Bioterrorism Diseases Annex

Infectious Disease Emergency Response (IDER) Plan

Contents

I. BACKGROUND

A bioterrorism event is defined for the purposes of this annex as the deliberate introduction of pathogenic microorganisms or their products (bacteria, viruses, fungi or toxins) into a community. Potential bioterrorism agents are categorized by the Centers for Disease Control and Prevention (CDC) by category. Category A agents (highest priority) include organisms that pose a risk to national security because they can be easily disseminated or transmitted from person-to-person; result in high mortality rates and have the potential for major public health impact; might cause public panic and social disruption; and require special action for public health preparedness. These include:

- Anthrax *(Bacillus anthracis*)
- Botulism (*Clostridium botulinum* toxin)
- Plague *(Yersinia pestis*)
- Smallpox (variola major)
- Tularemia (*Franciscella tularensis*)
- Viral Hemorrhagic Fevers (filoviruses, arenaviruses)

Of second highest priority are category B agents which are organisms that are moderately easy to disseminate; that result in moderate morbidity rates and low mortality rates; and that require enhanced diagnostic capacity and disease surveillance.

- Brucellosis (*Brucella* species)*
- Epsilon toxin of *Clostridium perfringens*
- Food safety threats (Salmonella species, *Escherichia coli* O157:H7, *Shigella*)
- Glanders (*Burkholderia mallei*)*
- Melioidosis (*Burkholderia pseudomallei*)*
- Psittacosis (*Chlamydia psittaci*)
- Q fever (*Coxiella burnetii*)
- Ricin toxin from *Ricinus communis* (castor beans)
- Staphylococcal enterotoxin B
- Typhus fever (*Rickettsia prowazekii*)
- Viral encephalitis (e.g. Venezuelan Equine Encephalitis, Eastern Equine Encephalitis, Western Equine Encephalitis)
- Water safety threats (e.g. *Vibrio cholerae*, *Cryptosporidium parvum*)

* These diseases are considered of high concern by the California Department of Public Health

This list of diseases is not all-inclusive. New diseases or syndromes not previously recognized and many food- or water-borne agents could potentially be used in a bioterrorist attack. Furthermore, while these definitions may facilitate the early recognition of bioterrorism, public health personnel should always be alert to the occurrence of any unusual epidemiologic features that may be found through the investigation

of a seemingly natural outbreak (e.g., absence of the usual risk factors for disease, or greater than expected morbidity or mortality).

Recognition of a potential bioterrorism event may occur by a variety of means including but not limited to: routine passive communicable disease surveillance, enhanced passive communicable disease surveillance (e.g., clinicians requested to watch for and report cases), active surveillance (e.g., calling laboratories or hospitals; this is routinely done in San Francisco by the California Emerging Infectious Diseases program – but only for select conditions), environmental detection (e.g., BioWatch, USPS biodetectors in mail processing centers), and law enforcement intelligence.

With the exceptions of smallpox, filoviruses, ricin, *Burkholderia pseudomallei*, and *Burkholderia mallei*, human diseases caused by these threat agents do occur in San Francisco and California residents, albeit rarely. The San Francisco Department of Public Health will use disease event definitions and priorities developed by the California Department of Public Health and surveillance data from 1990 to 2000 (see Activation and Notification Section below). Disease events are categorized to reflect the level of concern that a particular scenario may represent as a true bioterrorist event, as well as the acuity of the public health response that would be elicited.

For suspected or confirmed bioterrorism events that are due to respiratory aerosol transmissible diseases or due to water borne diseases, consult both this annex and the Respiratory Aerosol Transmissible Disease Annex or the Waterborne Disease Annex. For suspected bioterrorism events that are related to suspicious substances or detected by indoor or outdoor detection systems, consult both this annex and the Biological Agent Detection Annex.

In a suspected or confirmed bioterrorism or unusual events potentially involving biological agents or toxins, coordination with law enforcement agencies is needed in order to efficiently advance both the criminal and epidemiological components of the investigation. The San Francisco Department of Public Health (SFDPH) and the Federal Bureau of Intelligence will both have leadership roles. The San Francisco Police Department (SFPD) and Office of the Chief Medical Examiner will also have important roles.

II. ORGANIZATION

A. Leadership

In an overt bioterrorism event, the Federal Bureau of Investigation (FBI) will be the lead agency coordinating the investigation and mitigation of the attack. In a covert bioterrorism event, IDER will be the lead agency until an act of bioterrorism has been confirmed, after which the FBI will be the lead coordinating agency.

The FBI (along with other law enforcement agencies including SFPD) will be primarily responsible for assessing the credibility of the bioterrorism threat, gathering evidence to identify the perpetrators of the bioterrorism act, and providing security for staff from other response agencies. IDER is responsible for conducting public health investigations to determine the cause of disease and characterize the epidemiology of the incident and take action to control the spread of disease. Once a bioterrorism event is suspected, specimen collection, specimen collection and testing, and public messaging need to be coordinated with the FBI using unified command.

B. Participating Agencies

In a possible or confirmed bioterrorism event multiple city agencies will be required for a response. These may include:

Department of Public Health

- Behavioral Health
- Communicable Disease Control and Prevention
- Environmental and Occupational Health
- Emergency Medical Services
- Human Resources
- Office of Policy and Planning
- San Francisco Public Health Laboratory

City & County of San Francisco

- City Attorney's Office
- Department of Emergency Management
- Department of Human Resources
- Department of Public Works
- Human Services Agency
- Office of the Chief Medical Examiner
- Office of the Mayor
- San Francisco Fire Department
- San Francisco Police Department
- San Francisco Sheriff Department

Regional/State/Federal Agencies

- 95th Civil Support Team
- California Department of Homeland Security
- California Office of Emergency Services
- California Department of Public Health
- Centers for Disease Control and Prevention (CDC)
- Environmental Protection Agency (EPA)
- Federal Bureau of Investigation (FBI)
- Federal Department of Homeland Security

III. PURPOSE & OBJECTIVES

A. Infectious Disease Emergency Response Command Center

For possible or confirmed bioterrorism emergencies special emphasis will need to be placed on the following objectives:

Epidemiology & Surveillance

- Work with law enforcement to coordinate forensic epidemiology and evidence collection.
- Confirm the existence of a disease caused by a potential bioterrorism agent and obtain lab confirmation.
- Conduct surveillance and epidemiologic investigations to obtain information about the incident (e.g. size, source, geographic extent, risk factors for disease ongoing risk).

Disease Containment

- Implement disease containment measures to prevent transmission (e.g., isolation, quarantine, social distancing).
- Provide appropriate infection control guidance and resources (e.g., PPE) to responders.
- If indicated, and if prophylaxis is available, activate the mass prophylaxis point of dispensing (POD) sites and mobilize prophylaxis for responders and the public.

Information Dissemination

- Provide guidance to the medical community on diagnosis, treatment, infection control, and prevention.
- Provide guidance to the public on prevention, infection control, and when to seek health care.

B. Participating Agencies

Depending on the scale and scope of the response, the DOC or EOC will likely activate plans to initiate the following activities:

- Coordination of local, regional, state, and federal response and assets (e.g., mutual aid)
- Environmental sampling and assessment
- Public information
- Mental health support
- Continuity of city services
- Healthcare surge (hospital surge, alternate care)
- Community disaster response hubs
- Mass fatality

IV. ACTIVATION & NOTIFICATION

A. IDER Activation

Information about a potential bioterrorism release may come from any of the following sources:

- Routine passive communicable disease surveillance (e.g., routine disease reporting by clinicians or the public)
- Enhanced passive communicable disease surveillance (e.g., clinicians requested to watch for and report specific conditions or diseases)
- Active surveillance (e.g., calling/visiting laboratories or hospitals)
- Environmental detection* (e.g., outdoor sampling detection, indoor sampling detection, and/or evaluation and testing of suspicious substances or packages)
- Law enforcement intelligence

** Also see the Biological Agent Detection Annex and Sub-Annexes for response guidance.*

Consider activating IDER in the following situations:

Highly suggestive of bioterrorism (one or more):

1. A single definitively diagnosed or strongly suspected case of:
    - Smallpox
    - Inhalational anthrax
    - Cutaneous anthrax
    - Viral hemorrhagic fever (in a patient with no international travel history)
    - Glanders (in a patient with no international travel or relevant animal exposure)
    - Ricin poisoning

2. Greater than one case of pneumonic plague or pneumonic tularemia with at least one laboratory confirmed case, no known compatible risk factors, and occurring in a brief time period.

3. A higher than expected number of unexplained deaths occurring in a brief time period within a defined geographic region.

Moderately suggestive of bioterrorism (one or more):

1. A single definitively diagnosed or strongly suspected case of pneumonic plague or pneumonic tularemia occurring in a patient with no known compatible risk factors.

2. A cluster of brucellosis cases occurring in persons with no known compatible risk factors.

3. A higher than expected number of presumptively diagnosed botulism cases with no known compatible risk factors occurring in a brief time period.

4. A higher than expected number of cases of unexplained severe respiratory illness requiring hospitalization, especially if occurring outside the usual flu transmission season.

5. The occurrence of any unusual epidemiologic features in a seemingly natural outbreak (e.g., the absence of the usual risk factors for disease, or the presence of unusual risk factors, or greater than expected morbidity or mortality).

B. Scale and Scope of the Response

A bioterrorism event will be an event of national significance and will require a large scale response and coordination of many local, regional, state, and federal agencies. Public health will lead key investigative and response components. Public Health, in coordination with law enforcement, will conduct surveillance and epidemiologic investigations. Public Health will also respond with interventions intended to protect the public's health (e.g., recommendations for personal decontamination, recommendations for treatment and/or prophylaxis, provision of mass prophylaxis, isolation, quarantine).

Key factors that could increase the scale and scope of the response include:

- Suspicion or likelihood of ongoing threat
- Known person-to-person transmission of disease
- Multiple modes of transmission (contact, airborne, and/or droplet)
- The disease is infectious before symptom onset (people infect others before they know they are ill)
- A high basic reproduction number (mean number of secondary cases caused by a typical case)
- Minimal or no existing immunity in the population either due to previous infection or vaccination
- Availability of effective post-exposure prophylaxis and/or treatment
- Significant morbidity and/or mortality
- Initially unrecognized agent

The above information may not be available for new, or unknown, or emerging diseases. An aggressive approach should be used until further information becomes available.

C. Modules to Activate

The modules checked in the table below should be activated immediately. See the guidance below regarding additional modules to consider activating:

IDER Module Activation Priorities & Minimum Staffing Levels Required for a Bioterrorism Event

Module	Activate Immediately	Min # of Staff
EOC	✓	1
DOC	✓	1
IDER COMMAND		
• Incident Commander & Deputy	✓	2
• Liaison Officer	✓	1
• Safety Officer	✓	1
• Information Officer	✓	1
• Field Officer	*consider*[*]	2
PLANS SECTION	✓	1
• Situation Status Unit	✓	1
• Resource Status Unit	✓	1
• Documentation Unit	✓	1
• Technical Specialist Unit	*consider*[*]	1
• Demobilization Unit		
OPERATIONS SECTION	✓	2
Epi & Surveillance Branch	✓	1
• Investigation Group	✓	2
• Surveillance Group	✓	1
Laboratory Branch	✓	1
• Laboratory Testing Group	✓	1
• Lab Resources Management Group	*consider*[*]	1

Module	Activate Immediately	Min # of Staff
Disease Containment Branch	✓	1
• Infection Control Group	✓	1
• Restriction, Excl., & Clearance Grp	*consider*[*]	1
• Mass Prophylaxis Group	*consider*[*]	40-110/POD
• Isolation and Quarantine Group	*consider*[*]	1
Infectious Disease Info Branch	✓	1
• Info Triage Group	✓	1
• Info Content Creation Group	✓	1
• Info Dissemination Group	✓	1
Data Branch	✓	1
• Data Analysis Group		
• Application Support Group		
Continuity of Operations Branch	✓	2
LOGISTICS SECTION	✓	1
• Personnel Unit	✓	1
o Staff Staging Area	✓	8+
• Supplies Unit	✓	1
o RSS Warehouse	*consider*[*]	36+
• Communication Equipment Unit	✓	1
• Info Technology Unit	✓	1
FINANCE SECTION	✓	1

* Consider activation of the following modules and their support modules under the suggested circumstances:

- **Field Officer.** Consider activating if a field command site exists and public health input is required OR if epidemiologic field investigation activities will be conducted.
- **Technical Specialist Unit.** Consider activating if the disease is rare or new, or expertise is not available within the San Francisco Department of Public Health.
- **Mass Prophylaxis Group.** Consider activation when: 1) Prophylaxis is available, AND 2) a true public health threat exists, AND 3) if the number of people to prophylaxis is 200 or more. Request assistance from the DOC/EOC to set up POD sites, transport prophylaxis, and provide support to the PODs.
- **Isolation and Quarantine Facilities.** Consider activating if the disease is transmitted person to person.
- **Restriction, Exclusion, and Clearance Group.** Activate if a large number of cases and/or contacts in sensitive occupations or situations are anticipated and the disease is transmissible from person to person.
- **Receipt, Store, and Stage Warehouse.** Activate if mass prophylaxis or mass treatment is required from external mutual aid.
- **Lab Resources Management Group.** Consider if a high volume of specimens to test is anticipated.

D. Notification

Following a decision to activate IDER, at a minimum, the following parties should be notified (see Appendix B1, Activation and Notification Protocol, for contact numbers).

☑ **DPH Communicable Disease Control and Prevention Staff**
☑ **CDPH DCDC Duty Officer**

Request that CDPH make the following notifications:

☑ Local Bay Area Health Departments
(A regional conference call with Bay Area Counties may occur)

☑ **EMS Duty Officer**

Request that EMS or other parties make the following notifications (check others that apply):

☑ DPH Office of Policy and Planning
☑ DPH Public Information Officer
☑ SF Health Director/Officer
☑ SF Haz Mat Duty Officer
☑ DPH Laboratory
☑ DOC Activation Group
☐ DPH Personnel
☐ EMS Staff
☐ Medical Health Operational Area Coordinator (MHOAC)
☑ Weapons of Mass Destruction (WMD) Alert Group
☐ EOC Activation Group
☑ SF Department of Emergency Management (DEM) Duty Officer
☐ California Emergency Medical Authority (EMSA) Duty Officer
☐ Regional Disaster Medical Health Coordinator (RDMHC)/RDMHS (Specialist)

☑ **Other**
Request EMS notification of the FBI Weapons of Mass Destruction Coordinator

V. OPERATIONAL GUIDANCE

The Core IDER Plan should be utilized as a guide for the response with the following modifications. For environmental detectors and suspicious substances also utilize the Biological Agent Detection in the Environment Annex. For Plague and Smallpox also utilize the Respiratory Aerosol Transmissible Diseases Annex.

A. Command Staff

Safety Officer. During a bioterrorism emergency responders may be infected or exposed to the infectious agent and plans should be made for pre or post-exposure prophylaxis and/or personal protective equipment (PPE). If it is a respiratory transmissible disease, responders who require respiratory protection may require medical screening, fit-testing, and training prior to being deployed. There will likely also be significant mental health issues to address among responders.

Liaison Officer. This position should be activated for coordination between law enforcement and public health and between federal, state, and local public health and partner agencies.

Information Officer. During a potential or confirmed bioterrorism emergency, some information, especially specific details about the incident, may be considered sensitive by law enforcement partners.

All public messages will need to be coordinated with FBI/law enforcement and the EOC/JIC. No release will be issued without obtaining separate approval from each agency.

B. Plans Section

The Plans Section, Situation Status Unit, Resource Status Unit, and Documentation Unit should be activated immediately. See guidance below for when to activate the Technical Specialist Unit.

a. Situation Status Unit

Close coordination with the Liaison Officer may be necessary to monitor updates from partner agencies.

b. Resource Status Unit

Additional resources required for the response may include:

- Personal Protective Equipment (PPE) for responders if recommended by the Safety Officer (e.g., masks, PAPRS, gloves).
- Prophylaxis, if recommended by the Incident Commander.
- If activated, location, equipment, and supplies for POD(s) and POD Staff Assignment and Training (SAT) Area.

c. Documentation Unit

No modifications to the Core IDER Plan.

d. Technical Specialist Unit

Consider recruiting a technical specialist with disease specific or forensic epidemiology expertise if not addressed through partner agencies.

C. Operations Section

Immediately activate the Epidemiology & Surveillance, Laboratory, Disease Containment, Infectious Disease Information, and Continuity of Operations Branches. See guidance below regarding Groups and supporting modules to activate or consider.

a. Epidemiology & Surveillance Branch

The Epidemiology and Surveillance Branch, Investigation Group (including the Contact Tracing Team, Case Investigation Team, and Laboratory Liaison Team), and Surveillance Group (including the Surveillance Team) should be activated immediately.

In a bioterrorism event, the primary responsibilities of the Epidemiology and Surveillance Branch are to identify cases, identify possible time and routes of exposures, and define the population that may have been exposed and in need of treatment or prophylaxis.

a.1. Investigation Group

Case and contact investigation is a high priority in a bioterrorism event and will require close coordination with law enforcement. Laboratory confirmation, clinical characteristics, pathogen

characteristics, and information about source, duration, and location of exposure are important in a potential bioterrorism event. Appendix Eh provides various resources including forensic epidemiology MOUs, protocols, and pre-written questionnaires and forms.

Questionnaire development. The initial public health questionnaire drafted by the Investigation Group, should be shared with law enforcement. This may occur just prior to the interview. (See Appendix Eg and Eh for pre-developed questionnaires).

If possible, identify what information needs to be shared across public health and law enforcement agencies, at which granularity (e.g. travel history each patient shared on a person-level basis, clinical information to be shared on an aggregate basis only), and at what time interval. Lastly, identify which agencies will be entering what information into their respective databases for analysis, taking care to ensure that original copies of questionnaires with health-specific or other sensitive questions are stored securely and confidentially within the IDER response as per public health protocol.

Case Investigation Team. Initial case investigations will likely be conducted in person, in the field, and in coordination with law enforcement investigative staff. At some point it may be appropriate to conduct case investigations by phone.

Contact Investigation Team. In a large outbreak and if a disease is transmitted person to person it will be important to consider the usefulness of contact tracing. See Core Plan for guidance.

Field Investigation Team. Activate the Field Investigation Team to perform interviews on-site. All activities and data sharing that occur will comply with all applicable laws, rules and regulations that govern when routinely collected public health and law enforcement data can be shared with other parties.

Preparing for interviews. To facilitate timely gathering of exposure information and sharing of relevant information between agencies, joint investigations where patients, contacts, and potential suspects are interviewed by both public health and law enforcement staff, may be beneficial. However, clinical information should only be collected by public health. Other questions asked during the interview may also be of a sensitive nature (e.g. immigration status). In order to elicit truthful responses from patients or suspects during the interview, identify which questions should be asked by members of which agency on a one-on-one basis. Interviewers should review the questionnaire together before leaving for the field to clarify essential information that needs to be gathered from the interviews and which questions are to be asked by each team member during the interview. Alternately, this review can occur at a meeting place near the interview site.

Conducting interviews. Interviews may be conducted jointly by both public health and law enforcement. After joint questions have been conducted, the law enforcement team member should leave the room so that health-specific sensitive questions may be asked, and vice versa. If field teams require security request through Logistics Branch to the DOC/EOC.

Specimen collection. The Laboratory Branch will provide guidance on specimen collection and safety measures. Ensure that the correct number of specimens are collected and that the correct forms are included. In a bioterrorism response samples must be accompanied by Chain of Custody Forms (Appendix J8).

After interviews. Public health personnel may need to conduct medical chart abstractions or interviews with patient physicians; law enforcement personnel should not be present during these follow-up activities. Data collected will be shared and protected in accordance with all applicable laws and regulations.

Laboratory Liaison Team. No modifications to the Core IDER Plan.

a.2. Surveillance Group

No modifications to the Core IDER Plan.

b. Laboratory Branch

Immediately activate the Laboratory Branch to confirm cases.

b.1. Laboratory Testing Group

The San Francisco Public Health Lab can provide conventional and Real-Time PCR testing for some bioterrorism agents. Consult Appendix J6 for agents and testing capabilities. Confirmatory testing will need to be completed by a reference Laboratory Response Network (LRN) lab. The Laboratory Testing Group will work with the Surge Capacity Team to forward samples to an appropriate reference laboratory.

When the suspected agent is potentially a bioterrorism agent, the Laboratory Testing Group will require additional safety measures, commensurate with the known hazards of such organisms. Please consult the Respiratory Aerosol Transmissible Annex for guidance on pneumonic plague, smallpox, and viral hemorragic fevers.

b.2. Laboratory Resources Management Group

The Laboratory Safety Officer will provide guidance and oversight regarding procedural modifications associated with the reception, processing, and testing of specimens considered to be possible bioterrorism agents. The Laboratory Safety Officer should request the procurement of proper safety equipment through the Logistics Section, if necessary.

Specimen Receiving Documentation Team. Chain of custody protocols will be instituted for a suspected or confirmed bioterrorism event. The protocol requires that specimens be accompanied by first responders or health department personnel. A chain of custody form (Appendix J8) must be completed upon time of receipt and must be signed by the proper individuals.

Surge Capacity Team. The Surge Capacity Team will forward all positive specimens tested by the Laboratory Group, and those that exceed the capacity of the lab, to LRN labs for confirmatory testing. Negative specimens will only be sent if deemed necessary by the Operations Section Chief or Incident Commander. Chain of custody forms (Appendix J8) should accompany specimens.

The Surge Capacity Team will ensure that proper packaging materials are available and utilized for the preparation of transferring potential bioterrorism specimens to alternative testing sites. Moreover, the Surge Capacity Team will ensure that only individuals that are trained and certified in the packing and shipping of infectious materials will be involved in the forwarding of potential bioterrorism specimens. Consult the Respiratory Aerosol Transmissible Annex and Appendix J9 for guidance on packaging for specimens from patients with suspected pneumonic plague, smallpox, and viral hemorragic fevers.

c. Disease Containment Branch

The Infectious Disease Containment Branch and Infection Control Group should be activated immediately. See guidance below on when to activate other modules.

c.1. Infection Control Group

The primary goal of the Infection Control Group is to prevent exposure when avoidable.

When the disease is known. Consult Appendix Dc for disease specific infection control recommendations.

When the disease is new or unknown. When the organism or the mode of transmission is new or unknown assume that the organism can be transmitted via all modes: standard, droplet, contact, and airborne. For making infection control recommendations when the disease is unknown see Appendix Gb9.

c.2. Restriction, Exclusion, & Clearance Group

No modifications to the Core IDER Plan.

c.3. Mass Prophylaxis Group

The Incident Commander can activate mass prophylaxis dispensing. Consider activation when:

1. At least 200 people need prophylaxis in a timely manner; and
2. It is known what types of prophylaxis may be effective; and
3. When prophylaxis can be obtained.

Push dispensing strategies (providing pre-identified organizations and/or businesses with instructions and antibiotics so they can dispense to groups unable or unwilling to use PODs) may be useful. See Appendix Hc for Push operation materials.

Considerations for POD distribution of mass prophylaxis in a bioterrorism event include:

- **Provide prophylaxis to responders.** Activate plans to provide prophylaxis to emergency responders.
- **Estimate the number of public prophylaxis recipients.** For point source exposures it may be necessary to provide prophylaxis to select individuals.
- **Infection Control.** If recommended by the Safety Officer, request personal protective equipment for POD staff from the Logistics Section. Ensure that infection control and PPE guidelines are also covered as part of staff training at the Staff Assignment and Training (SAT) and that hard copies of all recommendations exist at all operating PODs. Ancillary staff such as security, transportation, and traffic control must be aware of standards.
- **Triage**. Special triaging activities should be used when the disease is transmitted person-to-person. Focus resources and attention to the front door of a POD to ensure that disease does not enter and spread within (e.g., add door monitoring staff). Triage guidelines should be sought from the Communicable Disease Information Branch (e.g., take temperature of anyone who feels ill).
- **Contact Tracing.** Consider activation of surveillance stations (e.g. contact interviewing/tracing station) at a POD.
- **Data Collection and Entry.** Depending on the scale of the event, data entry will either take place on-site or all collected paperwork will be sent to a central clearinghouse for data entry. Data on whether smallpox vaccines take or do not take, as well as data on adverse events will be entered by the Data Branch. The immunization registry is able to accommodate this information, but it should also be entered into a national adverse event tracking system, Vaccine Adverse Event Reporting System.
- **Smallpox Vaccine Actions and Adverse Reactions.** For response details see the Respiratory Aerosol Transmissible Diseases Annex.

c.4. Isolation and Quarantine Group

A Bioterrorism emergency may generate fear among the public, city responders, and medical community. Reliable, useful and timely information will allay some of our population's fears. To protect their ability to conduct an investigation (and prosecute), law enforcement partners may want to restrict release of some information. A clear approval process should be established with the Information Officer. Risk communication should be coordinated regionally via Joint Information Centers (JICs) with various organizations and should be clear, accurate, and timely.

Consider activating if the disease is transmitted from person-to-person. For Plague, Smallpox, and Viral Hemorrhagic Fevers consult the Respiratory Aerosol Transmissible Disease Annex.

d. Communicable Disease Information Branch

The Infectious Disease Information Branch, Information Triage Group, Info Content Creation Group (including the Treatment and Prophylaxis Team, Document Development Team, and Clinician Consultation Team), and Info Dissemination Group should be activated immediately.

d.1. Information Triage Group

No modifications to the Core IDER Plan.

d.2. Information Content Creation Group

Clinician Consultation Team. Consult Appendix Dd for disease specific recommendations.

Document Development Team. Important risk communication documents may include:

- **Health Alert** (for clinicians)
  - Pre-written Disease Specific Health Alerts, (Appendix Db)
- **Fact Sheets**
  - Pre-written Disease Specific Fact Sheets for the Public (Appendix Dc)
- **Mass prophylaxis**
  - Directions to POD(s) (Appendix Ha17)
  - What happens at a POD Fact Sheet (Appendix Hd3)
  - Ciprofloxacin and Doxycycline Fact Sheets in multiple languages (Appendix He - Hp)
- **Telephone Scripts**
  - Public Health Information Line Scripts (Appendix Da4)
- **Press Releases/Talking Points**
- **Website Content**

d.3. Information Dissemination Group

Coordinate information dissemination with Joint Information Centers (JICs).

e. Data Branch

e.1. Data Analysis Group

If the Mass Prophylaxis Group is activated the Mass Prophylaxis Data Team should be activated.

f. Continuity of Operations

No modifications to the Core IDER Plan.

D. Logistics

The Logistics Section Personnel, Supplies, and Communication Equipment, and IT units should be activated immediately. If the Mass Prophylaxis Group is activated the Pharmaceutical and Medical Supplies Sub-Unit should be activated.

a. Personnel Unit

At the Staff Staging Area all responders should be educated and trained on what is known about the bioterrorism disease, the situation, and given any personal protective equipment (PPE) and guidelines (provided by the Safety Officer). The Personnel Unit will track responders who have been fit-tested and/or trained for PPE and will share this information with the Safety Officer.

If pre or post-exposure prophylaxis is necessary for responders, this will be coordinated by the Mass Prophylaxis Group.

If the Mass Prophylaxis Group is activated, immediately request personnel via the DOC/OPP to staff the POD(s) and Receipt Store, and Stage (RSS) Warehouse.

b. Supplies Unit

Additional supplies required for the IDE response may include personal protective equipment (PPE) for responders. If the mass prophylaxis POD is activated, immediately activate the Pharmaceuticals & Medical Supplies Sub-Unit (and supporting modules) and obtain antibiotics/antivirals/vaccines through the local cache, hospital pharmaceutical caches (via the DOC EMS lead), or request them via the DOC/EOC.

c. Communication Equipment Unit

No modifications to the Core IDER Plan.

d. Information Technology Unit.

No modifications to the Core IDER Plan.

E. Finance

No modifications to the Core IDER Plan.

VI. RESOURCES

A. Bioterrorism Disease-Specific Documents

Items	Location
Infectious Disease Information: Health Alerts	
Anthrax Pre-written BT Health Alert	Appendix Db6
Botulism Pre-written BT Health Alert	Appendix Db7
Brucellosis Pre-written BT Health Alert	Appendix Db8
Burkholderia Pre-written BT Health Alert	Appendix Db9
Plague Pre-written BT Health Alert	Appendix Db10
Smallpox Pre-written BT Health Alert	Appendix Db11
Tularemia Pre-written BT Health Alert	Appendix Db12
VHF Pre-written BT Health Alert	Appendix Db13
Infectious Disease Information: Fact Sheets	
Anthrax FAQs	Appendix Dc1
Botulism FAQs	Appendix Dc2
Brucellosis FAQ's	Appendix Dc3
Burkholderia FAQ's	Appendix Dc4
Plague FAQ's	Appendix Dc5
Smallpox FAQ's	Appendix Dc6
Tularemia FAQ's	Appendix Dc7
VHF FAQ's	Appendix Dc8
Clinician Reference Documents	
Anthrax, Infectious Disease Emergency Guide	Appendix Dd3
Avian Influenza, Infectious Disease Emergency Guide	Appendix Dd4
Botulism, Infectious Disease Emergency Guide	Appendix Dd5
Brucellosis, Infectious Disease Emergency Guide	Appendix Dd6
Plague, Infectious Disease Emergency Guide	Appendix Dd7
Smallpox, Infectious Disease Emergency Guide	Appendix Dd8
Tularemia, Infectious Disease Emergency Guide	Appendix Dd9
Vial Hemorrhagic Fevers, Infectious Disease Emergency Guide	Appendix Dd10
Epidemiology and Surveillance: BT Forms	
Smallpox Screening Form	Appendix Eg3
Pneumonic Plague Screening Form	Appendix Eg4
Pneumonic Plague Contact Monitoring Form	Appendix Eg9
Smallpox Contact Monitoring Form	Appendix Eg10
CDC Plague Case Investigation Report	Appendix Eg13
CDHS Anthrax (Human) Case Report Form	Appendix Eg14
CDC Form 1. Smallpox Post-Event Surveillance Form	Appendix Eg16
CDC Form 1. Smallpox Post Event Surveillance Form Instructions	Appendix Eg17
Anthrax Screening Form	Appendix Eh1
Botulism Screening Form	Appendix Eh2
Tularemia Screening Form	Appendix Eh3
Viral Hemorrhagic Fevers Screening Form	Appendix Eh4
Brucellosis Screening Form	Appendix Eh5
Anthrax Questionnaire – phone interview	Appendix Eh6
Anthrax Questionnaire – self-administered	Appendix Eh7
Botulism Questionnaire – phone interview	Appendix Eh8
Botulism Questionnaire – self-administered	Appendix Eh9
Tularemia Questionnaire – phone interview	Appendix Eh10
Tularemia Questionnaire – self-administered	Appendix Eh11
VHF Questionnaire – phone interview	Appendix Eh12
VHF Questionnaire – self-administered	Appendix Eh13
Brucellosis Questionnaire – phone interview	Appendix Eh14

Brucellosis Questionnaire – self-administered	Appendix Eh15
Template Contact Tracing Line List	Appendix Eh16
VHF Contact Monitoring Form	Appendix Eh17
CDHS Anthrax (Human) Case Report Form	Appendix Eh18
CDHS Botulism Case Report – Wound or Foodborne	Appendix Eh19
CDHS Case Report :Brucellosis (Undulant Fever)/Q Fever/Tularemia	Appendix Eh20
Bioterrorism Disease Specific Investigation Algorithms	Appendix Eh21
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