Be prepared for Bioterrorism

A supplement to Opus Communications publications
Dear reader,

To help you learn more about how to prepare for a bioterrorist attack, we have culled reports on bioterrorism from the Centers for Disease Control and Prevention, the Department of Health and Human Services, and the General Accounting Office. We looked at frequently asked questions about each of the agents, fact sheets, model communication plans, hospital preparedness in terms of both communications and staffing, public health alerts, and more. From the hundreds of federal documents we sifted through, we are proud to offer you the following 28-page special report, Be prepared for bioterrorism.

Be prepared for bioterrorism looks at the major players in a bioterrorist attack, and also lists Web sites where you can find information on bioterrorism, frequently asked questions and fact sheets on each of the four agents, tips on handling anthrax in your facility, and tips on staffing and communications. Also included is an outline of response activities that your facility may want to follow in the event of a bioterrorist attack. It features tips on properly staffing your facility in an attack, including ways to deal with supplemental staff and volunteer physicians. We also look at what the Emergency Medical Treatment and Labor Act and the Joint Commission on Accreditation of Healthcare Organizations have to say about bioterrorism and disaster preparedness.

We hope you find this report a useful resource in your facility.

Sincerely,

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Be prepared for bioterrorism
On alert: Learn who responds to bioterrorism

If a bioterrorist attack breaks out in your region, different levels of bureaucracies get involved. The Model Emergency Response Communications Plan, a May 2000 report by the Association of State and Territorial Directors of Health Promotion and Public Health Education, included the following list of players you should be aware of in the event of an attack.

It's important for your health care facility to know the following agencies and their responsibilities:

Local agencies
• Frontline health providers—Report infectious disease case information to local health agency.
• First responders—Fire, police, and emergency medical services (EMS) personnel relay information to health officials or to the incident commander, especially in the case of announced terrorist-related infectious disease outbreaks.
• Hospitals and laboratories—Report and refer suspicious specimens to higher-level laboratories at the local/state level.
• Local department officials—Report and refer case information to state health agencies. For small-scale outbreaks, local health directors may serve as primary media spokespersons or delegate this function to a public information officer. Health directors may give final approval to release of emergency information.
• Local school officials—Function as a local resource to support the response effort. May be called upon to disseminate information to school populations. (In very serious situations, they may assist with consequence management by helping to arrange mass care, since schools are often used for this purpose.)
• Local media outlets—May be called upon to cooperate in public education efforts. For example, the media may maintain advance emergency information packets for release at the request of local officials. Media organizations will likely seek to verify field reports of the emergency’s development with health officials.
• Elected officials—Function primarily as recipients of information. May participate in press conferences, as well as the unified command system in the case of large-scale emergencies.
• Public information system—Media spokespersons representing law enforcement, elected officials, and other entities outside the public health system may participate in the joint information center (JIC) in the case of large-scale emergencies.

State players
• State health department (SHD) officer/director—Oversees activities of core public health working group during an emergency response. Ensures coordination of health agency activities with the JIC and unified command (UC) system and serves as liaison with the governor, as necessary. May also review/approve all or select public communications.
• SHD public information officer—Responsible for all media contact and public relations activities, including rumor control, release of health education information to the public and to health professionals, release of emergency response information, and so on. Consults with other SHD staff as necessary to ensure that all materials are current and accurate. May be designated as lead public health representative to the JIC.
• SHD laboratory director—Informs lower-level laboratories to watch for suspicious specimens. Provides protocols for the isolation of specific organisms and the safety of laboratory personnel. Provides instructions for the shipping/handling of infectious agents. Provides chain of evidence form (to be used in criminal investigations).
• SHD epidemiologist—Directs disease surveillance statewide. Designs and implements the statewide program to locate diagnosed and undiagnosed cases of illness and coordinates efforts to identify the causative agent in suspected outbreaks. Coordinates epidemiologic investigations with clinical laboratories and infection control practitioners statewide. Advises hospital infection control personnel and local health officials on information pertinent to public health, including protocols for disease investigation, control, and treatment. Notifies health care practitioners and, when necessary, the public.
appropriate, notifies or coordinates the notification of those affected by the disease. Communicates with and requests assistance as required from other SHD epidemiologists and the Centers for Disease Control and Prevention (CDC). Updates the public information officer and other core working group members on the nature and scope of the outbreak and likely routes of transmission. Develops and implements public information programs for mass media distribution, including fact sheets for health education and public affairs staff within the health agency, and for Web site posting and press releases. Represents the health agency as required in public forums, including press and media briefings.

- SHD environmental health official—Serves as liaison to local environmental health staff and to the state/U.S. Department of Agriculture. May oversee collection of pathogen samples, especially when water- or food-borne.

- SHD emergency medical services agency—Supports regional EMS offices and local EMS agencies. Specific functions are similar to those of the SHD laboratory and SHD environmental health division.

- District/regional health officer—Serves as local public health contact. May designate local public affairs spokespersons in consultation with state staff. (Note: A variety of state public health organizational structures exist. For example, the state health department may also serve as a local health department. Therefore, a chain of communication from the state to the local level must be determined in advance.)

- Department of Agriculture—Responsible for food inspections. Coordinates public education activities with health department staff and the JIC.

- State educational official—Functions as a state resource to support the response effort. May be called upon to disseminate information to school populations. May also be called upon to help arrange mass care, since schools are often used for this purpose.

- Elected officials (political)—Function primarily as recipients of information. The governor signs the declaration of a regional or state emergency, designates someone from his or her office (usually a press secretary) to participate in the JIC, and, if necessary, requests that the president declare a national emergency. The governor may choose to participate in press conferences, as well as the UC system, in the case of large-scale emergencies.

- State press officers—Serve as liaisons to the JIC on behalf of the governor. (Note: All state and federal staff work to support local players.)

Federal players

- CDC—Upon request, CDC staff provide states with backup assistance in many areas, including data analysis, laboratory support, and public communications/education. If necessary, CDC will send communications staff/other experts on-site to provide assistance. Generally, CDC strives to coordinate its activities with states. The agency also conducts national surveillance activities and alerts states if worrisome trends become apparent. CDC facilitates the Health Alert Network for information technology assessment, development, and enhancement. Either independently or in collaboration with states, CDC conducts extensive research activities and often issues national announcements with regard to research findings. CDC has quarantine power over ports of entry.

- U.S. Department of Agriculture—Involved in cases of agricultural bioterrorism or large-scale foodborne outbreaks. May provide laboratory backup and serve as a press liaison to the JIC.

- Food and Drug Administration—Involved in food- or water-borne outbreaks. May also be involved with providing information on the availability of vaccines.

- National Institutes of Health—Supports laboratory diagnostics and conducts research to determine the sensitivity/resistance of the infectious agent to therapeutic antibiotics.
Understand the symptoms that signal an infectious outbreak or bioterrorist attack

The Centers for Disease Control and Prevention has put together a list of phenomena that should arouse suspicion about the nature and severity of an infectious outbreak. These events require further epidemiological investigation and may frequently prompt activation of the emergency response communications plan:

- Large numbers of ill persons with similar disease or syndrome
- Large numbers of unexplained disease, syndrome, or deaths
- Unusual illness in a population (e.g., an increase in influenza-like illness that might be anthrax in disguise or an increase in pox-like illness that might be smallpox)
- Higher morbidity and mortality in association with a common disease or syndrome, or failure to respond to usual therapy
- Single case of disease caused by an uncommon agent (e.g., Burkholderia mallei or pseudomallei, smallpox, viral hemorrhagic fever, pulmonary anthrax)
- Multiple unusual or unexplained disease entities coexisting in the same patient without other explanation
- Disease with an unusual geographic or seasonal distribution (e.g., tularemia in nonendemic area, influenza in the summer)
- Unusual “typical patient” distribution (e.g., several adults with unexplained rash)
- Unusual disease presentation (e.g., pulmonary v. cutaneous anthrax)
- Similar genetic type among agents isolated from temporally or spatially distinct sources
- Unusual, atypical, genetically engineered, or antiquated strain of agent (includes antibiotic resistance pattern)
- Endemic disease with unexplained increase in incidence (e.g., tularemia, plague)
- Simultaneous clusters of similar illness in noncontiguous areas, domestic or foreign
- Disease transmitted through aerosol, food, or water suggestive of sabotage
- Ill persons presenting near the same time
- No illness in persons not exposed to common ventilation systems (have separate closed ventilation systems) where illness is seen in those persons in close proximity
- Death or illness among animals, which may be unexplained or attributed to a bioterrorist agent, that precedes or accompanies illness or death in humans

The outbreak of infectious disease will almost always be identified by local, state, or federal public health agencies after public and private health care providers at the local level have diagnosed a significant number of cases of the disease to attract state or federal notice.

An unannounced act of bioterrorism likewise will be detected only after a significant number of symptomatic conditions have been identified at the local, state, and/or federal levels. However, detection capabilities among the states will vary, as will the level and efficiency of communications between public and private health care providers and the state public health agency.

The overt release of a biological agent affecting the public or its water and food supply will cause an immediate need for credible public health information.

Response activities
A general outline of response activities is listed below. Although these activities are presented sequentially, several may occur simultaneously.

A. Initiating event (laboratory reports, cluster of symptomatic individuals, report from the general public, etc.)

B. Initial public health response
1. Begin disease investigation (including increased surveillance)
2. Convene internal “core working group” (see chart on p. 6)
3. Communicate with relevant local entities >p. 6
C. Communicate risk information
Evaluate the need to communicate information about the event to the public

D. Initiate Public Communication Activities
Depending on the perceived severity of the threat and the level of independent media activity, health officials must determine the need for and scope of public communications. Communication activities at this point may include any, all, or none of the following:

1. Issue press release
2. Designate public health media spokesperson
   (may be the public information officer, state health officer, lead epidemiologist, etc.)
3. Hold press briefing
4. Activate statewide communications systems (e.g., Emergency Alert System)
5. Monitor media reports

E. Reassessment of Resource Needs
As the disease investigation progresses (and the perceived severity or scope of the emergency changes), public health authorities may need to enlist the support of additional key players.

Sample outbreak scenario chart
- Local/state/regional laboratory personnel receive information that leads them to suspect a possible infectious disease or bioterror outbreak
- Laboratory staff relay the information to epidemiology staff
- Epidemiology staff relay information to state health officer (SHO)
- SHO convenes core working group, which could contain
  - state lab representative
  - epidemiology representative
  - state infectious disease bureau
  - health communications staff
  - administrative coordinator
  - community health staff from affected area
  - state health department nursing staff
  - state emergency management staff
  - state agriculture department or Environmental Protection Agency staff

Symptoms <p. 5>
### What to do if you receive an anthrax threat

The U.S. Postal Service offers these suggestions on what to do if you receive an anthrax threat in the mail. We include them as an aid to protect your facility from the threat of bioterrorism.

#### How likely is it that someone would receive a harmful biological or chemical substance in the mail?
The Postal Service delivers approximately 208 billion pieces of mail per year. As of October 30, most incidents of anthrax bacteria being sent through the mail have been sent to government offices and high-profile media outlets.

#### What should I do if I receive an anthrax threat by mail?
- Do not handle the piece of mail or package suspected of contamination.
- Notify your supervisor, who will immediately contact the Inspection Service, local police, safety officer, or designated person.
- Make sure that damaged or suspicious packages are isolated and the immediate area cordoned off.
- Ensure that all persons who have touched the piece of mail wash their hands with soap and water.
- List all persons who have touched the letter/envelope. Include contact information.
- Provide the list to the Inspection Service.
- Place all items worn when in contact with the suspected piece of mail in plastic bags and keep them in the place where you change your clothes and have them available for law enforcement agents.
- As soon as possible, shower with soap and water.
- If prescribed medication by medical personnel, take it until otherwise instructed or until it runs out.
- The Inspectors will assess the threat situation and coordinate with the FBI.
- Designated officials will notify local, county, and state health departments.
- Designated officials will notify the state emergency manager.
- Notify the Center for Disease Control Emergency Response at 770/488-7100 for answers to any questions.

#### What constitutes a suspicious letter or parcel?
Some typical characteristics that ought to trigger suspicion include letters or parcels that:
- have any powdery substance on the outside
- are unexpected or from someone unfamiliar to you
- are addressed to someone no longer with your organization or are otherwise outdated
- have no return address, or have one that can’t be verified as legitimate
- are of unusual weight, given their size, or are lopsided or oddly shaped
- have an unusual amount of tape on them
- are marked with restrictive endorsements, such as “Personal” or “Confidential”
- have strange odors or stains
- show a city or state in the postmark that doesn’t match the return address

#### What should I do if I’ve received a suspicious letter or parcel in the mail?
- Do not try to open the piece of mail
- Isolate the piece of mail
- Evacuate the immediate area
- Call a Postal Inspector to report that you’ve received a parcel in the mail that may contain biological or chemical substances.
Staffing is critical in a mass-casualty disaster. A facility’s staffing status is probably the best indication of how well the facility is prepared for a mass-casualty incident.

In disaster plans, staff augmentation is regularly addressed by extending hours of present staff and calling in supplemental staff, including medical staff, nursing staff, technicians, and support services staff. Because a mass-casually incident will tax the entire community as opposed to one hospital, facilities may find their resources unavailable because they have already been utilized at another facility.

Recent tragedy serves as example
In the wake of the World Trade Center tragedy in New York City, rescue workers rushed hundreds of injured people to Manhattan-area hospitals.

To accommodate this large influx of patients, hospitals called on their own medical staff members and accepted the help of hundreds of volunteer physicians from other parts of the city, state, and country. North General Hospital on Madison Avenue was one of the hospitals that readied itself for a wave of victims and volunteer physicians. It began its preparations with New York’s Education Law.

North General also asks for a list of the physicians’ past hospital affiliations, but Nilda Conrad, MBA, CMSC, CPCS, director of medical staff services at North General, explains that sometimes there isn’t time to call and verify each one. To safeguard against fraud, emergency volunteer physicians should be paired up with regularly credentialed staff members in the same specialty.

Finally, the disaster plan should include a medical staffing office command center so that the medical director can work with the credentialing committee chair to help decide how many and what types of physicians are needed.

Forum identifies community staffing needs
A March 2000 forum conducted by the American Hospital Association with the support of the Office of Emergency Preparedness, and the U.S. Department of Health and Human Services recommended the following to avoid the problem of double-counted staff augmentation within a community:

- Develop a community-wide concept of “reserve staff” identifying physicians, nurses, and hospital workers who are retired, have changed careers to work outside of health care, or now work in areas other than direct patient care. Once this staff reserve is identified, protocol needs to be developed to utilize such staff efficiently and safely.
- Because a physician may not be able to reach the facility where he or she is credentialed, facilities need to work with their credentialing committees to develop a policy on the recognition of temporary privileges in emergency or disaster situations. This can easily be accomplished if facilities within a community regularly share lists of staffs and their privileges.
- When a mass-casualty incident occurs, first responders—emergency medical service, police and fire personnel—will be fully engrossed in securing the area, administering aid, caring for the injured, and decontaminating both the area and patients. As the incident progresses and initial casualty numbers start to fade, first responders may be utilized as potential sources to augment hospital staff.
- Biological terrorism will pose additional challenges of both uncertainty and fear among the general population and health care workers. Staff concerns can be reduced through appropriate education and the use of universal precautions until the nature of the disease agent is understood. Plans also need to include contingencies in case medical professionals or other volunteers don’t show up.
- Given that staff members will be under enormous stress, the influx of volunteers may add to the problems of staff identification and crowd control. A disaster volunteer coordinator position should be well established.
- Regular readiness drills and inservice training for mass-casualty incidents are an absolute requirement.
Communication is key in attack response

In any bioterrorist or chemical attack, the scale of the incident will create a demand for public information. In most cases, at least some of the information will not be readily available while the incident develops.

In the absence of clear and credible information, speculation may reign and increase the stress and pressure resulting from the incident, especially on the hospital and its staff.

Planned and structured arrangements for communication throughout the incident and during its response are critical components of hospital and community preparedness.

- **Single channel network.** Hospitals need an ongoing, open channel of communication with emergency response teams that may have first contact with the incident scene.

In a mass-casualty incident, don’t limit the channel of communications so that the Emergency Medical Service (EMS) unit has to use a different channel or means of contact with each organization. Use a community-wide network on the same channel. Test the network daily, with the test rotating across the various health care facilities and EMS shifts.

Build redundant backup capability into the preparedness plan in case the usual means of communications fail. The backup capability also requires regular testing.

- **Victims’ relatives.** The arrival of casualties will be accompanied by calls from family and friends seeking to learn the person’s whereabouts and condition. These well-meaning calls can rapidly overload the hospital’s telephone system and isolate the facility.

Community-wide mass-casualty preparedness plans will improve the responsiveness of health care organizations if they include a single, community site for obtaining patient locator information. In many communities, the Red Cross is equipped and experienced in serving as this third party, off-site source of information.

A bioterrorist event can become even more disastrous if every organization in the community attempts to establish its own media briefings. Unaware of what others are saying, and despite the best of intentions, the use of different words and phrases can confuse the public and undermine the trust essential to the “orderly chaos” of a well-managed disaster.

**All organizations involved in the community preparedness plan for mass casualties, including hospitals, need to agree in advance on who will serve as the single, regional spokesperson.**

Use of a community-wide spokesperson will minimize disruption within hospitals if the press events are conducted away from health care facilities and use regularly scheduled and pre-announced media briefing times.

All organizations participating in the community preparedness plan will facilitate communications and reduce disruption of their own staffs if the plan for a pre-arranged community spokesperson also clearly identifies what others are not to say.

Hospitals often have established relationships with local health reporters. In a mass-casualty incident, the health reporter may not be the prime media contact.

The government reporter, or crime reporter in the case of terrorism, may have the lead on the incident. The community spokesperson needs to be known and trusted by this reporter prior to any incident. Health experts who will be used to assist the spokesperson also should be known in advance to the reporter(s), if possible.
Disaster preparedness requirements by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are written to apply to the full range of hospitals from small rural facilities to academic medical centers in urban areas. The preparedness standards are focused in four areas:

- Secure environment plans (Standard EC.1.2)
- Hazardous materials and waste management plan (Standard EC.1.3)
- Emergency management plan (Standard EC.1.4)
- Emergency preparedness drills (Standard EC.2.9.1)

The Emergency Management Plan (Standard EC.1.4) should address four phases of emergency management activities: mitigation, preparedness, response, and recovery. JCAHO standards for the emergency management plan require hospitals to address the following:

- Specific procedures in response to a variety of disasters based on a hazard vulnerability analysis
- Specific procedures in response to a variety of disasters or emergencies
- Their role in the community-wide plan
- External authorities role
- Space, supplies, security
- Personnel notification and assignment
- Evacuation and alternative care site
- Patient management
- Backup for utilities and communication
- Orientation and education
- Performance monitoring
- Annual evaluation

Separate from, but related to, the standards for the Emergency Management Plan are JCAHO standards addressing each hospital’s Security Management Plan. In this component of its plan, hospitals must address the following:

- Actions taken in the event of a security incident or failure
- Vehicular access to urgent care areas
- Civil disturbance and media response
- Human and vehicle traffic

Although some incidents, such as a power failure, do not produce hazardous materials, incidents such as chemical accidents or industrial explosions may. JCAHO standards require hospital plans to address these items:

- Handling and disposing of wastes
- Space and equipment
- Emergency procedures for exposures
- Personal protective equipment

These requirements are likely to be highly relevant to any mass-casualty incident, especially if they result from terrorism.

Finally, JCAHO standards require hospitals to conduct two emergency preparedness drills per year. These simulations are designed both to provide training exercises and identify unanticipated shortcomings of the current plan so that it may be revised. The hospital is responsible for determining the particular disaster scenarios, but one drill must involve an influx of patients beyond those presently being treated by the hospital. The second drill may involve either an internal or an external disaster.

Community disaster planning
If the disaster is a mass-casualty event, such as a major earthquake or biological terrorism, the patient load may overwhelm all of the hospitals, offices of physicians, and general resources of the community. A disaster plan limited to an individual facility is inadequate. A single facility’s plan may address part of the spectrum of disasters appropriately, but its weakness is that it may ignore larger scale incidents. Therefore, hospital preparedness should expand from planning within the context of a single hospital organization to planning a community-wide initiative to address mass casualties. This would necessitate participation in community-wide preparedness drills.

Non-JCAHO-accredited facilities
While most hospitals are accredited by the JCAHO, some hospitals are not. Nevertheless, all hospitals should include mass-casualty incidents in their preparedness plan. When hospitals are not JCAHO-accredited, the state licensing body or a similar entity has the responsibility for confirming that the hospital’s disaster plan addresses both incidents of limited and mass casualties.
Considerations for EMTALA

In a disaster, especially one with mass casualties, a hospital may receive more patients than it can handle. If the incident results from chemical or biological exposure, the community may need to protect itself by designating some hospitals as open to victims and others as open only to patients who have not been exposed to the chemical or biological contaminants.

The Emergency Medical Treatment and Labor Act (EMTALA) governs what a hospital must do when potential patients present themselves, even if the hospital has closed its emergency room because of an excess of patients or to protect the health of current patients.

The implementing regulations for EMTALA state the following:

“If any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself or with another person to the emergency department and a request is made on the individual’s behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules and regulations), the hospital must provide for an appropriate Medical Screening Examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department.”

The implementing guidelines provided by CMS states the following:

“The hospital has a legal obligation to provide at least a medical screening examination to any patients who present themselves physically at the hospital or on hospital property. Under present law, there is no provision to “waive” this requirement even if a failure to accept, screen, or treat a patient would benefit the community’s health.

EMTALA woes unique to disaster preparedness
If a community’s preparedness plan designates hospitals into those allowed to accept patients exposed to chemicals and those limited to unexposed patients, the hospital that delegated the unexposed patient role would incur an EMTALA violation if it turned away a patient exposed to the chemicals. This violation would stand even if turning the patient away was in the best interest of the community. The hospital designated to accept exposed patients would also incur an EMTALA violation if it did not accept a transfer from a non-designated facility, since it would be considered a “higher level of care.”

Similarly, in a biological incident, an effective community plan may seek to classify hospitals into those accepting exposed patients and those limited to unexposed patients.

Implementing the plan would place some of the hospitals in violation of EMTALA.
How to handle anthrax and other biological agent threats

In October, the Centers for Disease Control and Prevention released this health advisory on handling anthrax. We include it as a helpful guideline for handling biological agent threats, such as anthrax, in your facility.

Facilities have received anthrax threat letters in communities around the country. Most were empty envelopes; some have contained powdery substances.

The purpose of these guidelines is to recommend procedures for handling such incidents.

Do not panic
1. Anthrax organisms can cause infection in the skin, gastrointestinal system, or the lungs. To do so, the organism must be rubbed into abraded skin, swallowed, or inhaled as a fine, aerosolized mist. Disease can be prevented after exposure to the anthrax spores by early treatment with the appropriate antibiotics. Anthrax is not spread from one person to another person.

2. For anthrax to be effective as a covert agent, it must be aerosolized into very small particles. This is difficult to do and requires a great deal of technical skill and special equipment. If these small particles are inhaled, a life-threatening lung infection can occur, but prompt recognition and treatment are effective.

If you encounter a suspicious unopened letter or package marked with a threatening message such as “anthrax”:
1. Do not shake or empty the contents of any suspicious envelope or package.

2. Place the envelope or package in a plastic bag or some other type of container to prevent leakage of contents.

3. If you do not have any container, then cover the envelope or package with anything (e.g., clothing, paper, a trash can, etc.), and do not remove this cover.

4. Leave the room and close the door, or section off the area to keep others away.

5. Wash your hands with soap and water to prevent spreading any powder to your face.

6. What to do next . . .
   • If you are at home, report the incident to local police.
   • If you are at work, report the incident to local police and notify your building security official or an available supervisor.

7. List all people who were in the room or area when this suspicious letter or package was recognized. Give this list to both the local public health authorities and law enforcement officials for follow-up investigations and advice.

If you encounter an envelope with powder and the powder spills out onto surface:
1. Do not try to clean up the powder. Cover the spilled contents immediately with anything (e.g., clothing, paper, a trash can, etc.), and do not remove this cover.

2. Leave the room and close the door, or section off the area to prevent others from entering.

3. Wash your hands with soap and water to prevent spreading any powder to your face.

4. What to do next . . .
   • If you are at home, report the incident to local police.
   • If you are at work, report the incident to local police.
local police and notify your building security official or an available supervisor.

5. Remove heavily contaminated clothing as soon as possible, and place in a plastic bag or some other container that can be sealed. This clothing bag should be given to the emergency responders for proper handling.

6. Shower with soap and water as soon as possible. Do not use bleach or other disinfectant on your skin.

7. List all people who were in the room or area, especially those who had actual contact with the powder. Give this list to both the local public health authorities so that proper instructions can be given for medical follow-up, and to law enforcement officials for further investigation.

If you are in a room contaminated by aerosolization:
For example: Small device triggered, warning that air handling system is contaminated, or warning that a biological agent released in a public space.

1. Turn off local fans or ventilation units.

2. Leave area immediately.

3. Close the door, or section off the area to prevent others from entering.

4. What to do next . . .
   • If you are at home, dial 911 to report the incident to local police and the local FBI field office.
   • If you are at work, dial 911 to report the incident to local police and the local FBI field office, and notify your building security official or an available supervisor.

5. Shut down air handling system in the building, if possible.

6. If possible, list all people who were in the room or area. Give this list to both the local public health authorities so that proper instructions can be given for medical follow-up, and to law enforcement officials for further investigation.

How to identify suspicious packages and letters
Some characteristics of suspicious packages and letters include the following:

• Excessive postage
• Handwritten or poorly typed addresses
• Incorrect titles
• Title but no name
• Misspellings of common words
• Oily stains, discolorations, or odor
• No return address
• Excessive weight
• Lopsided or uneven envelope
• Protruding wires or aluminum foil
• Excessive security material such as masking tape, string, etc.
• Visual distractions
• Marked with restrictive endorsements, such as “personal” or “confidential”
• Shows a city or state in the postmark that does not match the return address
Anthrax fact sheet

• Anthrax is an acute infectious disease caused by the spore-forming bacterium Bacillus anthracis. Anthrax most commonly occurs in hoofed mammals and can also infect humans.
• Symptoms of the disease vary depending on how the disease was contracted, but usually occur within seven days after exposure. The serious forms of human anthrax are inhalation anthrax, cutaneous anthrax, and intestinal anthrax.
• Initial symptoms of inhalation anthrax may resemble a common cold. After several days, the symptoms may progress to severe breathing problems and shock. Inhalation anthrax is often fatal.
• Cutaneous anthrax occurs after direct contact with infectious spores. It is commonly seen in the form of itchy lesions on the head, forearms, or hands. It is usually not fatal if treated with antibiotics.
• The intestinal disease form of anthrax may follow the consumption of contaminated food and is characterized by an acute inflammation of the intestinal tract. Initial signs of nausea, loss of appetite, vomiting, and fever are followed by abdominal pain, vomiting of blood, and severe diarrhea.
• Direct person-to-person spread of anthrax is extremely unlikely, if it occurs at all. Therefore, there is no need to immunize or treat those who come in contact with persons ill with anthrax, such as family, friends, or coworkers, unless they were also exposed to the same source of infection.
• In persons exposed to anthrax, infection can be prevented with antibiotic treatment.
• Early antibiotic treatment of anthrax is essential—any delay lessens the chances for survival. Anthrax usually is susceptible to penicillin, doxycycline, and fluoroquinolones.
• An anthrax vaccine can also prevent infection. Vaccination against anthrax is not recommended for the general public to prevent the disease and is not available.

Source: The Centers for Disease Control and Prevention (CDC).

Plague fact sheet

• Plague is an infectious disease of animals and humans caused by the bacterium Yersinia pestis. Y. pestis is found in rodents and their fleas in many areas around the world.

Pneumonic plague occurs when Y. pestis infects the lungs. The first signs of illness in pneumonic plague are fever, headache, weakness, and cough productive of bloody or watery sputum. The pneumonia progresses over two to four days and may cause septic shock and, without early treatment, death.

• Person-to-person transmission of pneumonic plague occurs through respiratory droplets, which can only infect those who have face-to-face contact with the ill patient.

• Early treatment of pneumonic plague is essential. Several antibiotics are effective, including streptomycin, tetracycline, and chloramphenicol.

• There is no vaccine against plague.

• Prophylactic antibiotic treatment for seven days will protect persons who have had face-to-face contact with infected patients.

Source: The CDC.
Botulism fact sheet

- Botulism is a muscle-paralyzing disease caused by a toxin made by a bacterium called Clostridium botulinum.
- There are three main kinds of botulism:
  1. Foodborne botulism occurs when a person ingests a pre-formed toxin that leads to illness within a few hours to a few days. Foodborne botulism is a public health emergency because the contaminated food may still be available to other persons besides the patient.
  2. Infant botulism occurs in a small number of susceptible infants each year who harbor C. botulinum in their intestinal tract.
  3. Wound botulism occurs when wounds are infected with C. botulinum that secretes the toxin.
- With foodborne botulism, symptoms begin within six hours to two weeks (most commonly between 12 and 36 hours) after eating toxin-containing food. Symptoms of botulism include double vision, blurred vision, drooping eyelids, slurred speech, difficulty swallowing, dry mouth, muscle weakness that always descends through the body: first shoulders are affected, then upper arms, lower arms, thighs, calves, etc. Paralysis of breathing muscles can cause a person to stop breathing and die, unless he or she receives assistance with breathing (mechanical ventilation).
- Botulism is not spread from one person to another. Foodborne botulism can occur in all age groups.
- The Centers for Disease Control and Prevention (CDC) maintains a supply of an antitoxin that is effective in reducing the severity of symptoms if administered early in the course of the disease. Most patients eventually recover after weeks to months of supportive care.

Source: The CDC.

Smallpox fact sheet

- Smallpox was eliminated from the world in 1977.
- Smallpox is caused by the variola virus. The incubation period is about 12 days (the range is seven to 17 days) following exposure. Initial symptoms include high fever, fatigue, and head and backaches. A characteristic rash, most prominent on the face, arms, and legs, follows in two to three days. The rash starts with flat red lesions that evolve at the same rate. Lesions become pus-filled and begin to crust early in the second week. Scabs develop and then fall off after about three to four weeks. The majority of patients with smallpox recover, but death occurs in up to 30% of cases.
- Smallpox is spread from one person to another by infected saliva droplets that expose a susceptible person who has face-to-face contact with the ill person. Persons with smallpox are most infectious during the first week of illness because that is when the largest amount of virus is present in saliva.
- However, some risk of transmission lasts until all scabs have fallen off.
- Routine vaccination against smallpox ended in 1972. The level of immunity, if any, among persons who were vaccinated before 1972 is uncertain; therefore, these persons are assumed to be susceptible.
- Vaccination against smallpox is not recommended to prevent the disease in the general public and, therefore, is not available.
- In people exposed to smallpox, the vaccine can lessen the severity of or even prevent the illness if given within four days after exposure. The vaccine against smallpox contains another live virus called vaccinia. The vaccine does not contain the smallpox virus.
- The United States currently has an emergency supply of the smallpox vaccine.
- There is no proven treatment for smallpox, but research to evaluate new antiviral agents is ongoing.

Source: The CDC.
Anthrax: Frequently asked questions

The following is a list of frequently asked questions about anthrax. These come from the Division of Bacterial and Mycotic Diseases, part of the Centers for Disease Control and Prevention’s (CDC) National Center for Infectious Diseases.

- What is anthrax?
- Why has anthrax become a current issue?
- How common is anthrax, and who can get it?
- How is anthrax transmitted?
- What are the symptoms of anthrax?
- Where is anthrax usually found?
- Can anthrax be spread from person to person?
- Is there a way to prevent infection?
- What is the anthrax vaccine?
- What is the protocol for anthrax vaccination?
- Are there adverse reactions to the anthrax vaccine?
- How is anthrax diagnosed?
- Is there a treatment for anthrax?
- Where can I get more information about a recent U.S. Department of Defense decision to require men and women in the armed services to be vaccinated against anthrax?

What is anthrax?
Anthrax is an acute infectious disease caused by the spore-forming bacterium Bacillus anthracis. Anthrax most commonly occurs in wild and domestic lower vertebrates (cattle, sheep, goats, camels, antelopes, and other herbivores), but it can also occur in humans when they are exposed to infected animals or tissue from infected animals.

Why has anthrax become a current issue?
Because anthrax is considered to be a potential agent for use in biological warfare, the Department of Defense has begun mandatory vaccination of all active duty military personnel who might be involved in conflict.

How common is anthrax, and who can get it?
Anthrax is most common in agricultural regions where it occurs in animals. These include South and Central America, Southern and Eastern Europe, Asia, Africa, the Caribbean, and the Middle East. When anthrax affects humans, it is usually due to an occupational exposure to infected animals or their products. Workers who are exposed to dead animals and animal products from other countries where anthrax is more common may become infected with B. anthracis (industrial anthrax). Anthrax in wild livestock has occurred in the United States.

How is anthrax transmitted?
Anthrax infection can occur in three forms: cutaneous (skin), inhalation, and gastrointestinal. B. anthracis spores can live in the soil for many years, and humans can become infected with anthrax by handling products from infected animals or by inhaling anthrax spores from contaminated animal products. Anthrax can also be spread by eating undercooked meat from infected animals. It is rare to find infected animals in the United States.

What are the symptoms of anthrax?
Symptoms of the disease vary depending on how the disease was contracted, but symptoms usually occur within seven days.

Cutaneous: Most (about 95%) anthrax infections occur when the bacterium enters a cut or abrasion on the skin, such as when handling contaminated wool, hides, leather or hair products (especially goat hair) of infected animals. Skin infection begins as a raised, itchy bump that resembles an insect bite but within one or two days, it develops into a vesicle and then a painless ulcer, usually 1 cm–3 cm in diameter, with a characteristic black necrotic (dying) area in the center. Lymph glands in the adjacent area may swell.

About 20% of untreated cases of cutaneous anthrax will result in death. Deaths are rare with appropriate antimicrobial therapy.

Inhalation: Initial symptoms may resemble a common cold. After several days, the symptoms may progress to severe breathing problems and shock. Inhalation anthrax is usually fatal.

Intestinal: The intestinal disease form of anthrax may follow the consumption of contaminated meat and is characterized by an acute inflammation of the intes-
tinal tract. Initial signs of nausea, loss of appetite, vomiting, and fever are followed by abdominal pain, vomiting of blood, and severe diarrhea. Intestinal anthrax results in death in 25%–60% of cases.

Where is anthrax usually found?
Anthrax can be found globally. It is more common in developing countries or countries without veterinary public health programs. Certain regions of the world (South and Central America, Southern and Eastern Europe, Asia, Africa, the Caribbean, and the Middle East) report more anthrax in animals than others.

Can anthrax be spread from person-to-person?
Direct, person-to-person spread of anthrax is extremely unlikely to occur. Communicability is not a concern in managing or visiting with patients with inhalation anthrax.

Is there a way to prevent infection?
In countries where anthrax is common and vaccination levels of animal herds are low, humans should avoid contact with livestock and animal products, and avoid eating meat that has not been properly slaughtered and cooked. Also, an anthrax vaccine has been licensed for use in humans. The vaccine is reported to be 93% effective in protecting against anthrax.

What is the anthrax vaccine?
The anthrax vaccine is manufactured and distributed by BioPort Corporation, in Lansing, MI. The vaccine is a cell-free filtrate vaccine, which means it contains no dead or live bacteria in the preparation. The final product contains no more than 2.4 mg of aluminum hydroxide as adjuvant. Anthrax vaccines intended for animals should not be used in humans.

Who should be vaccinated against anthrax?
The Advisory Committee on Immunization Practices has recommend anthrax vaccination for the following groups:

- Persons who work directly with the organism in the laboratory.
- Persons who work with imported animal hides or furs in areas where standards are insufficient to prevent exposure to anthrax spores.
- Persons who handle potentially infected animal products in high-incidence areas. (The incidence is low in the United States, but veterinarians who travel to work in other countries where the incidence is higher should consider being vaccinated.)
- Military personnel deployed to areas with a high risk for exposure to the organism (as when it is used as a biological warfare weapon).

The anthrax Vaccine Immunization Program in the U.S. Army Surgeon General's Office can be reached at 877/GETVACC (877/438-8222) or at www.anthrax.osd.mil.

Pregnant women should be vaccinated only if absolutely necessary.

What is the protocol for anthrax vaccination?
The immunization consists of three subcutaneous injections given two weeks apart followed by three additional subcutaneous injections given at six, 12, and 18 months. Annual booster injections of the vaccine are recommended thereafter.

Are there adverse reactions to the anthrax vaccine?
Mild local reactions occur in 30% of recipients and consist of slight tenderness and redness at the injection site. Severe local reactions are infrequent and consist of extensive swelling of the forearm in addition to the local reaction. Systemic reactions occur in less than 0.2% of recipients.

How is anthrax diagnosed?
Anthrax is diagnosed by isolating B. anthracis from the blood, skin lesions, or respiratory secretions or by measuring specific antibodies in the blood of persons with suspected cases.

Is there a treatment for anthrax?
Doctors can prescribe effective antibiotics. To be effective, treatment should be initiated early. If left untreated, the disease can be fatal.

Where can I get more information about the recent Department of Defense decision to require men and women in the armed services to be vaccinated against anthrax?
The Department of Defense recommends that servicemen and women contact their chain of command on questions about the vaccine and its distribution.
Botulism: Frequently asked questions

The following is a list of frequently asked questions about botulism. These come from the Division of Bacterial and Mycotic Diseases, part of the Centers for Disease Control and Prevention’s (CDC) National Center for Infectious Diseases.

- What is botulism?
- What kind of germ is Clostridium botulinum?
- How common is botulism?
- What are the symptoms of botulism?
- How is botulism diagnosed?
- How can botulism be treated?
- Are there complications from botulism?
- How can botulism be prevented?
- What are public health agencies doing to prevent or control botulism?

What is botulism?
Botulism is a rare but serious paralytic illness caused by a nerve toxin that is produced by the bacterium Clostridium botulinum.

There are three main kinds of botulism.

Foodborne botulism is caused by eating foods that contain the botulism toxin. Wound botulism is caused by a toxin produced from a wound infected with Clostridium botulinum. Infant botulism is caused by consuming the spores of the botulinum bacteria, which then grow in the intestines and release the toxin.

All forms of botulism can be fatal and are considered medical emergencies. Foodborne botulism can be especially dangerous because many people can be poisoned by eating a contaminated food.

What kind of germ is Clostridium botulinum?
Clostridium botulinum is the name of a group of bacteria commonly found in soil. These rod-shaped organisms grow best in low-oxygen conditions.

The bacteria form spores that allow them to survive in a dormant state until exposed to conditions that can support their growth. There are seven types of botulism toxin designated by the letters A through G; only types A, B, E, and F cause illness in humans.

How common is botulism?
In the United States, an average of 110 cases of botulism are reported each year. Of these, approximately 25% are foodborne, 72% are infant botulism, and the rest are wound botulism.

Outbreaks of foodborne botulism involving two or more persons occur most years and are usually caused by eating contaminated home-canned foods. The number of cases of foodborne and infant botulism has changed little in recent years, but wound botulism has increased because of the use of black-tar heroin, especially in California.

What are the symptoms of botulism?
The classic symptoms of botulism include double vision, blurred vision, drooping eyelids, slurred speech, difficulty swallowing, dry mouth, and muscle weakness. Infants with botulism appear lethargic, feed poorly, are constipated, and have a weak cry and poor muscle tone. These are all symptoms of the muscle paralysis caused by the bacterial toxin.

If untreated, these symptoms may progress to cause paralysis of the arms, legs, trunk, and respiratory muscles. In foodborne botulism, symptoms generally begin 18-36 hours after eating a contaminated food, but they can occur as early as six hours or as late as 10 days.

How is botulism diagnosed?
Physicians may consider the diagnosis if the patient’s history and physical examination suggest botulism. However, these clues are usually not enough to allow a diagnosis of botulism.

Other diseases, such as Guillain-Barré syndrome, stroke, and myasthenia gravis can appear similar to botulism, and special tests may be needed to exclude these other conditions. These tests may include a brain scan, spinal fluid examination, nerve conduction test (electromyography, or EMG), and a tensilon test for myasthenia gravis.

The most direct way to confirm the diagnosis is to demonstrate the existence of the botulinum toxin in the patient’s serum or stool by injecting serum or
stool into mice and looking for signs of botulism. The bacteria can also be isolated from the stool of persons with foodborne and infant botulism. These tests can be performed at some state health department laboratories and at the CDC.

How can botulism be treated?
The respiratory failure and paralysis that occur with severe botulism may require a patient to be on a breathing machine (ventilator) for weeks, plus intensive medical and nursing care. After several weeks, the paralysis slowly improves.

If diagnosed early, foodborne and wound botulism can be treated with an antitoxin which blocks the action of toxin circulating in the blood. This can prevent patients from worsening, but recovery still takes many weeks.

Physicians may try to remove contaminated food still in the gut by inducing vomiting or by using enemas. Wounds should be treated, usually surgically, to remove the source of the toxin-producing bacteria.

Good supportive care in a hospital is the mainstay of therapy for all forms of botulism. Currently, antitoxin is not routinely given for treatment of infant botulism.

Are there complications from botulism?
Botulism can result in death due to respiratory failure. However, in the past 50 years the proportion of patients with botulism who die has fallen from about 50% to 8%.

A patient with severe botulism may require a breathing machine as well as intensive medical and nursing care for several months.

Patients who survive an episode of botulism poisoning may have fatigue and shortness of breath for years, and long-term therapy may be needed to aid recovery.

How can botulism be prevented?
People can prevent botulism. Foodborne botulism has often developed from eating home-canned foods with low acid content, such as asparagus, green beans, beets, and corn. However, outbreaks of botulism from more unusual sources, such as chopped garlic in oil, chile peppers, tomatoes, improperly handled baked potatoes wrapped in aluminum foil, and home-canned or fermented fish, do exist.

Persons who do home canning should follow strict hygienic procedures to reduce contamination of foods. Oils infused with garlic or herbs should be refrigerated. Potatoes that have been baked while wrapped in aluminum foil should be kept hot until served or refrigerated.

Because the botulism toxin is destroyed by high temperatures, people who eat home-canned foods should consider boiling the food for 10 minutes before eating it to ensure safety. Instructions on safe home canning can be obtained from county extension services or from the U.S. Department of Agriculture.

Because honey can contain spores of Clostridium botulinum, a source of infection for infants, children younger than 12 months should not be fed honey. Honey is safe for people one year of age and older. Prevent wound botulism by promptly seeking medical care for infected wounds and by not using injectable street drugs.

What are public health agencies doing to prevent or control botulism?
Public education about botulism prevention is an ongoing activity. Information about safe canning is widely available for consumers. State health departments and the CDC have persons knowledgeable about botulism available to consult with physicians 24 hours a day.

If an antitoxin is needed to treat a patient, it can be quickly delivered to a physician anywhere in the country. Suspected outbreaks of botulism are quickly investigated, and if they involve a commercial product, the appropriate control measures are coordinated among public health and regulatory agencies.

Physicians should report suspected cases of botulism to a state health department.
The following is a list of frequently asked questions about plague. These come from the Division of Vector-Borne Infectious Diseases, part of the Centers for Disease Control and Prevention’s (CDC) National Center for Infectious Diseases.

How is plague transmitted to people? By the bite of fleas that become infected with the bacteria, Yersinia pestis, that causes plague.

What is the basic transmission cycle? Fleas become infected by feeding on rodents, such as chipmunks, prairie dogs, ground squirrels, mice, and other mammals that are infected with the bacteria Yersinia pestis. Fleas transmit the plague bacteria to humans and other mammals during the feeding process. The plague bacteria are maintained in the blood systems of rodents.

Could you get plague from another person? Yes, when the other person has plague pneumonia and coughs droplets containing the plague bacteria into air that is breathed by a noninfected person.

What are the signs and symptoms of plague? The typical sign of the most common form of human plague is a swollen and very tender lymph gland, accompanied by pain. The swollen gland is called a “bubo” (hence the term “bubonic plague”). Bubonic plague should be suspected when a person develops a swollen gland, fever, chills, headache, and extreme exhaustion, and has a history of possible exposure to infected rodents, rabbits, or fleas.

What is the incubation period for plague? A person usually becomes ill with bubonic plague two to six days after being infected. When bubonic plague is left untreated, plague bacteria invade the bloodstream. When plague bacteria multiply in the bloodstream, they spread rapidly throughout the body and cause a severe and often fatal condition. Infection of the lungs with the plague bacterium causes the pneumonic form of plague, a severe respiratory illness. The infected person may experience a high fever, chills, a cough, and breathing difficulty, and expel bloody sputum. If plague patients are not given specific antibiotic therapy, the disease can progress rapidly to death.

What is the mortality rate of plague? About 14% (one in seven) of all plague cases in the United States are fatal.

How many cases of plague occur in the United States? Human plague in the United States has occurred as mostly scattered cases in rural areas (an average of 10–20 persons each year). Globally, the World Health Organization (WHO) reports 1,000–3,000 cases of plague every year. Plague can be acquired at any time during the year.

How is plague treated? According to treatment experts, a patient diagnosed with suspected plague should be hospitalized and medically isolated. Laboratory tests should be done, including blood cultures for plague bacteria and microscopic examination of lymph gland, blood, and sputum samples. Antibiotic treatment should begin as soon as possible after laboratory specimens are taken. Streptomycin is the antibiotic of choice. Gentamicin is used when streptomycin is not available. Tetracyclines and chloramphenicol are also effective. Persons who have been in close contact with a plague patient, particularly a patient with plague pneumonia, should be identified and evaluated. The U.S. Public Health Service requires that all cases of suspected plague be reported immediately to local and state health departments and that the diagnosis be confirmed by CDC. As required by the International Health Regulations, CDC reports all U.S. plague cases to the WHO.

Where is plague most common? Generally, plague is most common in the southwestern states, particularly New Mexico and Arizona.

Who is at risk for getting plague? Outbreaks in people occur in areas where housing and sanitation conditions are poor. These outbreaks can occur in rural communities or in cities. They are usually associated with infected rats and rat fleas.
**Dissemination worksheet: Television stations**

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## Dissemination worksheet: Cable TV stations

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You can also establish phone trees or other neighborhood networks in rural areas where neighbors can alert each other in an emergency. Your emergency contact rosters can include phone tree initiators, where one person contacts the next, who contacts the next, and so on. Each designated person on the tree is responsible for contacting the next person on the tree until all essential personnel are contacted regarding the emergency.

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Infectious disease Web sites

The following is a list of Web sites where you can find information on infectious diseases, bioterrorism, food-borne diseases, immunization, and trade associations. This list comes from the May 2000 report of the Association of State and Territorial Directors of Health Promotion and Public Health Education Model Emergency Response Communications Plan for Infectious Disease, Outbreaks, and Bioterrorist Events.

• **Centers for Disease Control and Prevention (CDC), National Center for Infectious Diseases** ([www.cdc.gov/ncidod](http://www.cdc.gov/ncidod))
  Contains information about nearly 100 different diseases, as well as downloadable fact sheets on many of the diseases and images of the infectious agents.

• **National Institutes of Health (NIH), National Institute of Allergy and Infectious Diseases** ([www.niaid.nih.gov](http://www.niaid.nih.gov))
  This site offers news releases as well as information on Division of Microbiology and Infectious Diseases research activities.

• **CDC Bioterrorism Preparedness & Response Network** ([www.bt.cdc.gov](http://www.bt.cdc.gov))
  This site provides information about chemical and biological agents, press releases, training, contacts, and other information dealing with the public health aspects of bioterrorism preparedness and response.

• **Federal Bureau of Investigation (FBI)** ([www.fbi.gov](http://www.fbi.gov))
  Provides links to FBI field offices and contains copies of FBI press releases, as well as information about major ongoing investigations.

• **Soldier Biological and Chemical Command** ([www.sbccom.army.mil](http://www.sbccom.army.mil))
  A Department of Defense site addressing chemical and biological warfare agent classifications, etiologies, and recommendations for response.

• **U.S. Army Medical Research Institute of Infectious Diseases** ([www.usamriid.army.mil](http://www.usamriid.army.mil))
Data

• **Morbidity and Mortality Weekly Report** ([www2.cdc.gov/mmwr](http://www2.cdc.gov/mmwr))
  Provides information on disease trends, access to MMWR publications from 1992 to the present, and links to all state health departments and other sites of interest.

• **National Center for Health Statistics** ([www.cdc.gov/nchs/](http://www.cdc.gov/nchs/))
  Provides data about a number of infectious diseases. Also provides a search function, tabulated state data, and information/links to federally supported surveys and data collection systems.

Infectious disease

• **Federal Emergency Management Agency** ([www.fema.gov](http://www.fema.gov))
  Provides extensive information on emergency management of all types of disasters, including large-scale infectious outbreaks and bioterrorist incidents.

• **National Domestic Preparedness Office** ([www.ndpo.gov](http://www.ndpo.gov))
  The National Domestic Preparedness Office coordinates all federal efforts to assist state and local first responders with planning, training, and equipment to respond to a conventional or unconventional weapon of mass destruction incident.

• **National Emergency Management Association** ([www.nemaweb.org](http://www.nemaweb.org))
  This site contains NEMA policy statements, links to state emergency management contacts, and emergency management information and assistance resources for state officials.

Foodborne disease

• **CDC FoodNet** ([www.cdc.gov/foodnet](http://www.cdc.gov/foodnet))
  The Web site for the CDC Foodborne Diseases Active Surveillance Network (FoodNet), FoodNet is a collaborative project among CDC, several state and local Emerging Infectious Program sites, the U.S. Department of Agriculture, and the U.S. Food and Drug Administration.

• **U.S. Department of Agriculture (USDA)** ([www.usda.gov](http://www.usda.gov))
  You can access resources for food safety educators, consumer information (including a listing of product recalls), news releases and USDA food safety publications.

• **U.S. Food and Drug Administration (FDA)** ([www.fda.gov](http://www.fda.gov))
  The FDA provides general information on food safety, information about the National Food Safety Institute, links to other sites, and information for kids and educators.
Web sites

Immunizations

- CDC Immunizations Hotline
  Hotline numbers are 800/232-2522 (English) and 800/232-0233 (Spanish).

- National Coalition for Adult Immunization (www.nfid.org/ncai)
  Download adult and adolescent immunization schedules, identify state and local agencies with whom you might collaborate on adult immunization programs, and order educational materials.

- National Immunization Program (NIP) (www.cdc.gov/NIP/)
  Here you will find current recommended immunization schedules for children and adults and be able to access additional NIP reference materials and publications.

- Vaccines for Children Program (VFC) www.cdc.gov/NIP/vfc
  This site lists information about the VFC program and the Advisory Committee on Immunization Practices.

Professional associations

- Association for Professionals in Infection Control and Epidemiology (www.apic.org)
  Contains information on infectious diseases and hospital settings, including a “Bioterrorism Readiness Plan.” The plan provides a general overview of what hospitals and other health care entities need to consider when developing emergency response procedures for bioterrorism incidents.

- Council of State and Territorial Epidemiologists (www.cste.org)
  The site offers a list of diseases and conditions that health care providers and laboratories must report in each state.

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