of disease

- EVD is transmitted through direct contact with the blood or bodily fluids of an infected symptomatic person or through exposure to contaminated objects (such as needles or fomites).
- Persons are not contagious until they develop symptoms.
- Persons at highest risk for EVD include healthcare workers and family and friends of infected patients.
- Effective isolation of patients and appropriate infection control measures can control the spread of EVD.

3. Descriptions of Jurisdiction’s Capabilities

A description of each jurisdiction’s EVD response capabilities, as they pertain to this plan, is located in Appendix 1.

D. Planning Assumptions

The following are the planning assumptions for the purposes of this plan.

1. Patient Diagnosis & Preparation for Transport
a. The preferred Ebola treatment location in HHS Region IV is the Regional Ebola Treatment Facility at Emory University Hospital, if available.
b. The patient is confirmed Ebola positive, or
c. The patient has had a high-risk exposure, is symptomatic, and physicians have agreed that transport to the RETF is necessary.
d. The patient’s physician has determined that air or ground travel to a Regional Ebola Treatment Facility is appropriate.
e. Clinical staff members are available to accompany the patient from the hospital of origin, via EMS provider, to the receiving RETF or EMS air transport provider at the designated airport, as needed.

2. Patient Transportation Readiness
   a. EMS provider is ready within four hours of notification to transport the patient from the hospital of origin to the pre-designated airport for air medical transport
   b. The federally contracted air medical transport is available and ready to fly the patient from the designated airport of patient origin to the designated airport for the destination treatment facility.
   c. The airports within the state of patient origin and the receiving airport are ready to accept the federally contracted air medical transport for Ebola patient aeromedical evacuation
   d. The receiving EMS provider is ready within four hours of notification to transport the patient from the designated airport to the appropriate Ebola treatment facility.
   e. Ground transport bullets

3. Regional Ebola Treatment Facility (RETF) Readiness
   a. RETF is available to accept patients from within HHS Region VI within eight hours of notification
   b. RETF maintains capacity (beds and staff) to treat at least two Ebola patients at one time
   c. RETF maintains a capability to treat pediatric Ebola patients or agrees to transfer or redirect pediatric patient to Emory University Hospital / Children’s Hospital of Atlanta - Egleston
   d. RETF maintains the capability to handle Ebola-contaminated or other highly-contaminated infectious waste
   e. RETF maintains a capability to address behavioral health needs for patients and staff
   f. RETF maintains the capability to provide culturally and linguistically appropriate services during procedures and interventions
II. Organization and Assignment of Responsibilities

A. Organization

For disaster response, each of the eight states in Region IV adheres to the organizing principles outlined in the National Response Framework (NRF). The specific responsibilities required of the stakeholders noted in this plan are provided below in Section B - Assignment of Responsibilities.

B. Assignment of Responsibilities

1. Federal Level – U.S. Department of Health and Human Services
   a. Assistant Secretary for Preparedness and Response (ASPR) and HHS Secretary’s Operation Center
      Responsible for coordination and logistical considerations of any transport
      • Liaises and manage the multiple federal agencies engaged in transport
      • Requests air transport services from Department of State (DOS)
      • Provides interstate and interagency communications about the need for transfer of potential EVD patient
      • Assists with air and ground transportation logistics
      • Facilitates communication among all agencies and individuals about incoming patients
      • Facilitates logistics when appropriate; ensure secondary logistics are considered (e.g., law enforcement escort)
      • Facilitates conference call with all parties involved when arrangements are complete and prior to arrival
      • Keeps all parties informed during transport and until patient reaches final destination
      • Assists with patient return to home state as necessary
   b. Centers for Disease Control and Prevention (CDC)
      Provide consultation and expertise for clinical care and subject matter experts (SMEs) for patient management
      • Maintains an EOC 24 hours a day, 7 days a week for direction and control, communications, and information collection, analysis, and dissemination
      • Provides epidemiologic consultation for the determination of risk factors for illness and development of prevention and control strategies
      • Provides CDC experts (e.g., Epidemic Intelligence Service (EIS) Officers, program specific experts) for urgent public health responses and investigations
      • Provides reference diagnostic support to state public health laboratories, direct laboratory testing, and confirmatory capability beyond state laboratory capacity.
   c. Phoenix Air Group
      • Maintains aircraft and crew readiness for the safe transportation of patients with EVD
      • Maintains 24/7 communication capabilities
• Transports patient from airport in the originating state to airport near the designated treatment facility.

2. Regional Level
   a. Georgia Department of Public Health
      Responsible for developing and overseeing the implementation of the CONOPs
      • Receives request to transfer patient from another state
      • Communicates with Emory University Hospital to determine bed and staff availability
      • Participates in coordination calls with the other state, federal partners, and the accepting treatment center
   b. Emory University Hospital (EUH), Serious Communicable Diseases Unit (SCDU)
      Designated as the Regional Ebola Treatment Facility (RETF) in HHS Region IV for treatment of confirmed Ebola patients
      • Upon request, accepts patients from within HHS Region IV within eight hours of notification within capability and capacity limits
      • When the Serious Communicable Diseases Unit (SCDU) is not in operations, maintains capacity (beds and staff) to treat at least two Ebola patients at one time
      • Maintains respiratory isolation infectious disease capacity or negative pressure rooms for at least 10 patients, preferably, within the same unit
      • If necessary, accepts patients that are medically evacuated from Ebola-affected countries or other HHS regions.
      • Maintains a heightened state of readiness by conducting quarterly staff trainings and exercises
      • Maintains a capability to treat pediatric Ebola patients or partners with another facility for the treatment of pediatric patients
      • Maintains the capability to handle Ebola-contaminated or other highly-contaminated infectious waste
      • Maintains a capability to address behavioral health needs for patients, family members, and staff
      • Maintains the capability to provide culturally and linguistically appropriate services during procedures and interventions
      • Provides families of patients transferred to the Serious Communicable Diseases Unit with private waiting rooms, video-conferencing capability to communicate with patient, and isolated visiting area. Emory does not provide support services for families such as housing, meal services or transportation.

3. State Level
   a. Department of Health
      • Coordinates and provides situational awareness, as appropriate, with:
        o HHS
        o State Emergency Management Agency
o EMS
  o Healthcare Coalitions
  o Local Level
  o State Coroner / Funeral Home System
  o Waste Management
  o Other resources as needed
    • Implements their State Ebola Transport plan
b. State Emergency Management Agency
  • Coordinates additional state resources as needed
  • Facilitates Local emergency management assistance as needed

4. Local Level
a. Health departments
  • Coordinates with State Health Department
b. Assessment Hospitals (transferring hospitals)
  • Coordinates and arranges patient placement via state health department
  • Authorizes release of patient and provides report to providers at EUH
  • Maintains the capability to handle and dispose of Ebola-contaminated or highly
    contaminated infectious waste
  • Coordinates with EMS as appropriate
  • Maintains the capability to decontaminate ambulances
c. Healthcare coalitions
  • Coordinates with state ESF-8 and the state health department when appropriate and
    where applicable
  • Provides situational awareness to healthcare coalition members when appropriate
    and where applicable
d. Emergency Medical Services
  • Maintains capability for emergency medical transportation and treatment
  • Manages waste from patient transport per prearranged protocols
e. Emergency Management Agency
  • Facilitates communications with state emergency management
  • Facilitates local emergency management assistance as needed
f. Law Enforcement Agencies
  • Maintains law and order
  • Controls traffic during transport as needed
  • Coordination with local airport security / police as needed
III. Direction, Control, and Coordination

A. Authority to Implement Plan

1. Transfer to Region IV Regional Ebola Treatment Facility (RETF) at Emory University Hospital

   The authority to implement this plan lies with the affected state’s authorized public health coordinating agency in coordination with the Georgia Department of Public Health (GDPH). This process will include coordination with the Region IV HHS Regional Emergency Coordinators.

2. Transfer to a Region IV Ebola Treatment Center (ETC) other than Emory University Hospital

   For transfers to another ETC within Region IV, the authority to implement this plan lies with the affected state’s authorized coordinating agency in coordination with the appropriate receiving state’s authorized coordinating agency. This process will include coordination with the HHS Region IV Regional Emergency Coordinators.

3. Transfer to an HHS Regional RETF other than the HHS Region IV RETF

   For transfer to another HHS RETF other than the Region IV RETF, the authority to implement this plan lies with the affected state’s authorized public health coordinating agency in coordination with the appropriate receiving state’s authorized public health coordinating agency. This process includes coordination with the HHS Region IV Regional Emergency Coordinators. The process for this type of transfer is outside the scope of this plan and will be coordinated on a case by case basis with other states that have a Regional Ebola Treatment Facility.

B. Communication and Coordination

1. Federal Level

   a. HHS ASPR RECs will communicate mission requirements, situational awareness, and operational taskings with the HHS SOC, GDPH, and the state where the patient is located and other stakeholders as needed.

   b. The HHS Secretary’s Operations Center (SOC) and ASPR Emergency Management Group (EMG) will communicate mission requirements with the HHS ASPR RECs to support the overall patient movement and management operation as needed.

   c. As requested, HHS SOC, ASPR EMG, and RECs will communicate mission requirements to US State Department air medical transport contractor to provide air medical evacuation of an Ebola patient from the airport in the state where the patient is located to the destination airport of the Regional Ebola Treatment Facility.

   d. RECs will coordinate communication with all states involved directly with the transport of the patient, especially if by ground transportation.

2. Originating State

   a. Communicate and coordinate mission requirements for Ebola patient management and transport with the receiving state and the Region IV HHS RECs

   b. Communicates and coordinates mission awareness with the ESF-8 contacts of the pass-through states

3. Receiving State
a. Communicates and coordinates mission requirements for Ebola patient management and movement with sending state and the Region IV HHS REC's

C. Notification and Patient Placement

1. Notification
   a. Originating hospital contacts the POC from the Authorized Public Health and Healthcare Coordinating Agency (Sending)
   b. Originating state Authorized Public Health and Healthcare Coordinating Agency contacts GDPH with request
      1) The Point of Contact is the GDPH hotline - the 24 hour contact number for GDPH is (866) PUB-HLTH, (866) 782-4584.
      2) The initial method of communication is telephone (cellular or landline) to the GDPH contact number that is monitored 24/7.
      3) Subsequent communication and mode of communication will be arranged between the affected state's authorized coordinating agency and the GDPH during initial contact.

2. Patient Placement (Region IV RETF)
   a. GDPH contacts Emory University Hospital to determine bed availability
   b. If space is available, GDPH provides the feedback to the requesting state and then coordinates a conference call between EUH, the accepting physician at Emory, the sending facility, the treating physician at the sending hospital, the originating state, and GDPH. This call serves to coordinate information as required for a routine inter-facility patient transfer.
   c. If space is unavailable, GDPH will notify the originating state and the Region IV HHS Regional Emergency Coordinator so that arrangements for transport and coordination can be made for an alternate ETC either inside Region IV or to another RETF outside Region IV.

3. Patient Placement (RETF outside Region IV)
   a. Originating state coordinates with REC / HHS to determine which HHS Region has an RETF with available beds
   b. Originating state's REC coordinates with the receiving state's REC to implement their plan.

4. Acceptance of Patient at Region IV RETF
   a. GA DPH coordinates communication between sending facility and EUH to provide patient status information
   b. EUH confirms acceptance and completes patient report with sending hospital and state
   c. EUH notifies GA DPH of acceptance
   d. Originating state activates the transportation algorithm in coordination with GDPH and Region IV REC (see Section D. below)
D. Air Transportation Plan to the Regional Ebola Treatment Facility

1. Purpose
   To establish a mechanism for air transport of a high risk or confirmed EVD (or other infectious disease) patient to the Regional Ebola Treatment Facility (RETF) at Emory University Hospital in Atlanta, GA from any state in HHS Region IV.

2. Situation
   Fixed-wing air transport is an ideal and preferred method of transport to the Regional Ebola Treatment Facility (RETF) and should be ruled out as an option before ground transport is considered. Air transport is a coordinated local, state, and federal mission. The federal government, through the U.S. Department of State, has a sole-source contract with Phoenix Air for transport of Ebola patients. The service base is located in Cartersville, Georgia. This section D. of the plan is based on utilization of Phoenix Air for transport.

3. Assumptions
   a. From the time of request to the federal government, it takes approximately 2 hours for the aircraft to arrive in the requesting Region IV state (pending availability of an aircraft).
   b. Availability of aircraft is contingent upon weather and priority of competing mission assignments.
   d. Patient medical records and information will be transported in hard copy with the patient.

4. Concept of Operations
   There are three distinct components of an air transport, which are described in this plan:
   - Leg 1: Assessment Hospital to Airfield A
   - Leg 2: Airfield A to Airfield B
   - Leg 3: Airfield B to Regional Ebola Treatment Facility

   a. Leg 1: Assessment Hospital to Airfield A
      1) Prior to any deployment of local transport, the originating state health department contacts the Region IV REC to request air transport services via Phoenix Air Group.
2) Utilization of Phoenix Air must be requested through the federal government. To request this service, states complete the following:
   - Contacts the designated HHS Region IV Regional Emergency Coordinator to request air transport.
   - Provides location of Airfield A.
   - Provides a point of contact for coordination of transport times.
   - Provides general information about patient condition (specifically if patient is adult or pediatric and patient symptoms).

3) Local and/or State jurisdictions coordinate the transport of a patient from the assessment hospital to Airfield A, per individual state plans.

4) Airfield A is the designated airport in which the fixed-wing air ambulance will pick-up the patient. At Airfield A, patient care and interfacility checklist will be transferred from the local EMS transport provider to the air ambulance crew. The state and/or local jurisdictions are responsible for designating airfields to serve in this capacity and establishing an agreement to use the airfield in a real event.

5) The airfield must meet the following requirements:
   - Must have a 5000 feet runway able to accommodate a Gulfstream G-III jet with a maximum ramp weight of 70,200 lbs.;
   - Should have an outdoor direct route for the ambulance transporting the patient from the assessment hospital directly to the air ambulance;
   - Should be secure, with limited access and gated.

6) EMS providers should remain in PPE and return to a locally-designated location for decontamination of ambulances before doffing PPE. The transport vehicle should then be decontaminated per recommended guidance.

b. Leg 2: Airfield A to Airfield B

1) The originating and receiving states, in conjunction with the federal government, are responsible for coordinating the transport of a patient from Airfield A to Airfield B.

2) Airfield B is the designated airport in which the air ambulance will land. The location of Airfield B is determined in coordination with GDPH, Phoenix Air, EUH, and the federal government.

3) Phoenix Air services must be confirmed through the Region IV REC prior to Leg 1.

4) The HHS Regional Emergency Coordinator, in coordination with other federal officials, will:
   - Liaises with and coordinates the multiple federal agencies engaged in the transport
   - Requests air transport services from Department of State (DOS)
   - Provides interstate and interagency communications for the need for transfer of a potential EVD patient;
   - Assists with air and ground transportation logistics as needed;
   - Coordinates interoperable redundant communication methods;
Facilitates communication among agencies and individuals about incoming patients;
Facilitates logistics when appropriate and ensures logistics are considered (e.g., law enforcement escort);
Facilitates conference calls with parties involved when arrangements are complete and prior to arrival;
Keeps all parties informed during transport and until patient reaches final destination;
Assist with patient return to home state as necessary.

5) The federal government assumes financial responsibility either directly or through reimbursement for payment of an air transport of an Ebola patient to the Regional Ebola Treatment Facility (RETF).

c. Leg 3: Airfield B to the Regional Ebola Treatment Facility
   1) GDPH, in coordination with EMS and the RETF (EUH), is responsible for coordinating the transport of a patient from Airfield B to the Regional Ebola Treatment Facility.
   2) Grady EMS is the preferred ground transport provider from Airfield B to the RETF.
   3) If the patient is going to another one of GA’s treatment centers, ground transportation may be provided from another of Georgia’s Infectious Disease Transportation Network services other than Grady.
   4) The HHS Region IV Regional Emergency Coordinator will notify all parties involved upon arrival of the patient to the RETF.
E. Ground Transportation Plan to the Regional Ebola Treatment Facility (RETF)

1. Purpose

This section of the plan establishes a mechanism for ground transport of a high risk or confirmed EVD (or other infectious disease) patient to the RETF at Emory University Hospital in Atlanta, GA from any state in Region IV when air transport is not available for whatever reason. This plan is specifically designed for multi-leg transports from locations four (4) hours or more from the Regional Ebola Treatment Facility.

2. Situation

Fixed-wing air transport is an ideal and preferred means of transporting a patient to a Regional Ebola Treatment Facility. However, availability of air transportation is limited by the number of factors (e.g., available aircraft, competing mission assignments, weather) making it necessary to have an optional ground transportation plan for Region IV. Ground transport plans must account for duration of time EMS providers can provide care in personal protective equipment (two to four hours), personal needs of the crew, fueling and other logistical needs of the transport vehicle, and preventing contamination of stopping locations during transport.

3. Assumptions

a. In normal traffic, each state in Region IV has no more than a 10 hour ground transport time to the RETF (with the exception of the Florida Keys) from its farthest distance.

b. EMS providers are recommended to provide patient care in Powered Air Purifying Respirator (PAPR) for only two to four hours at a time.

c. 300 miles is the average distance an ambulance can drive before needing to re-fuel.

4. Concept of Operations

a. Patient Transfer Points (PTP) are identified at locations within an acceptable transport distance to the RETF. At these PTPs, the Georgia Infectious Disease Transportation Network will take over patient care and transport for the final leg to the RETF. Additional patient transfer points within Georgia may be utilized if necessary in unforeseen situations.

b. The state in which the patient presents is responsible for transport to the Patient Transfer Point. It may be necessary in some cases to change crews at a mid-point (or multiple points) during the transport to the Patient Transfer Point. The originating state is responsible for identifying locations to change crews and re-fuel transport vehicles as necessary. It is strongly recommended that all ground transport vehicles be followed by a support vehicle that can assist with re-fueling, provide logistics support, provide relief staffing and emergency support.

c. In most cases, ground transport will be a multi-leg transport. The diagram below depicts possible scenarios for two, three- and four-leg ground transports.
d. The identified Patient Transfer Points are listed in Appendix 2. Additional patient transfer points are available in Georgia if needed in unforeseen circumstances.

1) Patient Transfer Points will have the following capabilities
   a. Decontamination station for vehicle
   b. Designated donning / doffing area
   c. Designated area for personnel decontamination
   d. Secure patient transfer zone
   e. Waste disposal
   f. Redundant communications

2) Transporting states should establish individual agreements with the designated healthcare facilities at the Patient Transfer Points to serve as their transfer locations.

e. To activate this plan, states should contact the Georgia 24 hour contact at 1-866-PUB-HLTH or 1-866-782-4584. The originating state must provide:
   1) Selected Patient Transfer Point (PTP)
   2) Arrival time
   3) Patient information
   4) Redundant communication information
F. Waste Management

1. Purpose

This section is intended to provide key information about procedures and regulations regarding waste associated with the care of patients under investigation (PUIs) for or with confirmed Ebola virus disease (EVD).

2. Situation

Waste contaminated (or suspected to be contaminated) with Ebola virus is a Category A infectious substance regulated as a hazardous material under the U.S. Department of Transportation (DOT) Hazardous Materials Regulations (HMR; 49 CFR, Parts 171-180). Requirements in the HMR apply to any material DOT determines is capable of posing an unreasonable risk to health, safety, and property when transported in commerce. For off-site commercial transport of Ebola-associated waste, strict compliance with the HMR is required.

Waste generated in the care of PUIs or patients with confirmed EVD is subject to procedures set forth by local, state, and federal regulations. Basic principles for spills of blood and other potentially infectious materials are outlined in the U.S. Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard (29 CFR 1910.1030).

3. Assumptions

a. Each state, the treatment facilities, and assessment facilities have a waste management plan for Ebola-associated waste.

b. 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. Therefore, such waste no longer is considered a Category A infectious substance and is not subject to the requirements of the HMR.

c. 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 medical waste disposal.

4. Concept of Operations

a. Waste generated during the transport of patients from an originating facility to a designated air transport location will be returned to the originating facility in the transport vehicle for disposal based on the facility’s or EMS provider’s waste management plan.

b. Waste generated during ground transport will be managed per the following:

   1) The facility that has agreed to be the designated transfer point will dispose of the waste per their facility Ebola waste management plan.

   2) The waste will be disposed of at the final destination per the Emory University Hospital Ebola Waste Management Plan or by another Region IV ETC per their facility waste management plan.

c. EMS units will doff PPE at either the transfer location or the final destination and the EMS vehicle will be cleaned and disinfected at that site.
G. Mortuary Affairs

1. Purpose

This section of the plan is intended to assist EMS providers in the event that a patient dies in transport; to protect against the postmortem spread of Ebola infection during transport through arrangement of appropriate actions for transport to the mortuary for final disposition of remains.

2. Situation

Although Ebola-related deaths in the United States would likely occur within a hospital setting, an incident of death during transport of an Ebola patient is a possibility. Ebola can be transmitted in postmortem care settings through direct handling of human remains without proper precautions and use of PPE.

3. Assumptions

a. Each state has a plan to manage the remains of Ebola patients.

b. Ebola Treatment Facilities and Assessment Hospitals have a facility-specific plan to manage EVD fatalities.

4. Concept of Operations

a. Patient death during transport

   1) Should a patient die in transit decisions as to where the remains will be transported will be handled on a case-by-case basis by medical control depending on transport time to facility, provider time in PPE, state and/or location.

b. Available regional Fatality Management capabilities are listed in Appendix 1: Description of Jurisdiction’s EVD Capabilities
H. Medical / Legal

1. Transport Considerations
   a. Any state in which a patient will be transported through shall be notified through the established notification process.
   b. Transports shall be treated as non-emergent transports with no lights and sirens.
   c. During any leg of the transport, the state that has the primary responsibility for care and transport of the patient is also responsible for logistical emergencies and will use their 24/7 coordination point.
   d. It is recommended that the support vehicle be a second ambulance including staff and appropriate PPE.

2. Medical Treatment Considerations
   a. The Memorandum of Transfer will designate the receiving physician at the Regional Ebola Treatment Facility who will provide online medical direction and should be immediately consulted in any deviation in the patient’s condition. The sending and receiving physicians determine treatment protocols and provide written orders to the transporting EMS providers.
   b. The Memorandum of Transfer is signed by the sending physician and includes inter-facility orders checklist.
   c. Inter-facility orders checklist provides the medical orders for the treatment of an Ebola patient with specific medical control issues to include:
      1) Resuscitation status
      2) Invasive procedures (yes/no)
      3) Direct Number to 24/7 Coordination Point
      4) Direct Number to Online Med Control
IV. Administration & Finance

A. Administration
This section outlines general policies for administering resources, including the following:
The Authorized Public Health and Healthcare Agencies for each state are listed in this plan and should be the reference point for policy and administration questions or changes.

B. Finance
1. Reimbursement information for treatment and transport of confirmed Ebola case
   a. The Ebola Supplemental Patient Care Reimbursement Program is authorized by the Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113-235, Division G, Title VI, and section 311(c)(1) of the Public Health Service Act, 42 U.S.C. 243(c)(1). The U.S. Department of Health and Human Services’ (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) works with a third party vendor to assist the Government with the processing of applications and the payment of authorized reimbursement amounts for the Program. The Act allows for “reimbursement of domestic transportation and treatment costs (other than costs paid or reimbursed by the individual’s health coverage) for an individual treated in the United States for Ebola, before or after the date of the enactment of this Act” at the HHS Secretary’s discretion.
   b. The Ebola Reimbursement Program may reimburse providers for domestic transportation and treatment costs incurred by the provider for patients with laboratory confirmed Ebola consistent with statutory authorities referenced above. Providers will not be eligible for reimbursement of transportation or treatment costs already covered by an individual’s insurance, and reimbursement will be limited to direct, uncompensated costs for caring for or transporting Ebola patients.
   c. Reimbursement for each professional claim (those submitted using the CMS-1500 form) will be calculated as the total value of allowed charges submitted by the practitioner--less any payments already received or to be received by the practitioner from other payers.
   d. Additional reimbursement for Extraordinary Direct Patient Care Staffing Costs:
      1) Extraordinary direct patient care staffing costs are considered to be staffing costs above the normal staffing levels for the room and bed rate charges billed/reimbursed to date.
      2) While it is anticipated that reimbursement will be most applicable to hospitals, it is possible that patient transportation and other providers may have also experienced effort levels above the Relative Value Units (RVUs) normally set for a procedure.
      3) Electronic copies in PDF format or hard copies of payroll records, time and attendance system records or other supporting are required for such a submittal.
      4) The organization seeking reimbursement must provide as much narrative and supporting documentation as you deem necessary to document and explain these extraordinary direct staffing costs incurred while providing patient care or supporting the environment of care for confirmed Ebola-infected patients and why they are not fully reimbursed as part of payments received to date from other payers.
2. Ebola Treatment Reimbursement Program for U.S. Hospitals
   a. Any provider that has treated or transported a patient with Ebola is eligible for reimbursement.
   b. The federal government is reimbursing hospitals because several hospitals around the country treated patients with confirmed cases of Ebola disease and incurred unusual expenses in delivering that care. Congress appropriated funds to be used for “reimbursement of domestic transportation and treatment costs for an individual treated in the United States for Ebola.”
   c. The Hospital or transportation provider must seek reimbursement for care from the private insurance company prior to submitting the reimbursement claim to HHS.
   d. Generally, eligible expenses will be limited to the direct costs of care not already covered by other methods of reimbursement, including, but not limited to:
      1) All clinical care and interventions
      2) Increased staffing costs
      3) Personal protective equipment
      4) Waste management, removal, and disposal
      5) Increased laboratory costs, including expenses of shipping of samples
      6) Patient transport costs
   e. The following expenses are ineligible for reimbursement:
      1) Costs already covered by other methods of reimbursement (e.g. insurance)
      2) Training
      3) Facility modification
      4) Lost revenue
      5) Increased security
      6) Post exposure monitoring of staff, etc.
   f. Under this authority, HHS will reimburse for direct, uncompensated costs for caring for or transporting Ebola patients using funds appropriated to the Public Health and Social Services Emergency.
   g. HHS will reimburse the full difference between calculated costs and payments received. HHS will reimburse any “extraordinary” costs at 102% to account for increased administrative efforts and other indirect expenses associated with the care of Ebola patients.
V. Training & Exercise

A. Training Plan

The designated public health authorities recommend training individuals on elements applicable to this plan. Personnel also need to receive training on how the jurisdiction will execute this plan. Leaders must understand how their organizations and agencies contribute to the proper functioning of the regional hospital tiered system. All personnel must understand what their role is in ensuring operations are coordinated with other partners and their responsibilities in ensuring proper communication between these partners. Ensure adequate training regarding roles and responsibilities under the CONOPS. Effective training must be sustainable (e.g., recorded webinars, online training, detailed presentations) and be conducted with appropriate personnel before conducting exercises. Documenting the training will help in identifying gaps in educating partners on the various plans and provide the means necessary to meet evolving needs.

Jurisdictions may also sponsor staff from their ETCs or Ebola assessment hospitals to train at the National Training and Education Center as outlined in the 2015 EVD HPP Funding Opportunity Announcement.

1. Training Plan development and Implementation:
   a. A training development team is identified and coordinated through efforts of the Training & Exercise (T&E)subcommittee for the Region IV ESF8 Unified Planning Coalition (UPC).
   b. Training will be coordinated to the extent possible and when applicable through the Georgia Department of Public Health, in coordination with Emory University Hospital.
   c. Each state and facility is responsible to ensure the appropriate training is completed to ensure success of the HHS Region IV Ebola Virus Disease Coordination and Transportation Plan.

B. Exercise Plan

1. Exercise Plan development:
   a. The exercise development team is identified and coordinated through efforts of the T&E subcommittee for the Region IV ESF8 Unified Planning Coalition (UPC).
   b. For exercise development related to this plan, the Georgia Department of Public Health, in coordination with Emory University Hospital, is the T&E Lead Coordinator.
   c. For ease of coordination, the exercise calendar will be based on the HPP-PHEP grant cycle beginning on July 1 and ending on June 30. However, the official year end date is May 15.
   d. In year one (2015-2016), the T&E Lead will coordinate the development of the exercise schedule and exercise materials by 30 SEP 2015.
   e. In year two and following, all exercise schedules and exercise materials will be developed by 30 June of that year.

2. Exercise implementation
   a. Annually (4th quarter - April 1- June 30), the T&E Lead will coordinate yearly exercises with EUH for the 8 states.
b. At a minimum, all states will complete a notification drill with GDPH and EUH annually. Templates are available from the T&E Subcommittee.

c. Exercises will follow a progressive planning approach.

1) Year 1: The T&E Subcommittee will arrange a seminar during a UPC function. Each state will perform a communication drill during the 4th quarter.

2) Year 2: The T&E Subcommittee will arrange a table-top exercise

3) Year 3-5: Each state may choose to implement an annual functional or full-scale exercise in coordination with their state exercise plan

d. All states will complete a simulated or actual patient movement to the RETF at least once during year 3, 4, or 5

e. Air coordination will be included in the exercises when applicable

f. Each state will maintain their own exercise plan

3. Measures for transport exercise:

a. Specific requirements for the frequency and type of exercises are covered in each of the 2015 EVD Funding Opportunity Announcements and Grant Application Instructions for ELC, PHEP, and HPP. Each jurisdiction should outline requirements for exercise reporting and capture the results that evaluate personnel and procedures pertaining to the plan. Larger scale exercises will focus on response capabilities across the system, with the understanding that these may include sectors, agencies, and organizations that do not always conduct exercises together. Following HSEEP guidelines should smooth the process. Improvement plans will drive changes to the plan and inform training on the plan itself.

b. Hospital Preparedness Program measures for regional exercise:

<table>
<thead>
<tr>
<th>ASP R PM#</th>
<th>Part</th>
<th>Activity</th>
<th>Measure</th>
<th>Responsible Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A A</td>
<td>Time, in minutes, it takes from an assessment hospital’s notification to the health department of the need for an inter-facility transfer of a patient with confirmed Ebola to the arrival of a staffed and equipped EMS/inter-facility transport unit, as evidenced by a no-notice exercise (Goal: Within 240 minutes or 4 hours).</td>
<td>Coalition or AH exercise or real event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 B A</td>
<td>Time from confirmation of Ebola patient at assessment hospital or ETC to notification by the health department and/or transferring hospital (assessment hospital or ETC) to the health department in the state/jurisdiction where the regional Ebola and other special pathogen treatment center is located about the need for patient transfer (Goal: Within 30 minutes).</td>
<td>AH or ETC exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 B A</td>
<td>Proportion of states/jurisdictions in the HHS region that have demonstrated the ability to move a patient across jurisdictions by ground or air to a regional Ebola and other special pathogen treatment center, as evidenced by a real-world event or participation in a multi-jurisdiction exercise (Goal: 100%).</td>
<td>Part B awardee measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 B B</td>
<td>Time until a regional Ebola and other special pathogen treatment center is ready to admit a patient with confirmed Ebola (adult or pediatric patient), as evidenced by an exercise or actual patient transfer (Goal: Within 8 hours of notification).</td>
<td>Part B exercise or actual patient transfer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VI. Plan Development and Maintenance

A. Development

1. Lead Agencies
   a. Georgia Department of Public Health (GDPH) and Region IV ESF8 Unified Planning Coalition (UPC) are responsible for coordinating emergency planning.

2. Supporting Agencies
   a. The Authorized Public Health and Healthcare representative of each jurisdiction is responsible for supporting emergency planning.
   b. The ASPR OEM Hospital Preparedness Program Field Project Officer and Regional Emergency Coordinators are responsible for assisting GDPH with facilitation of planning efforts, providing input into operational planning, and providing guidance on ASPR policies and requirements.
   c. Emory University Hospital is responsible to review the plan and provide input related to operational changes.
   d. A designated representative from the CDC will be consulted to provide guidance and input as warranted.
   e. The Region IV assessment hospitals and treatment hospitals are responsible for reviewing this plan via their State Authorized Public Health and Healthcare Lead Agency.

B. Maintenance

1. Requirements
   a. The GDPH, in coordination with the UPC, will maintain, distribute, and update the plan. The Plan will be maintained in the UPC plan repository housed at the Florida Department of Health. The Plan may be accessed through contact with the UPC Coordinator. Review and distribution of the plan will be coordinated by GDPH and the UPC.
   b. To comply with requirements outlined in ASPR's Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities (CFDA #93.817) the plans of jurisdictions located within Region IV must be annually reviewed, updated (if needed), and certified to be current.
   c. Directors of supporting agencies have the responsibility of maintaining internal plans, SOPs, and resource data to ensure prompt and effective response to and recovery from emergencies and disasters.

C. Review and Update

1. Review
   a. The Plan and its appendices must be reviewed annually by the Authorized Public Health and Healthcare Agency representatives indicated in this plan.
   b. The Plan will be reviewed NLT June 30th of each year.
   c. The process for the annual review of planning documents will be set by the lead planning agencies listed above NLT December 31st of each year, to include the preparation and distribution of revisions or changes.
2. Updates and Changes
   a. Updates and changes should be made to plans and appendices when the documents are no longer current. Changes in planning documents may be needed for several reasons related to changes in risk, scope, personnel, operational capabilities or other event. Responsible officials in State or local agencies should recommend changes and provide updated information periodically (e.g., changes of personnel and available resources). Revisions will be forwarded to people on the distribution list.
   b. To make an update to any part of the plan that is specific to a single state, that state’s representative should contact the UPC Coordinator at Courtney.Williams@flhealth.gov. The changes should be provided to the coordinator and the coordinator will make the update, record the change on the record of change, and distribute the revised plan.
   c. Updates to the overarching plan that require signature of the Authorized Public Health and Healthcare Agency representatives will be completed during the annual review process.

VII. Authorities and References

A. Legal Authority
   1. Federal
      a. Pandemic and All-Hazards Preparedness Reauthorization Act (PAPRA)
      b. The National Response Framework
      c. The Robert T. Stafford Disaster Relief and Emergency Assistance, Public Law 93-288 as amended
      d. Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113-235, Division G, Title VI, and section 311(c)(1) of the Public Health Service Act, 42 U.S.C. 243(c)(1).
   2. State
      a. States adhere to the authorities from their own states.

B. References
   1. Federal
      a. ASPR's Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities (CFDA #93.817)
      b. CDC’s Domestic Ebola Supplement to Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) – Building and Strengthening Epidemiology, Laboratory and Health Information Systems Capacity in State and Local Health Departments (CK14-1401PPHFSUPP15).
      c. CDC’s PHEP Supplemental for Ebola Preparedness and Response Activities (CDC-FRA-RP12-12010302SUPP15)

2. State
   a. States authority is contingent upon their own state’s reference documents.
Appendix 1: Descriptions of Jurisdictions’ EVD Capabilities

A. Alabama

1. Authorized Public Health and Healthcare Coordinating Agency: Alabama Department of Public Health
2. Primary Point of Contact: 24/7 Center for Emergency Preparedness Duty Officer at 1-866-264-4073
3. Active Monitoring / Direct Active Monitoring
   - ADPH receives information from CDC for persons identified at ports of entry that have traveled in EVD-affected countries. When ADPH learns of persons from CDC or by other means we contact these individuals and initiate a 21-day active monitoring period for identified travelers or contacts, following CDC recommendations. ADPH has identified 4 risk exposure categories; high risk, some risk, low risk and no identifiable risk. Individuals identified as high risk or having some risk undergo direct active monitoring for 21 days.
   - Direct active monitoring includes a face to face initial assessment and twice daily public health monitoring in person or by phone, text or email. Individuals identified as low risk undergo active monitoring for 21 days. Active monitoring for low risk individuals includes an initial assessment in person and a once daily phone contact to assess twice daily temperature and symptoms. Those persons who have no identifiable risks are not monitored.
   - Detailed protocols for Active and Direct Active Monitoring are maintained by the Bureau of Communicable Disease.
   - Self-Monitoring (Low Risk): People being self-monitored should measure and record their temperature twice daily, monitor themselves for symptoms, report as directed to the public health authority, and immediately notify the public health authority if they develop fever or other symptoms. Initial contact is a phone call and they are instructed on contacting ADPH for symptoms can be as nonspecific as fatigue so ADPH can coordinate care for further evaluation.
4. EMS
   - A team from the University of Alabama in Birmingham has been identified to transport a confirmed Ebola case to Emory
   - Minimum of 8 airports designated for transfer to Atlanta
   - Activation occurs through Alabama Department of Public Health (ADPH) and the Alabama Trauma Communication Center (ATCC)
   - Upon activation, monitored patients will be taken to closest assessment hospital; for unmonitored suspect patients, EMS personnel will follow the ADPH Guidelines for Emergency Medical Service Personnel Regarding Care and Transport of Patients with Suspected Ebola Virus Disease (EVD)
5. Hospital System:
   - Alabama has a 2 tier hospital system. Every hospital has the capability to isolate, identify and transfer to an assessment facility.
   - Assessment Hospitals – 4 ( in progress)
   - Treatment Hospitals - 0
6. Waste Management:
   - ADPH will notify, or refer calls to, Alabama Department of Environmental Management for inquiries concerning medical waste, including clean up.
7. Laboratory:
   - The Bureau of Clinical Laboratories (BCL) will provide specimen handling guidance to hospital and reference laboratories. The BCL will provide training opportunities for shipping Category A substances. Assessment hospitals will be required to have designated space to perform requested laboratory testing as needed for patient care. Any testing for Ebola virus will be performed at the BCL.
2. Authorized Public Health and Healthcare Coordinating Agency: Florida Department of Health
3. Primary Point of Contact: 24/7 Florida Department of Health Duty Officer at 1-866-786-4673
4. Active Monitoring / Direct Active Monitoring:
   - The Florida Department of Health has established an active monitoring protocol for all travelers entering the state from Ebola-affected nations through its 67 county health departments.
   - Traveler follow-up consists of twice daily temperature checks and observation of any illness symptoms, with verification of health status and compliance by in-person visits by the county health officials. The traveler should immediately report by phone to the county health department any fever or other symptoms for a period of 21 days after departure from an EVD outbreak country.
   - All high risk travelers will be advised to voluntarily quarantine themselves for the duration of the monitoring period. Non-compliance with voluntary quarantine will result in involuntary quarantine by the County Health Officer.
5. EMS System:
   - Florida has established a regional transport capability that consists of specially trained and equipped response teams located in each of Florida’s seven Regional Domestic Security Task Force regions. The teams will work in conjunction with State ESF 8 through, the FDOH Operations Section, to complete assigned highly infectious disease transport missions.
   - Each local jurisdiction will identify an airport for air transport of an Ebola patient. These airports will meet the requirements to accept the Phoenix Air Gulfstream G-III jet. Location of the airports will be communicated to the Regional Emergency Coordination with the request for assistance.
6. Hospital System:
   - Currently, Florida has no hospitals specifically designated for infectious disease care. All 210 acute care hospitals have been provided guidance, resources, training and / or exercises to assure they are able to identify, isolate and inform health officials of suspected or confirmed EVD cases.
   - The State Department of Health is able to augment local capabilities as necessary for patient care.
7. Waste Management:
   - Waste generated in a hospital will be managed through existing hospital waste management procedures.
   - Waste generated during transport will be collected at designated locations during transport by a Category A Waste Transporter. The locations will be pre-staged with Category A waste bins. The waste will be collected and disposed of by permitted waste transporters.
8. Laboratory:
   - All EVD Testing occurs at one of the Florida Department of Health Public Health Laboratories.
C. Georgia

1. Authorized Public Health and Healthcare Coordinating Agency: The Georgia Department of Public Health

2. Primary Point of Contact: 24/7 Contact number is 1-866-PUB-HLTH to reach the medical epidemiologist on call

3. Active Monitoring / Direct Active Monitoring:
   - GDPH has two contract houses to reside patients; each house can house two PUIs
   - Patients are encouraged to go to one of the assessment centers for further evaluation and if history/physical assessment and lab test are positive, or encouraged to go to Emory for treatment
   - If a hospital has a patient that needs assessment or is seeing a PUI that becomes ill, they contact the GDPH on-call Medical Epidemiologist for telephone interview
   - Medical Epidemiologist determines if the patient warrants further evaluation and coordinates as necessary to transport patient to an assessment hospital or a treatment center
   - If further evaluation is required, the patient is transported to nearest assessment hospital
   - If a PUI is confirmed positive, the patient is transported to a treatment center
   - Medical Epidemiologist contacts Metro Ambulance Service to arrange for transportation once the receiving facility is determined

4. EMS System:
   - 25 EMS services designated
   - Receiving airport: Peachtree DeKalb Airport
   - Activation occurs through Metro Atlanta Ambulance Service’s dispatch center (statewide dispatch capability)
   - Upon activation, the patient is taken to one of the nine (9) assessment hospitals
   - Grady EMS is the preferred transport for EVD patients arriving at Peachtree DeKalb Airport
   - Patients have the right to choose the facility they wish to go to for treatment

5. Hospital System:
   - GA has a 3-Tier hospital system. Every facility has capability to identify and transfer to an assessment hospital (Tier 2). If confirmed case, patient is transferred to a treatment center (Tier 1).
   - Treatment Centers - 5
   - Assessment hospitals – 9

6. Waste Management:
   - Stericycle is the Category A waste vendor for all hospitals in Georgia
   - Emory will autoclave waste prior to pick up by Stericycle
   - All other hospitals will have waste picked up as Category A without autoclaving
   - EMS will dispose of Category A waste at designated Tier 1 and Tier 2 hospitals

7. Laboratory:
   - EVD tests occur at the Georgia Public Health Lab.
   - Grady Hospital has a separate lab for blood cultures, malaria smears, and other pertinent labs so that assessment hospitals can more easily rule out certain disease processes.
D. Kentucky

1. Authorized Public Health and Healthcare Coordinating Agency: Kentucky Department for Public Health (KDPH)

2. Primary Point of Contacts:
   Primary: Kraig Humbaugh, M.D., M.P.H, Senior Deputy Commissioner
   Alternate: On-Call Epidemiologist at 1-888-9REPORT

3. Active Monitoring / Direct Active Monitoring:
   After KDPH receives notification of a traveler from CDC or other means, KDPH will initiate contact with the traveler to establish a communication method for the recommended 21 day monitoring period. A telephone interview will be conducted to determine epidemiologic risk factors for exposure to EVD and to perform a risk exposure assessment. There are four risk factor categories identified per CDC: high risk, some risk, low (but not zero) risk or no identifiable risk.
   Direct active monitoring activities will be conducted when a traveler is identified as having high risk or some risk of exposure to EVD. The designated EAH and EMS agencies will be informed when high risk travelers are being monitored by the Regional Epidemiologist. Direct active monitoring includes a face-to-face initial assessment and twice daily public health monitoring of a traveler directly to obtain temperatures, then public health personnel will read the display on the thermometer and assess for any symptoms. After the initial face-to-face assessment, direct active monitoring activities may be performed via a video conference call which will occur at set times agreed on by both involved parties twice per day. Set times for monitoring activities are to be determined at the initial face to face assessment.
   Active monitoring activities will be conducted when a traveler is identified as having low (but not zero) risk of exposure to EVD. Active monitoring includes a face-to-face initial assessment, having the traveler obtain temperatures twice a day, identifying any symptoms, and reporting each temperature reading and absence or presence of any symptom to public health personnel.

4. EMS System:
   The KY Ebola Response Plan identifies designated EMS agencies within each of the 13 Healthcare Coalition Regions. Not all ambulances are prepped and stocked full time, but can be prepared with notice.
   Designated airports have been identified for transfers to a Regional RETF (see table below).
   Upon notification, patients will be transported to a Kentucky Ebola Assessment Hospital by one of the designated transport services.
   Policies have been developed that require dispatch to obtain travel history and inquire about Ebola-related signs and symptoms. This allows prompt notification to EMS crews to don PPE and takes additional precautions.
5. **Hospital System:**
Kentucky has identified six (6) Ebola Assessment Hospitals as points of referral for individuals who have a travel history, potential exposure, and symptoms suggestive of Ebola.
KDPH, through coordination with the 13 Regional Healthcare Coalitions, has developed the Kentucky Ebola Response Plan to cover the referral, transportation, reception and testing of these individuals.

<table>
<thead>
<tr>
<th>Area</th>
<th>Hospital</th>
<th>System</th>
<th>Assessment Role</th>
<th>Primary Airport</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>Baptist Health Paducah</td>
<td>Baptist Health</td>
<td>Adult</td>
<td>Barkley Regional Airport (PAH)</td>
</tr>
<tr>
<td>Louisville</td>
<td>Jewish Hospital</td>
<td>Kentucky One Health</td>
<td>Adult</td>
<td>Louisville International Airport (SDF)</td>
</tr>
<tr>
<td>Region</td>
<td>Kosair Children’s Hospital</td>
<td>Norton Healthcare</td>
<td>Pediatric</td>
<td>Louisville International Airport (SDF)</td>
</tr>
<tr>
<td>North</td>
<td>St. Elizabeth – Edgewood</td>
<td>St. Elizabeth HealthCare</td>
<td>Adult</td>
<td>Cincinnati/Northern Kentucky International Airport (CVG)</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td>Healthcare System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East</td>
<td>Pikeville Medical Center</td>
<td>Pikeville Medical</td>
<td>Adult</td>
<td>Pike County Airport (PBX)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Center, Inc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>UK HealthCare System</td>
<td>UK HealthCare</td>
<td>Adult and Pediatric</td>
<td>Blue Grass Airport (LEX) “TAC Air”</td>
</tr>
<tr>
<td>(Lexington)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. **Waste Management:** All waste materials generated by patient transportation teams and medical treatment facility will be treated as infectious waste unless laboratory analysis proves otherwise. All waste will be transported and disposed of by an approved vendor in accordance with all applicable state and federal laws.

7. **Laboratory:**
KDPH Division of Laboratory Services (DLS) will provide EVD testing for PUIs. All positive samples will be forwarded to the CDC for further analysis.
Collaborate with EAHs on implementation and continuance of clinical diagnostic testing used in patients being evaluated for EVD.
Provide consultation to the EAHs for, packaging, transporting/shipping of EVD specimens to the state lab.

8. **Fatality Management:**
   b. Kentucky’s Infectious Disease Fatality Management Team (IDFMT) is composed of Coroners and Funeral Directors who will serve as the state’s strike team to manage any Ebola decedents.
   c. Crematories have been identified and have signed the Declaration of Willingness to cremate remains of Ebola decedents.
   d. Equipment and Supplies have been purchased to support the IDFMT.

E. **Mississippi**
   1. Authorized Public Health and Healthcare Coordinating Agency: Mississippi State Department of Health (MSDH)
   2. Primary Point of Contact: Jim Craig, Director of Health Protection
   3. Active Monitoring / Direct Active Monitoring
MSDH receives information from CDC for persons identified at ports of entry that have traveled in EVD-affected countries. When MSDH learns of persons from CDC or by other means we contact these individuals and initiate a 21-day active monitoring period for identified travelers or contacts, following CDC recommendations, MSDH has identified 4 risk exposure categories; high risk, some risk, low risk and no identifiable risk. Individuals identified as high risk or having some risk undergo direct active monitoring for 21 days.

- Direct active monitoring includes a face to face initial assessment and twice daily public health monitoring in person or via video chat and phone, text or email. Individuals identified as low risk undergo active monitoring for 21 days. Active monitoring for low risk individuals includes an initial assessment in person and a once daily phone contact to assess twice daily temperature and symptoms. Those persons who have no identifiable risks are not monitored.

4. EMS System

- MSDH Office of Emergency Planning and Response (MSDH OEPR) has transportation capabilities through the MSDH Bureau of Emergency Medical Services (MSDH BEMS) and redundant capability through contracts with licensed EMS services.
- Designated Airport: Jackson-Medgar Evers International Airport (JAN)
- MSDH OEPR Public Health Coordination Center will receive information from the assessment hospital, the University of Mississippi Medical Center (UMMC), and MSDH will implement the Patient Transportation component as appropriate.
- Members of the MSDH Transportation team will transport all known travelers that display any signs and symptoms of EVD as covered in Section 3 above.

5. Hospital System

- Assessment Hospitals - The University of Mississippi Medical Center (UMMC) is Mississippi's only academic health sciences campus and is the Assessment Hospital designated to receive potential EVD patients while preliminary testing is performed. Upon receipt of a positive and confirmatory testing, MSDH will coordinate the patient being transferred to the appropriate regional treatment hospital.

6. Waste Management

- All waste materials generated by MSDH patient transportation teams and UMMC medical treatment will be processed by UMMC and/or their vendor(s) as appropriate.

7. Laboratory

- All EVD testing will occur at the MSDH Public Health Lab (PHL).
- UMMC assessment center staff will obtain all lab specimens.
- MSDH will transport all lab specimens from UMMC to MSDH PHL.
- UMMC has a separate lab that will be used to rule out any other pertinent disease processes until confirmatory testing is completed by MSDH and CDC.

8. Fatality Management

- Mississippi currently has a fatality management plan and adequate resources to process the remains of EVD decedents.
- Mississippi currently has a deployable mission ready package to assist with the processing of the remains of EVD decedents in HHS Region IV. This capability includes staff, equipment and commodities that would be necessary to support the safe processing and transport of a deceased EVD patient.
F. North Carolina


2. Primary Point of Contact
   - DHHS/DPH/PHP&R Shift Duty Officer: (888) 820-0520
   - DHHS/DHRS/NCOEMS Shift Duty Officer: (919) 855-2687

3. Active Monitoring / Direct Active Monitoring:
   - The North Carolina Division of Public Health has established an active monitoring protocol for all travelers entering the state from Ebola-affected nations through its 85 local health departments and districts. NC Adopts by reference guidelines produced by CDC.
   - Traveler follow-up consists of twice daily temperature checks and observation of any illness symptoms, with verification of health status and compliance by in-person visits by the county health officials. The traveler should immediately report by phone to the local health department any fever or other symptoms for a period of 21 days after departure from an EVD outbreak country.
   - All high risk travelers will be advised to voluntarily quarantine themselves for the duration of the monitoring period. Non-compliance with voluntary quarantine can result in involuntary quarantine.

4. EMS System:
   - While the EMS systems across the 101 local jurisdictions are prepared and capable of transporting a patient if needed, the first-line option for transport will be hospital-based critical care services for transport to an in-state or out of state assessment hospital or treatment center.
   - There are multiple airports within North Carolina that can accommodate the Phoenix Air Gulfstream G-III jet. Based on the location of the patient, the specific airport will be identified that allows for ease of ingress and egress for transport, as well as adequate site security.
   - Activation of transportation assets will be through the NC Office of Emergency Medical Services and coordination of transport will be conducted with the Division of Public Health and Division of Emergency Management.

5. Hospital System:
   - North Carolina will have a maximum of seven (7) assessment hospital geographically distributed across the entire state in order to effectively meet the needs of potential patients or risk populations. These will be from the group of academic medical centers affiliated with the regional healthcare preparedness program.
   - Assessment Hospitals – maximum of 7
   - Treatment Hospitals - 1

6. Waste Management:
   - Waste generated in a hospital will be managed through existing hospital waste management procedures.
   - Waste generated during transport will be collected at designated locations during transport by a Category A Waste Transporter. The locations will be pre-staged with Category A waste bins. The waste will be collected and disposed of by permitted waste transporters.

7. Laboratory:
   - NC Division of Public Health maintains the NC State Laboratory of Public Health which is capable of performing Ebola testing 24/7.
   - NC SLPH maintains a laboratory response network within the state of hospital and private clinical laboratories and coordinates testing protocols and processes throughout the state. Within that program is a robust training program for safe packaging and transportation of samples to the SLPH.
G. South Carolina

1. Authorized Public Health and Healthcare Coordinating Agency: South Carolina Department of Health and Environmental Control


3. Active Monitoring / Direct Active Monitoring:
   - SC receives traveler notifications from Epi-X of travelers coming into SC from West Africa.
   - Travelers returning from Sierra Leone and/or Guinea are placed under Active or Direct Active Monitoring depending on the travelers’ exposures.
     - For active monitoring, regional epidemiology staff contact the traveler twice daily during the 21-day monitoring period to obtain symptom and temperature information and record this information in a monitoring worksheet. Upon initial contact with a traveler, a risk assessment and travelers’ acknowledgement form are completed.
     - For direct active monitoring, regional epidemiology staff physically observe the traveler taking their temperature and assess for symptoms at least once daily for 21 days after the traveler departed Sierra Leone and/or Guinea. Temperature and symptom information are recorded in a monitoring worksheet for each traveler. Upon initial contact with a traveler, a risk assessment and travelers’ acknowledgement form are completed. A traveler’s activities may be restricted depending on the person’s exposures.
     - All travelers are provided with the state Ebola phone number and informed to call that number if any symptoms develop. This phone is carried by a state medical consultant 24/7.
     - Travelers who will have contact with pets during their monitoring receive a fact sheet. For travelers under direct active monitoring, it is recommended that the pet be removed from contact with the traveler during the 21-day monitoring period.

4. SC does have a process in place to contact travelers who are not responding to requests for temperature and symptom information, which includes home visits. SC would report travelers that are lost to follow-up for >48 hours to CDC. EMS System:
   - There are 8 primary regional transport services designated for PUI transport, but all 46 counties have trained on the recognition and treatment of a PUI.
   - The designated airports for transport to Emory by Phoenix Air are Charleston International, Columbia, and Greenville.
   - When the primary PSAP receives a call and screens a PUI, the local incident commander or PSAP will make contact via one of four regional DHEC EPI representatives. That person will then further screen the patient as a PUI. When and if it is determined by the local Epi and Central Office that we have a true PUI, a regional transport team will be called in to transport (or transfer if from a healthcare facility) the patient to a regional assessment hospital.
   - If the patient is in critical condition on scene, the local EMS system will not wait for a regional team, they will assess, package, treat, and transport the patient to the nearest hospital.

5. Hospital System:
   - SC has a two-tiered hospital system of referral hospitals and treatment hospitals. All hospitals may be required to isolate and care for PUI for up to 48 hours.
   - The Referring Hospital and the Regional Treatment Hospital will coordinate the EMS transport of the PUI to a (SC) Regional Treatment Hospital.
- Treatment Hospitals – 4
  The following hospitals have self-identified as EVD Regional Treatment Hospitals:
  - Medical University of South Carolina (Charleston)
  - Greenville Memorial Medical Center (Greenville)
  - Palmetto Health-Richland (Columbia)
  - Spartanburg Regional Healthcare System (Spartanburg) Assessment Hospitals

6. Waste Management:
   - Hospital staff will manage their infectious waste in accordance to South Carolina Infectious Waste Management Regulation 61-105 which can be found at:
     [http://www.scstatehouse.gov/code/t44c093.php](http://www.scstatehouse.gov/code/t44c093.php) and
   - Infectious waste transporters are required to be registered with SCDHEC as well as have a current DOT special permit SP16279. A list of registered transporters with the DOT special permit can be found at:
     [http://www.scstatehouse.gov/code/t44c093.php](http://www.scstatehouse.gov/code/t44c093.php) and

7. Laboratory:
   - EVD tests occur at the South Carolina Department of Health and Environmental Health Laboratory.
   - Malaria smears for PUI can also be done at the South Carolina Department of Health and Environmental Health Laboratory.
H. Tennessee

1. Authorized Public Health and Healthcare Coordinating Agency: Tennessee Department of Health
2. Primary Point of Contact: Paul Petersen
3. Active Monitoring / Direct Active Monitoring:
   - TDH receives information from CDC for persons identified at ports of entry that have traveled in EVD-affected countries. When TDH learns of persons from CDC or by other means we contact these individuals and initiate a 21-day monitoring period. Following CDC recommendations, TDH has identified 4 risk exposure categories; high risk, some risk, low risk and no identifiable risk. Individuals identified as high risk or having some risk undergo direct active monitoring for 21 days. Direct active monitoring includes a face to face initial assessment and twice daily public health monitoring in person or via video chat and phone, text or email. Individuals identified as low risk undergo active monitoring for 21 days. Active monitoring for low risk individuals includes an initial assessment in person and a once daily phone contact to assess twice daily temperature and symptoms. Those persons who have no identifiable risks are not monitored.
4. EMS System:
   - 1 - Memphis, 1 - Jackson, 3 - Nashville, 1 - Knoxville
   - 6 airports: Memphis, Jackson, Nashville, Chattanooga, Knoxville, Johnson City
   - TEMA RRF for air transport, Notification through ESF8 for ground and air
   - Upon activation, monitored patients will be taken to closest assessment hospital by a designated ambulance service
   - For unmonitored suspect patients, ambulance crews will ask high risk questions for travel and other factors with PPE.
5. Hospital System:
   - 130 acute care hospitals
   - Assessment Hospitals – 10
   - Treatment Hospitals - 0
6. Waste Management:
   - EMS vehicles will be decontaminated at the point of conclusion of the transport, all medical waste will be disposed of in established hospital waste streams.
7. Laboratory:
   - As of August 2015, the lab in Nashville can test for Ebola with PCR. The turnaround time is 6-8 hours after receipt of the sample. The two other state labs in Knoxville and Memphis are scheduled to have Ebola capability testing when the CDC funding is utilized after CDC publishes the required information for equipment purchase and provides the test kit
Appendix 2: Transport Algorithms

I. Patient Transfer Points

<table>
<thead>
<tr>
<th>City</th>
<th>Miles to RETF</th>
<th>Approximate Time to RETF</th>
<th>Transfer Site Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenville, SC</td>
<td>141</td>
<td>2h 12m</td>
<td>Greenville Memorial Medical Center, 701 Grove Road, Greenville, SC 29605, Contact: Lance Evans: 864-522-3157</td>
</tr>
<tr>
<td>Augusta, GA</td>
<td>148</td>
<td>2h 18m</td>
<td>Augusta University Medical Center, 1120 15th Street, Augusta GA 30912</td>
</tr>
<tr>
<td>Macon, GA</td>
<td>93</td>
<td>1h 29m</td>
<td>Navicent Health, 777 Hemlock Street, Macon, GA 31201</td>
</tr>
<tr>
<td>Columbus, GA</td>
<td>113</td>
<td>1h 52m</td>
<td>Midtown Medical Center, 710 Center Street, Columbus, GA 31901</td>
</tr>
<tr>
<td>Montgomery, AL</td>
<td>166</td>
<td>2h 29m</td>
<td>Baptist Medical Center East, 400 Taylor Road, Montgomery, Alabama 36117 Contact: Chip Hicks 334 451 0873</td>
</tr>
<tr>
<td>Birmingham, AL</td>
<td>153</td>
<td>2h 23m</td>
<td>University of Alabama in Birmingham, 1802 6th Ave. S., Birmingham, Alabama 35233 Contact: Dr. Sarah Nafziger UAB Transport Team Pager 1 205 934 3411</td>
</tr>
<tr>
<td>Chattanooga, TN</td>
<td>122</td>
<td>1h 59m</td>
<td>Erlanger Health System Contact: 1-800-523-6723</td>
</tr>
</tbody>
</table>

* Additional patient transfer points within Georgia may be utilized if necessary in unforeseen situations.
II. Transport Process – Notification Flowchart

**EBOLA PATIENT TRANSPORT PROCESS - NOTIFICATION**

**Confirmed** or **High Risk** Ebola patient at assessment hospital

Transfer request to GDPH Hotline:
- (866) PUB-HLTH
- (866) 782-4584

Assessment hospital contacts state public health-healthcare coordinating agency; provides patient information

GDPH Hotline: 866-782-4584

GDPH requests RETF bed status from Emory University Hospital

GDPH notifies originating state health department and Region IV REC that no beds at EUH available

ALTERNATE PROCESS:
1. Transfer to another region’s RETF (1st option)
2. Transfer to another ETC within Region IV (2nd option)

**Bed Available**

**Decision to transfer to RETF**

Transfer process confirmed and coordinated between:
1. GDPH
2. Originating state health dept.
3. Region IV REC

Originating state initiates Air or Ground Transport process in coordination with GDPH / Region IV REC

Pt. transfer specifics coordinated:
1. GDPH
2. Originating state health dept.
3. Assessment hospital
4. Emory University Hospital

SEE PROCESS:
Air Transport or Ground Transport

HD #:

REC #:

SEE PROCESS:
Air Transport or Ground Transport
III. Transport Process – Air Transport Flowchart

**EBOLA PATIENT TRANSPORT PROCESS – AIR TRANSPORT**

- **Patient transfer decision to RETF confirmed**
- **Originating state contacts REC to request air transport**
  - Provides: 1) airfield location, 2) POC, 3) patient info
- **Region IV REC contacts ASPR Patient Movement Coordinator to arrange air transport by Phoenix Air Group (PAG)**

1. **Originating state and hospital coordinates transport time with REC and arranges EMS transport to Airfield A**
   - Ambulance service transports patient to Airfield A
   - Transfers pt care to PAG aircrew
   - EMS returns to predesignated doff and decontamination site

   1. PAG transports pt to Airfield B
   2. Transfers pt care to EMS
   3. PAG follows service protocol for doff and decontamination

2. **REC communicates PAG transport status and arrival at Airfield B with GDPH/EUH**
   - GDPH/EUH arranges for EMS patient transport at Airfield B

   1. EMS transports pt to EUH
   2. Transfers patient care to EUH
   3. EMS follows protocol for doff and decontamination

3. **REC communicates EMS transport status and arrival at EUH with appropriate officials**

   **Pt care at EUH commences**

**SEE ALTERNATE PROCESS: Ground Transport**
IV. Transport Process – Ground Transport Flowchart

**EBOLA PATIENT TRANSPORT PROCESS – GROUND TRANSPORT**

- Patient transfer decision to RETF confirmed; air transport unavailable → Originating state contacts GDPH to implement ground transport plan
  - GDPH Coordinates transport with:
    1. Region IV REC
    2. Originating state health dept.
    3. Emory University Hospital
    4. Pass-through state health department
    5. Assigned EMS service

- Appropriate Patient Transfer Point (PTP) placed on alert (See PTP table)

- Originate state implements patient movement to PTP per state protocol

- 1. Originating ambulance service transports patient to PTP
   2. Transfers patient care to EMS
   3. EMS doffs / decontaminates at PTP per agreement

- Originating state implements medical control and 24/7 logistical coordination point

- REC communicates with originating state regarding transport status and EMS arrival at PTP

- GDPH/EUH arranges EMS patient transport at PTP

- REC communicates EMS transport status and arrival at EUH with appropriate officials

- EMS transports patient to EUH
  - 1. Transfers patient care to EUH staff
  - 2. EMS follows protocol for doff and decontamination

- Pt care at EUH commences

**GDPH Hotline:** 866-782-4584

**24/7 #:**

**REC #:**
Appendix 3: Sample Transport Checklist

If medical condition of the patient warrants additional orders during transport prior to arrival at Emory University Hospital, additional medical orders will be provided per accepting physician. The accepting physician at Emory University Hospital will serve as the medical control officer.

Accepting Physician/Medical Control Officer: ________________________________
Direct Contact Number: ________________________________
Direct Number to Medical Control: ________________________________

Direct number to 24/7 Coordination Point for non-medical issues:

State: __________________ Emergency Contact Number: __________________

Georgia 24 hour contact: 1-866-782-4584

The following concerns should be discussed between the transferring and accepting physicians. Decisions should be determined prior to patient departure from transferring facility.

Resuscitation status during transport:

FULL CODE
DO NOT INTRAVENOUS INFUSION
DO NOT ATTEMPT RESUSCITATION

Invasive procedures performed during transport:

- Endotracheal Intubation: YES or NO
- Nasopharyngeal intubation: YES or NO
- Open suctioning of airways: YES or NO
- Initiation of intravenous access: YES or NO
- Administration of intravenous meds: YES or NO
- Injection with needles: YES or NO
- Perform testing to obtain blood sugar: YES or NO

Address of final destination:

Emory University Hospital
1364 Clifton Road
Atlanta GA 30322

*This document does not replace EMTALA Memorandum of Transfer form. This document should be sent with the EMS providers that will transport a patient with the final destination to Emory University Hospital. The EMTALA Memorandum of Transfer includes the following information: diagnosis, medical condition, request made to receiving facility, copy of medical records sent to Emory University Hospital, physician certification of medical risks and benefits, mode/support during transfer, and patient consent.*
## Appendix 4: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADPH</td>
<td>Alabama Department of Public Health</td>
</tr>
<tr>
<td>ASPR</td>
<td>Office of the Assistant Secretary for Preparedness and Response</td>
</tr>
<tr>
<td>CONOPS</td>
<td>Concept of Operations</td>
</tr>
<tr>
<td>DOS</td>
<td>US Department of State</td>
</tr>
<tr>
<td>EMG</td>
<td>ASPR's Emergency Management Group</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>ESF-8</td>
<td>Emergency Support Function 8</td>
</tr>
<tr>
<td>EUH</td>
<td>Emory University Hospital</td>
</tr>
<tr>
<td>EVD</td>
<td>Ebola Virus Disease</td>
</tr>
<tr>
<td>FDOH</td>
<td>Florida Department of Health</td>
</tr>
<tr>
<td>GDPH</td>
<td>Georgia Department of Public Health</td>
</tr>
<tr>
<td>HCC</td>
<td>Health Care Coalition</td>
</tr>
<tr>
<td>HHS</td>
<td>US Department of Health and Human Services</td>
</tr>
<tr>
<td>HPP</td>
<td>Hospital Preparedness Program</td>
</tr>
<tr>
<td>KDIPH</td>
<td>Kentucky Department for Public Health</td>
</tr>
<tr>
<td>MSDH</td>
<td>Mississippi State Department of Health</td>
</tr>
<tr>
<td>NCDPH</td>
<td>North Carolina Division of Public Health</td>
</tr>
<tr>
<td>NCOEMS</td>
<td>North Carolina Office of Emergency Medical Services</td>
</tr>
<tr>
<td>OEM</td>
<td>ASPR's Office of Emergency Management</td>
</tr>
<tr>
<td>PAG</td>
<td>Phoenix Air Group</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>REC</td>
<td>Regional Emergency Coordinator</td>
</tr>
<tr>
<td>RETF</td>
<td>Regional Ebola Treatment Facility</td>
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<tr>
<td>SCDHEC</td>
<td>South Carolina Department of Health and Environmental Control</td>
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<tr>
<td>SCDU</td>
<td>Serious Communicable Diseases Unit (at Emory University Hospital)</td>
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<tr>
<td>SOC</td>
<td>ASPR's Secretary's Operation Center</td>
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<tr>
<td>TDH</td>
<td>Tennessee Department of Health</td>
</tr>
<tr>
<td>UPC</td>
<td>Region IV ESF8 Unified Planning Coalition</td>
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</table>