

Exercise Plan

Slippery Slope 2005 Bioagent Exercise

January 19, 2005

Co-sponsored by
New York City Department of Health
and Mental Hygiene (DOHMH) and
Central Brooklyn Center for Bioterrorism
Planning and Preparedness (CBPP)



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I. PURPOSE

- A) Slippery Slope is a major full-scale, field, bioagent exercise conducted in four rotations that will exercise four CBPPs and the hospitals that make up those networks. Funded by NYCDOHMH for the purpose of furthering the preparation of New York City hospitals to respond to an outbreak of an infectious disease, four CBPPs respond to different time periods of a major bioagent event. DOHMH has chosen Severe Acute Respiratory Syndrome (SARS) as the bioagent. The exercise will be conducted in four rotations with the first rotation occurring in January (initial recognition of the event). Through cooperative planning and exercising, the City of New York hospitals and the Health Department will be better able to respond to a major public health emergency event. This exercise will allow other organizations to work with the health and medical community in responding to a bioagent event.
- B) The purpose of this rotation of the exercise is to:
- 1) Exercise disaster response of CBPP member hospitals and allied organizations.
 - 2) Practice policies and Standard Operating Guidelines (SOGs) that will be implemented in response to a Bioterrorism event or other public health emergency.
 - 3) Orient participating hospitals and NYCDOHMH employees to their likely roles and responsibilities during the response and recovery phases of a Bioterrorism event.
 - 4) Identify policy decisions that need to be made during response activities.
 - 5) Satisfy Joint Commission on Accreditation of Health Care Organizations (JCAHO) requirements for hospital emergency preparedness.
 - 6) Test intra- CBPP cooperation and communication.
 - 7) Strengthen interagency coordination, cooperation and communication.
 - 8) Identify short and long term efforts needed to both respond and recover from this type of catastrophic disaster.

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II. NEEDS ASSESSMENT

The DOHMH has completed a hazards vulnerability assessment. This tool confirmed that the City of New York is at risk for a number of natural and man-made disasters. The City has received grant funds from multiple sources within the federal government to improve readiness to respond to a terrorist event, including the Department of Homeland Security (DHS) State Homeland Security Grant Program, the Centers for Disease Control and Prevention (CDC) Bioterrorism Cooperative Agreement, and the Health Resources Services Administration (HRSA) Hospital Bioterrorism Preparedness Program.

The hospitals in the City of New York have revised their Emergency Response Plans in order to prepare for the response to a Bioterrorism event. This exercise will allow those plans to be exercised and gaps identified

A) There is a need to/for:

- 1) DOHMH to exercise their plans to assess the public health and medical infrastructure and test their ability to allocate medical resources in a disaster environment.
- 2) Exercise the joint CBPP medical response programs that may be called upon in a major disaster event.
- 3) Conduct hospital exercises that are consistent with the JCAHO Management of the Environment of Care Standards for Emergency Management.
- 4) Provide training for hospital personnel in their roles and responsibilities during a Bioterrorism or other public health emergency.
- 5) Test their emergency response plans, including use of the Hospital Emergency Incident Command System (HEICS).
- 6) Determine hospital logistical needs and the process to supply the hospitals with needed medical supplies and pharmaceuticals.
- 7) Hospitals to exercise their hospital emergency response plans for surge capacity and identify barriers, if any, to establishing adequate surge capacity.

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III. EXERCISE GOALS AND OBJECTIVES

Goal 1: Engage participant knowledge and skills, as they practice their roles using their current checklists and procedures.

Goal 2: Practice command and control, decision-making, coordination and communications skills for disaster operations, with a focus on effective resource management.

Goal 3: Increase the ability of the CBPPs to manage an intentional or unintentional biological event.

Goal 4: Develop needs assessment data to determine areas of focus for inclusion in future CBPP training and planning programs.

Goal 5: Increase the readiness of the hospital personnel assigned to disaster response duties when there is an outbreak of an infectious respiratory disease impacting the community.

Objectives 1 through 8 are to be designed into either the field or tabletop portions of each sub-exercise. The remaining optional objectives are chosen for the specific rotation of the exercise.

Objective 1: Modify pre-designated areas of the hospital(s) to function as isolation units, wards or floors.

Objective 2: Monitor and provide efficient management of critical physical plants, personnel and material resources throughout the network or ad hoc hospital group.

Objective 3: Integrate and practice emergency response plans (ERP) and triage protocols for mass casualty incidents between hospitals and participating or associated outpatient facilities.

Objective 4: Train key staff throughout the hospital on their roles and responsibilities within ERP and triage protocols.

Objective 5: Enhance flexibility during emergencies or disasters to identify equipment and personnel sources, through memoranda of understanding (MOUs) with CBPP and other partners and contracts with vendors (per Appendix 9.2, "Surge Capacity Planning Requirements for CBPPS).

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Objective 6: Activate the Emergency Operations Center (EOC) and the incident management [e.g., Hospital Emergency Incident Command System (HEICS) system of each participating facility].

Objective 7: Demonstrate redundant communication systems for internal and external use.

Objective 8: Use appropriate communication with DOHMH, NYSDOH, OEM, EMS, internal staff, CBPP partners and other city agencies, as warranted.

Objective 9: Perform rapid distribution of PPE to staff, fit testing.

Objective 10: Demonstrate use of pretriage screening protocols in Emergency Departments and outpatient clinics.

Objective 11: Mobilize appropriate hospital personnel via call down system.

Objective 12: Increase overall staffed bed and isolation bed capacities utilizing surge capacity plans for additional staff, beds, equipment and supplies.

Objective 13: Activate the hospital's emergency isolation protocols.

Objective 14: Perform cohorting for event-related patients, if indicated, based on the scenario.

Objective 15: Complete case finding for previously unknown event-related in-patients and identification of possible hospital contacts (i.e., patients, visitors or staff).

Objective 16: Exercise transition from emergency medicine to disaster medicine practices.

Objective 17: Exercise the ability of hospitals within Central Brooklyn CBPP to identify the bioagent event as requiring activation of disaster protocols.

Objective 18: Exercise communication and coordination between hospitals within the CBPP and the DOHMH.

Objective 19: Exercise the use of HEICS.

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IV. EXERCISE ASSUMPTIONS

- A) Organizations have in place adequate emergency response and communication plans.
- B) Employees have been trained in all relevant emergency response plans.
- C) Employees have been educated and trained to use personal protective equipment (PPE).
- D) All organizations will participate to meet both exercise and individual organizational goals.
- E) Organizations will participate in all aspects of the exercise including the planning, management, and evaluation of the exercise.
- F) Conflicts and communication shortfalls between hospitals and DOHMH and hospitals are likely to occur and will lead to post-exercise discussions to resolve identified issues.
- G) The exercise will identify gaps and opportunities for improvement within individual hospitals.

V. EXERCISE ARTIFICIALITIES

- A) In order to conduct the exercise within the period of time established, certain events and actions will be accelerated or certain selected response elements will be pre-positioned and played at pre-determined times.
- B) In order to conserve resources, patients will not be transported to hospitals by ambulance. Patients will be pre-staged at, or near, the hospitals.
- C) The bioagent chosen for this exercise was chosen for organizations to exercise their policies, procedures and organizational responses to an extreme event. For this exercise, the bioagent will act as described in the exercise messages. During exercises it is tempting to solve complex problems in a short period of time. Participants are encouraged to suggest realistic solutions and solve problems in time frames that are consistent with the length of time it would take to implement the solution proposed.

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VI. EXERCISE IMPLEMENTATION AND RULES

A) During the play, all players will adhere to the following rules:

- 1) Real world emergencies take priority over exercise actions. It is possible that not all parts of the exercise will be conducted as outlined.
- 2) Exercise players will use real world response procedures. Hospitals can choose to use draft policies, procedures and/or plans to evaluate their effectiveness prior to adoption.
- 3) All messages made during the exercise will begin and end with the following words:

"This is a Slippery Slope 2005 Exercise message."

- 4) Safety in conducting the exercise is priority. Each participating hospital is responsible for ensuring safe play. If an unsafe situation is observed, the Safety Officer, Evaluator or simulated patients. The phrase "Real World" will be used to stop play. If this phrase is heard, play will be stopped until the unsafe condition is identified and corrected. Play will resume as soon as it is safe to do so. It is the responsibility of all participating organizations to ensure that all participants understand exercise safety; the safety phrase (Real World), how it will to be used, and that play will cease when this phrase is heard.

VII. EXERCISE MANAGEMENT

- A) Slippery Slope 2005, Central Brooklyn CBPP is divided into two sections. The first is a field exercise in which the four hospitals within the Central Brooklyn will respond as institutions and as a network to a bioagent incident. This field exercise, described in the Exercise Scenario section of this plan, will require the hospitals to identify a new outbreak of a biological agent. They will exercise the early response activities and evaluated using a tool based on the exercise goals and objectives identified in Section 3 of this plan. The second section of the exercise will be a tabletop exercise where the HEICS leadership and key players from each hospital from the field exercise and other invited participants will work through a number of CBPP issues that extend into the next several operations period .relating to the outbreak.

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- B) The exercise is being managed using a unified command structure. The CBPP Exercise Director and Contracted Exercise Director jointly act as exercise command. The Contracted Exercise Director will assist planning and will help conduct and evaluate the exercise using the ICS structures.
- C) Because of the nature and location of the activity, exercise twists will be kept to a minimum. Individuals from other hospitals who wish to observe may be included in the corps of evaluators. They must be willing to assist by completing a written evaluation of the portion of the exercise they evaluated.
- D) A Visiting Important People (VIP) coordination program will be established to ensure that VIPs observe the exercise to the extent possible. The CBPP Exercise Director will be the person who approves individuals for the VIP program. The CBPP Exercise Director will determine what part or parts of the exercise the VIP will be allowed to observe. VIPs are asked not to interact with participants to ensure play is not disrupted or guided.
- E) Access to the exercise sites will be restricted to the extent possible on the day of the exercise play. Participants and exercise management staff will be required to display identification to obtain access to the exercise area. Participants will wear their organizations' picture IDs. Exercise Management staff will wear one ID badge that will be recognized by all participating hospitals.

VIII. PARTICIPANTS

- A) The participants for this rotation of the Slippery Slope 2005 include
 - 1) NYCDOHMH
 - 2) Central Brooklyn CBPP
 - a) SUNY Downstate Medical Center (SUNY Downstate)
 - b) Kings County Hospital (Kings County)
 - c) King County Hospital Building G (G Building)
 - d) Kingsboro Psychiatric Center (Psych Center)
 - e) Kingsbrook Jewish Medical Center and affiliated Nursing Homes. (Jewish Medical Center)

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IX. EXERCISE SCENARIO

Pre-Exercise

CDC reports an outbreak of SARS in Canada. One case of potential SARS has been identified.

NYCDOHMH puts out a warning message 1/19/04 via facsimile warning of the situation above. (This alert will be at 9:00 a.m.)

CDC reports that December and January has been a higher than normal flu season. Lack of flu vaccine for most individuals and mild winter has produced a large than normal flu season in the NYC area.

Terrorism alert level continues nationally at yellow with New York City continuing at orange. NYPD has expressed concern that the background chatter has turned silent.

A group of students and adults spent between Christmas and New Years on a school sponsored ski trip in Canada. Transportation for the group was provided by bus service. By the time they got back to Brooklyn, a significant number of the students and chaperones feel sick with coughing and fever and malaise. One of the group had suffered a dislocated shoulder on first day snowboarding and brought to Canadian hospital for treatment. A substantial number of group visited injured boarder in hospital in Canada.

Field Exercise

At **10:00 A.M.** a patient from Kingsboro Psychiatric Center is brought to the King County Medical Center main Emergency Department via Kingsboro transportation. The patient returned from a weekend pass. This was the second weekend pass in two weeks. Today Wednesday he woke up complaining of flu symptoms. The Patient stated that he was having trouble breathing, fever of 100.4 and complaining of pain in his chest when he breathes. Kingsboro Psychiatric Center policy is to bring medical patients to the Kings County Hospital Emergency Department. He is accompanied by a Kingsboro Psychiatric Center Staff Member. Patient is evaluated by an ED Resident physician and a chest film and blood test are ordered. (all blood tests are within normal limits.) PG2 Radiology Resident noted a bit of chest congestion, but thinks it is consistent with the flu. The patient is given the diagnosis of upper respiratory tract infection. The patient is upset. He requests his morning meds and says that he wants to be evaluated at “G” Building by a psychiatrist prior

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to returning to Kingsboro. The Patient receives his medication which are sedating. The Patient is transferred to G Building for further evaluation. The patient sleeps in “G’ Building emergency department from 12:30 pm to 3:30 pm. If the patient is asked he tells the ED staff at “G” Building that he spent Sunday January 9th with his sister in Canada. His sister became ill this last weekend. She is an RN in Toronto, assumed that she just has a bad case of the flu, and is at home in bed.

At **3:00 P.M.** An attending radiologists “over reads” the chest film from the patient who is still in G Building Emergency Department. The Radiologist indicates that the patient x-ray is consistent with SARS.. He recommends clinical correlation.

3:10 P.M. Patients begin presenting at all of the three Emergency Departments complaining of similar illnesses. Each ED receives between ten and fifteen patients between **3:10 P.M.** and **4:00 P.M.** Patients will be fed in accordance with the MSEL. Patients will present with pneumonia like symptoms. Seven will have the exercise focus illness and three will have different but symptomatically similar illnesses. .

5:00 P.M. Field Exercise ends. Hotwash lead by the controller in each area occurs. Participants and volunteer patients complete exercise critiques. Controllers are responsible to ensure the designated people who are to attend the Tabletop Exercise travel to the tabletop location. Incident Command and General Staffs from each of the Hospital EOCs and selected other participants come to Kings County Hospital for a tabletop exercise. Refreshments will be served between **5:15 P.M.** and **5:45 P.M.**

5:00 P.M. to **5:30 P.M.** Volunteers go to Cafeteria of UHB Hospital to get refreshments, their awards and certification/gifts event and turn in their critiques. Other players complete their critiques at their work sites. Evaluators from each site are responsible to return evaluations to the hospital exercise coordinator before they leave. Refreshments will be served at the location of the tabletop prior to the beginning of the tabletop exercise.

Tabletop Exercise

The Central Brooklyn CBPP Tabletop exercise has the following objectives

1. Develop unit cohesion and inter hospital communication and coordination.
2. Discuss how the hospitals continue to deal with the unfolding bioagent event.
3. Improve understanding of the Incident Management System
4. Get experience in using the Incident Planning Process to manage the future activity of the hospital and CBPP.

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5. Prepare for the influx of patients from an infectious respiratory disease.

Timetable

5:15 P.M. to 5:45 P.M. Dinner

5:45 P.M. to 6:00 P.M. Introduction of Tabletop Exercise

Participants will be divided by their hospitals four tables.

6:00 P.M. to 6:30 P.M.

It is now 12 hours since potential SARS patients have accessed four of the CBPP hospitals. Between the four hospitals and Building G, approximately 30 patients have been admitted with lower respiratory ailments consistent with SARS. Samples have been sent to NYCDOHMH lab for conformation. Hospitals are using the presumptive diagnosis of SARS. Develop an Incident Action Plan (IAP) for the next 12 hours. In this plan describe your major objectives and activities that need to be accomplished in the next 12 hours. You have 20 minutes to develop this plan. The Planning Section Chief will act as scribe and the Operations Chief will have 5 minutes to present your IAP to the rest of the teams. You will be provided forms to assist you in this process.

6:30 P.M. to 6:45 P.M.

Brief out of Incident Action Plans from each hospital to the four Incident Commanders

6:45 P.M. to 7:00 P.M.

Break for all players, except the four Incident Commanders

The four Incident Commanders will develop a common Incident Action Plan

7:00 P.M. to 7:30 P.M.

Participants will be arranged by functions with all Command Staff at one table, Operations at another, etc.

The four Incident Commanders has developed a common Incident Action Plan. Each Section group will take 20 minutes and describe what they will do to help accomplish these joint tactical objectives. Prepare a report that you will give to the Four Incident Commander in front of all of the exercise players.. Operations

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Section has 5 minutes to brief the four Incident Commanders. The other sections have 3 minutes to brief the four Incident Commanders.

7:30 P.M. to 7:45 P.M.

Sections brief the four Incident Commanders on how they will help accomplish the Incident Action Plan.

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APPENDIX A

Exercise Evaluation Program

The overall exercise is being evaluated using the Department of Homeland Security Terrorism Exercise Evaluation Program (October 2003).

Evaluators and controllers will be assigned to each major exercise site. Each will provide input into the exercise evaluation program.

Each exercise participant will be invited to provide input through written comments regarding the exercise. The format for that input is provided on the next page. Individuals can submit their evaluation form by turning it in at the end of the exercise. Each organization is invited to be a part of the debriefing conference.

A draft After Action Report (AAR) will be submitted to the NYCDOHMH. Comments from the NYCDOHMH will be returned to the consultant. The final draft of the AAR will be submitted to the NYCDOHMH for distribution to participating hospitals.

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Evaluation Form

1. I was a participant in the (Number/Letter) _____
group(s).

*Please circle all that apply. Example "2/e"
"SUNY/EOC"*

1. NYCDOHMH
2. SUNY Downstate Medical Center (University Hospital of Brooklyn)
3. King(S) County Hospital **Center**
4. Kingsboro Psychiatric Center
5. Kingsbrook Jewish Medical Center
6. Kings County Psychiatric Emergency (Building G)
 - a. Infection Control
 - b. ED
 - c. Ward
 - d. Security
 - e. EOC/ICC
 - f. Patient volunteer
 - g. Other Please specify _____

2. **What is your assessment of the exercise design and conduct?**

Please rate, on a scale of 1 to 4, your overall assessment of the exercise relative to the statements provided below, with 1 indicating strong disagreement with the statement and 4 indicating strong agreement.

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	Strongly Disagree 1	2	3	Strongly Agree 4	N/A
Assessment Factor					
a. The exercise was well structured and organized.	1	2	3	4	N/A
b. The exercise scenario was plausible and realistic.	1	2	3	4	N/A
c. I understood my role during the exercise scenario.	1	2	3	4	N/A
d. I was able to participate to the best of my ability.	1	2	3	4	N/A
e. The exercise material used to prepare for and/or participate in the exercise was useful.	1	2	3	4	N/A
f. Participation in the exercise was appropriate for someone in my position.	1	2	3	4	N/A
g. The participants included the right people in terms of level and mix of disciplines.	1	2	3	4	N/A
h. The exercise provided a good test of my knowledge/skills.	1	2	3	4	N/A
i. I feel better prepared for an actual event.	1	2	3	4	N/A

3. Please describe any notable observations of the exercise that demonstrate either strengths or weaknesses of the activity you participated.

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APPENDIX B



THE CITY OF NEW YORK

DEPARTMENT OF HEALTH & MENTAL HYGIENE

Michael R. Bloomberg

Thomas R. Frieden, M.D., M.P.H.

Mayor

Commissioner

**2003 HEALTH ALERT #8 – UPDATE ALERT REGARDING THE OUTBREAKS OF
SEVERE ACUTE RESPIRATORY SYNDROME IN ASIA**

Please Share With Colleagues in Critical Care, Emergency Medicine, Family Practice, Internal
Medicine, Laboratory Medicine, Pediatrics and Pulmonary Medicine

TO: Physicians, Laboratory Directors, Infection Control Practitioners and other Healthcare
Providers

FROM: XXXX, Medical Epidemiologist

XXXX, Assistant Commissioner

Bureau of Communicable Diseases

DATE: March 15, 2003

RE: Surveillance for Severe Acute Respiratory Syndromes in Patients with Recent
Travel to Asia or Their Close Contacts

**1 – Patients with recent travel to Asia who develop fever and acute respiratory disease
syndromes should be rapidly isolated in an airborne infection isolation room with airborne
and contact precautions**

**2 – All patients who meet the CDC case definition (see below) should be immediately
reported to the New York City Department of Health and Mental Hygiene**

**3 - Information on the suspect case-patient from Singapore who visited New York City is
provided at the end of this alert**

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The New York City Department of Health and Mental Hygiene (NYC DOHMH), in conjunction with the federal Centers for Disease Control and Prevention (CDC), is requesting heightened surveillance for persons presenting with:

A severe acute respiratory syndrome or an atypical pneumonia who either (a) traveled in Asia within the 7-day period prior to the onset of symptoms or (b) have had direct contact with an ill person who meets the CDC case definition below.

Since mid-February, the World Health Organization (WHO) has been actively investigating outbreaks of severe acute respiratory disease in Viet Nam, Hong Kong, and the Guangdong province in China, as well as recent reports of suspect cases from other parts of Asia, including Singapore, Thailand, Indonesia, the Philippines and Taiwan. In addition, there are six cases in Toronto, Canada among one family, in which one family member had recently traveled to Hong Kong. Two family members have died, including the index case. To date, the WHO reports more than 150 suspect cases of what has been termed severe acute respiratory syndrome (SARS). It is as yet unclear if all of these outbreaks are related and the etiology of this disease remains unknown.

No link so far has been established between these outbreaks of acute respiratory illness in Hanoi and Hong Kong and the outbreaks of 'bird flu' A (H5N1) reported previously from Hong Kong; initial laboratory testing for H5N1 among the recent SARS cases is reported to have been negative. Currently the outbreaks appear to be mostly confined to the hospital environment. Those at highest risk appear to be family members and health care workers who have had direct contact with these patients.

The first reported cluster began in Viet Nam with a single initial case hospitalized for treatment of severe acute respiratory syndrome of unknown origin. The index patient felt unwell during travel and became ill shortly after arriving in Hanoi from Hong Kong and Shanghai, China. According to WHO, following his admission to the hospital, approximately 20 hospital staff became sick with similar symptoms. The index patient has died, and the results from the autopsy investigation are pending.

In Hong Kong, an outbreak of respiratory illness has been reported in a public hospital. According to WHO, after admission of the index patient, 26 health care workers developed a febrile illness and 10 have evidence of pneumonia.

In February, the Chinese government reported an outbreak of atypical pneumonia in the Guangdong Province. To date, 305 cases have been reported, including 5 deaths. Although there were reports that this outbreak may be due to *Chlamydia pneumoniae*, this has not yet been confirmed. Chlamydia has not been identified as the etiology in the recent cases from Viet Nam, Hong Kong and Singapore according to preliminary reports. It is unclear if this outbreak in Guangdong is related to the more recent outbreaks in Asia.

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Clinical Presentation

Early disease manifestations include an initial flu-like illness with high fever followed by muscle aches, headache, dry cough, sore throat and shortness of breath or difficulty breathing. Early laboratory findings may include thrombocytopenia and leukopenia. In some, but not all, cases this is followed by hypoxia and pneumonia (often interstitial) and may progress to acute respiratory distress requiring mechanical ventilation. Some patients are recovering but some have died and others remain critically ill.

The incubation period has been reported to be as short as 1-2 days or as long as 7 days (mean of 4 days). Most secondary cases have been either healthcare workers or family members who have had direct contact with case-patients.

Reporting of Suspect Cases to the New York City Department of Health and Mental Hygiene:

In order to enhance surveillance for this illness and to detect its possible importation into New York City, we are requesting immediate reporting of any suspect or probable cases. The CDC has developed the following case definition for severe acute respiratory syndrome (SARS).

A person presenting with a history of illness onset since February 1, 2003 that includes:

- (a) high fever (> 38 °C or 101.4 °F) AND
- (b) one or more respiratory signs or symptoms, including cough, shortness of breath, difficulty breathing, hypoxia, or radiographic findings of pneumonia or respiratory distress syndrome AND
- (c) either recent travel to areas reporting cases of SARS (including Hong Kong, Guangdong Province in the People's Republic of China, and Hanoi, Viet Nam) within 7 days prior to illness onset OR close contact¹ with a person who has been diagnosed with SARS.

Any suspected or probable cases should be reported immediately to the Bureau of Communicable Disease at 212-788-9830. After hours and on weekends, cases should be reported to Poison Control at 212-POISONS (212-764-7667) or 1-800-222-1222.

¹ Close contact is defined as caring for, having lived with, or having had direct contact with respiratory secretions and body fluids of a patient with suspect or probable SARS.

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Isolation Precautions for Any Suspect or Probable Cases:

If the patient is first seen in an emergency department or clinic, a surgical mask should be placed immediately on the patient and s/he should be escorted directly to the airborne infection isolation room.² Ensure that the airflow is negative pressure. Infection control personnel should be immediately notified regarding the suspect case. If not already involved, consultations should be requested from an infectious disease specialist.

As secondary spread to healthcare workers has occurred in the outbreaks in Asia, all suspect case-patients should be isolated in an airborne infection isolation room.² All staff and visitors entering the room should adhere to both airborne and contact precautions.

Standardized isolation signs noting the need for airborne and contact precautions should be displayed outside the case-patient's room. Ensure that all staff and visitors entering the room are instructed in the meaning of contact, airborne and standard precautions. All hospital staff (including transport personnel) and visitors must don contact and airborne personal protection equipment prior to entering a suspected patient's room (i.e., disposable gloves and gowns and an N-95 or higher respirator). When caring for patients, health care providers should wear eye protection for all patient contact. Standard precautions include careful attention to hand hygiene.

These precautions should be maintained until the etiology and route of transmission for this illness are known.

Laboratory Testing:

Clinicians should evaluate any patient suspected of meeting the above CDC case definition for SARS. The initial diagnostic testing should include chest radiograph, pulse oximetry, complete blood counts, blood cultures, sputum Gram's stain and bacterial culture, and nasopharyngeal, throat swabs, sputum, or other respiratory specimens for testing for viral respiratory pathogens (including influenza A and B and respiratory syncytial virus). If bronchoscopy, transtracheal and/or lung biopsy are performed, both fresh, frozen tissue and formalinized specimens should be obtained for testing at CDC and other reference laboratories.

² Airborne infection isolation rooms are defined as negative pressure isolation rooms with a minimum of 6-12 air exchanges per hour and direct exhaust to the outside which is located more than 25 feet from an air intake and from where people may pass (if air cannot be exhausted directly to the outside more than 25 feet from an air intake and from where people may pass, then air should be filtered through an appropriately installed and maintained HEPA filter).

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Clinicians should save any available clinical specimens (respiratory, blood and serum) for additional testing until a specific diagnosis is made.

NYC DOHMH will provide additional information on appropriate specimen collection at the time of consultation. We will also arrange rapid transport of these specimens to the NYC DOHMH Public Health Laboratory for shipment to the CDC and other reference laboratories.

Any fatal cases meeting the WHO case definitions must be reported immediately to the Office of the Chief Medical Examiner at 212-447-2030. An autopsy to obtain tissues for diagnostic examination will be arranged.

Treatment:

Because the etiology of these illnesses has not yet been determined, no specific treatment recommendations can be made at this time. Empiric therapy should include coverage for organisms associated with any community-acquired pneumonia of unclear etiology, including agents with activity against both typical and atypical respiratory pathogens (*See Bartlett, et al reference below*). Treatment choices may be influenced by severity of the illness and an infectious disease consultation is recommended.

Suspect Case in a Traveler to New York City:

The NYC DOHMH was notified this morning of a potential case in a traveler from Singapore who was visiting New York City and was hospitalized this morning in Frankfurt, Germany on his return home. This patient is a physician and prior to departing for the United States on March 11th, he had cared for two suspect cases who had unexplained respiratory illness in Singapore. To date, 16 cases of SARS have been reported in Singapore.

The visiting Singapore physician developed a febrile illness with severe myalgias and a maculopapular rash prior to leaving for the United States. The rash resolved within 2-3 days. He did not report any respiratory symptoms. He sought medical care from an outpatient provider in New York City and was noted to have a left lower lobe pneumonia on chest x-ray, and his blood counts were all normal. He was treated with oral antibiotics and was not hospitalized.

He left New York City on March 14th, and en route back to Singapore was hospitalized in Frankfurt, Germany due to concern that his illness may be related to the outbreak in Singapore. His admission laboratory tests revealed a normal blood count and his oxygen levels were normal on room air. He is clinically stable and remains in isolation pending further evaluation. This patient was traveling with two family members, one of whom developed fever and myalgias this morning and is also in isolation pending further evaluation.

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During the 3 days this patient was in New York City, he had minimal direct contact with anyone outside of the two family members who were traveling with him. He attended a medical conference for only 2 hours and reports that he did not sit near any other attendees and had minimal contact with anyone else during his stay in New York City. The NYC DOHMH has notified the physician who treated this patient in New York City, the hotel where he stayed, as well as the conference organizers.

Travel Advisory:

The CDC will be issuing health alerts to travelers returning from Asia. Any patient traveling to an area where SARS has been reported should be instructed to seek medical attention if they develop fever and respiratory symptoms.

As always, the NYC DOHMH appreciates the ongoing collaboration with the medical and laboratory community in responding to emerging infectious diseases issues in New York City and worldwide.

X. REFERENCES

For additional information on this evolving outbreak, check the following websites:

Centers for Disease Control and Prevention: <http://www.cdc.gov>

World Health Organization <http://www.who.int/en/>

References on infection control precautions include:

1. Garner JS, Hospital Infection Control Practices Advisory Committee. Guideline for isolation precautions in hospitals. *Infect Control Hosp Epidemiol* 1996;17:53-80, and *Am J Infect Control* 1996;24:24-52. <http://www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm>
2. Bartlett JG, Dowell SF, Mandell LA, File Jr, TM, Musher DM, and Fine MJ. Practice Guidelines for the Management of Community-Acquired Pneumonia in Adults. *Clin Infect Dis* 2000;31:347-82. <http://www.journals.uchicago.edu/CID/journal/issues/v31n2/000441/000441.web.pdf>

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DEPARTMENT OF HEALTH & MENTAL HYGIENE

Michael R. Bloomberg

Thomas R. Frieden, M.D., M.P.H.

Mayor

Commissioner

nyc.gov/health

2003 Health Alert #12- Severe Acute Respiratory Syndrome (SARS) Update

Please Share With Colleagues in Critical Care, Emergency Medicine, Family Practice, Internal Medicine, Laboratory Medicine, Pediatrics and Pulmonary Medicine

TO: Physicians, Laboratory Directors, Infection Control Practitioners and other Healthcare Providers

FROM: XXXX, Medical Epidemiologist

XXXX, Assistant Commissioner

Bureau of Communicable Disease

DATE: April 3, 2003

1 – Seven New York City residents have been identified as meeting the CDC's case definition for SARS after travel to endemic regions in S.E. Asia. There is no evidence for local acquisition of infection among healthcare workers or family contacts in New York City.

2 – CDC SARS case definition changed to include all of mainland China (the People's Republic of China)

3 – Due to the concern that there may be unrecognized cases of SARS in New York City, we request that providers also report any patients with pneumonia or acute respiratory distress without an identifiable etiology occurring in the following hospitalized persons:

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- **A health care worker who is employed in an acute or primary medical care setting**
- **A cluster of two or more members of a family or group of people who have close contact with each other**

4 – Important steps in the management of a suspect SARS case

5 – Biosafety Level 3 laboratory facilities are required when attempting viral culture from a patient meeting the suspect SARS case definition

6 – Interim guidelines for management of exposures to SARS in healthcare settings

7 – Upcoming CDC Broadcast and Webcast on preventing the spread of SARS on April 4, 2003

As of April 2, 2003, a cumulative total of 2,223 cases Severe Acute Respiratory Syndrome (SARS) and 78 deaths (case fatality rate of 3.5%) have been reported from 16 countries, including the United States. Outside of the most severely affected areas in the People's Republic of China (including Hong Kong), the majority of cases reported to date involve direct contact, especially among health care providers caring for patients with SARS. Although the international outbreak investigation has made great strides towards identifying the cause of this illness, the definitive etiologic agent and a full understanding of the epidemiology (especially regarding the modes of transmission and the period of contagiousness) of this illness are not yet known.

The CDC has issued a travel advisory recommending that individuals who are planning nonessential travel to the People's Republic of China (including Hong Kong); Hanoi, Vietnam or Singapore may wish to postpone their trip until further notice.

In the United States, 94 of the 100 suspected SARS cases reported as of April 2, 2003 involved persons who had returned from affected areas within the 10 days before illness onset. Of the remaining six, four were household contacts and two were health care workers with exposure to a suspect SARS patient. An updated clinical and epidemiologic summary of the cases in the United States has been published in this week's *Morbidity and Mortality Weekly Report*, which is available at www.cdc.gov/mmwr/.

1 - Seven Possible SARS Cases in New York City

Seven New York City residents have been identified as meeting the Centers for Disease Control and Prevention's (CDC) case definition for SARS. These individuals, ranging in age from 1 to 91 years old, had onset of symptoms during travel or shortly after return from a region in S.E. Asia with known community transmission of SARS. All seven New

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York City suspect cases have mild symptoms (typically just fever and cough) and are recovering. Laboratory specimens have been sent to the CDC for testing; all results are still pending and it is possible, given the broad spectrum of illness that is currently included in the surveillance case definition that some of these patients may not have SARS. The New York City Department of Health and Mental Hygiene (NYC DOHMH) is posting updated information on SARS surveillance data in New York City on our Website at: <http://www.nyc.gov/html/doh/html/cd/cdsars.html>

The NYC DOHMH has been monitoring cases and their household contacts until 10 days after the SARS patient has recovered. There has been no evidence to date of secondary cases among health care workers or household members, nor evidence of community transmission of SARS in New York City.

In addition to traditional disease reporting, the NYC DOHMH continues to monitor for unusual increases or geographic clustering of disease syndromes (including fever and respiratory syndromes) through our syndromic surveillance systems. Current systems include daily monitoring of electronic data from 911 ambulance calls, emergency department chief complaint logs, absenteeism records and pharmacy sales. Based on this data, there has been no recent evidence of a fever or respiratory outbreak in the City.

2 - Updated CDC SARS Case Definition

The CDC SARS case definition has been updated to include individuals who traveled to mainland China (the People's Republic of China), as there is now evidence of community transmission beyond Guangdong Province.

The current case definition is:

A person presenting with a respiratory illness of unknown etiology with an onset since February 1, 2003 that includes:

- A measured temperature > 38°C (100.4°F)

AND

- One or more respiratory signs or symptoms, including cough, shortness of breath, difficulty breathing, hypoxia, or radiographic findings of pneumonia or respiratory distress syndrome

AND

- Either travel to areas reporting community transmission of SARS (see below) within 10 days of symptom onset or close contact within 10 days of symptom

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onset with a person with respiratory illness after travel to an area reporting community transmission of SARS

Areas with suspected or documented community transmission of SARS currently include: the People’s Republic of China (including Hong Kong); Hanoi, Vietnam and Singapore. As this international outbreak is evolving, please check the CDC website at www.cdc.gov/ncidod/sars/ to get the most up-to-date information on countries with suspected or documented community transmission. [NOTE: Canada is NOT currently included in this list since there has been no evidence of community transmission. All SARS cases in Canada are travel related or have been linked directly to the index family cluster that occurred after two family members returned from travel to Hong Kong].

3 – Reporting Suspect Cases to the NYC DOHMH

Although the SARS outbreak in the United States has remained mild compared to other affected countries, the NYC DOHMH recognizes the need to remain vigilant for evidence of both imported SARS cases and community transmission. To ensure our ability to detect both imported cases, and persons who may represent the first evidence of community transmission, we ask providers to be alert to and report any of the following to the NYC DOHMH:

- Any individual meeting the CDC SARS case definition (See #2 above). Providers should take a travel history from all patients presenting with fever and respiratory illnesses to ensure that potential cases are recognized as soon as possible.
- Pneumonia or acute respiratory distress without an identifiable etiology after a standard workup occurring in the following hospitalized people:
 - Health care workers who are employed in acute or primary medical care settings (due to the potential that, during the 10 days prior to their illness onset, he/she may have had an unrecognized exposure to a patient with SARS).
 - Two or more members of a family or other group of people who have close contact with each other.

Please be advised that we consider the conditions listed above to be unusual manifestations of disease and are, therefore, reportable to the Department pursuant to Section 11.03(b) of the New York City Health Code. All suspect cases of SARS should

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be reported immediately to the Bureau of Communicable Disease at 212-788-9830. After hours and on weekends, cases should be reported to the NYC Poison Control Center at 212-764-7667 or 1-800-222-1222.

4 - Important Points in the Management of a Suspect SARS Patient

All clinicians are encouraged to review infection control guidelines published in previous DOHMH Health Alerts and the CDC website at www.cdc.gov/ncidod/sars/ic.htm. In addition to these guidelines, these important points should be emphasized:

- If you are transferring or referring a patient who could have SARS to another facility:
 - a) Place a surgical mask on the patient prior to transfer.
 - b) Inform the transport personnel that the patient is a suspect SARS case; they should observe appropriate infection control practices including the use of an N-95 respirator, eye protection, gloves and gowns.
 - c) Call the receiving facility (Emergency Department, Infection Control and/or receiving physician) prior to transport to ensure appropriate infection control measures are implemented on arrival.

- Certain health care procedures, such as the use of nebulized medication, may potentiate the risk of SARS in health care workers. All health care workers performing aerosol-generating procedures in a suspect SARS patient should observe strict airborne and contact precautions; see the CDC website at www.cdc.gov/ncidod/sars/ for complete guidelines.

- Due to concern that SARS may also be transmitted by direct contact with infected secretions or body fluids, all health care workers should wash their hands promptly in soap and water after they remove their gloves when they are finished taking care of a suspect SARS patient.

- Close contacts (e.g., family members) of SARS patients are at risk for infection. Close contacts with either fever or respiratory symptoms should not be permitted to enter the health care facility as visitors and should be educated about this policy. A system for screening close contacts of SARS patients who are visitors to the facility for fever or respiratory symptoms should be in place. Health care facilities should educate all visitors about the need for infection control precautions when visiting SARS patients and their responsibility for adherence to them.

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- The NYC DOHMH will provide instruction sheets for both patients and their contacts to advise them of the steps that need to be taken on discharge to prevent any transmission to household members (*Copies are attached*). These fact sheets are being translated into both Chinese and Vietnamese, and will be available on our website at <http://www.nyc.gov/html/doh/html/cd/sars1.html>.

5 - Biosafety Level 3 Laboratory Facilities Required when Attempting Viral Culture

According to the CDC's Interim Biosafety Guidelines for Handling and Processing Specimens Associated with SARS (www.cdc.gov/ncidod/sars/sarslabguide.htm), the following activities require biosafety level 3 (BSL 3) facilities and practices:

- Culture-based attempts to isolate the agent, including inoculation onto cell culture, bacteriological or mycological media, and eggs.

Until the agent causing SARS is fully characterized, attempts to isolate routine viral respiratory pathogens by cell culture in a patient meeting the SARS case definition should only be attempted in BSL-3 facilities. If a BSL-3 facility is not available, contact the Bureau of Communicable Disease during regular business hours at 212-788-9830 to arrange shipment to the New York State Wadsworth Laboratories. The Wadsworth Laboratories will only accept samples from patients meeting the CDC SARS case definition after clearance by the NYC DOHMH Bureau of Communicable Disease.

6 - Interim Guidelines for Management of Exposures to SARS in Healthcare

Settings

Several health care workers in Asia have been reported to develop SARS after caring for patients with SARS. Transmission to health care workers appears to have occurred after close contact with symptomatic individuals (e.g., persons with fever or respiratory symptoms) before recommended infection control precautions for SARS were implemented (i.e., unprotected exposures). Personal protective equipment appropriate for contact and airborne precautions (e.g., hand hygiene, gown,

gloves, N95 respirator and eye protection) have been recommended for healthcare workers to prevent transmission of SARS in health care settings.

The CDC has proposed the following interim guidelines for management of employees with unprotected exposures to SARS in a health care facility:

- a) Exclusion from duty is recommended for a health care worker if fever or respiratory symptoms develop during the 10 days following an unprotected

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exposure to a SARS patient. Exclusion from duty should be continued for 10 days after the resolution of fever and respiratory symptoms. During this period, infected workers should avoid contact with persons both in the facility and in the community. Guidance for the management of a suspect SARS patient as an outpatient is available from NYC DOHMH Health Alert #10 on our website (<http://www.nyc.gov/html/doh/html/cd/03md10.html>) and the CDC website: www.cdc.gov/ncidod/sars/infectioncontrol.htm

b) Exclusion from duty is **not** recommended for an exposed health care worker if they do not have either fever or respiratory symptoms; however, the worker should report immediately any unprotected exposure to a SARS patient to the infection control or employee health department at the facility.

c) Hospitals should conduct daily monitoring of any health care workers with unprotected exposure for fever and respiratory symptoms. Workers with unprotected exposure developing such symptoms should not report for duty, but should stay home and report symptoms to the appropriate facility point of contact immediately.

d) Hospitals should consider conducting passive surveillance (e.g., review of occupational health or other sick leave records) among all health care workers in a facility with a SARS patient, and all health care facility workers should be educated concerning the symptoms of SARS.

7 - CDC SARS Broadcast and Webcast

CDC will be presenting a lecture entitled “Preventing the Spread of Severe Acute Respiratory Syndrome (SARS)” on the Public Health Training Network Satellite Broadcast & Webcast (<http://www.phppo.cdc.gov/phtn/sars/>) network on April 4, 2003 at 10:00 AM - 11:30 AM ET. The program will be rebroadcast on April 4, 2003 at 2:00 PM - 3:30 PM ET.

The NYCDOHMH will be posting all SARS-related medical materials (such as Health Alerts, fact sheets, and discharge instructions for patients) on the SARS Provider page on our website at <http://www.nyc.gov/html/doh/html/cd/sars1.html>.

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2003 Health Alert #13-Unexplained Viral Illness in Patients in Staten Island

Please share with colleagues in Critical Care, Emergency Medicine, Family Practice, Internal Medicine, Infectious Disease, Neurology Laboratory Medicine, Pediatrics and Pulmonary Medicine

TO: Physicians, Laboratory Directors, Infection Control Practitioners and other Healthcare Providers

FROM: XXXX, Medical Epidemiologist

XXXX, Medical Epidemiologist

Bureau of Communicable Disease

DATE: October 10, 2003

RE: New York City Department of Health and Mental Hygiene (NYCDOHMH) is currently investigating 5 cases of severe, unexplained illness in Staten Island

NYCDOHMH requests immediate reporting of all critically ill patients presenting with nonspecific, viral-like prodrome, central nervous system (CNS) changes, abnormal CSF including high protein, mild increase WBCs and negative gram stain and culture. Other symptoms may include seizures and pulmonary infiltrates.

The NYCDOHMH is currently investigating 7 cases of severe unexplained illness in Staten Island. The patients are all critically ill and intubated; 1 patient died. All had onset between 9/17/03 and 10/8/03 and reportedly had non-specific prodrome including fever, headache,

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fatigue, and malaise. Some have had mental status changes and seizures or are obtunded. Common laboratory findings include high normal or elevated peripheral WBC counts with left shifts, CSF with elevated protein and/or mildly increased WBC (0-7). Some patients have abnormal chest x-rays. One patient had a rash consistent with erythema multiforme. The median age of the patients is 39 (range 22-54); 5 are male. All live in Staten Island.

Two of the six patients have tested negative for West Nile Virus. The illness these patients have is NOT consistent with SARS which presents primarily as a pulmonary syndrome. It remains unclear whether or not these cases are related. In order to determine whether or not there are similarly ill patients elsewhere in New York City and to further our investigation, the NYCDOHMH requests immediate reporting of all:

Critically ill patients with nonspecific viral with nonspecific, viral-like prodrome, central nervous system (CNS) changes and abnormal CSF including high protein, mildly elevated WBCs and negative gram stain and culture. Other symptoms may include seizures and pulmonary infiltrates.

Any suspected or probable cases should be reported immediately to the NYCDOHMH Bureau of Communicable Disease at 212-788-9830. After hours and on weekends, cases should be reported to Poison Control at 212-POISONS (212-764-7667) or 1-800-222-1222.

After consultation with a NYCDOHMH medical epidemiologist, providers will be advised on specimens to be collected for further testing. There are no specific isolation precautions currently recommended beyond standard precautions.

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APPENDIX D

SLIPPERY SLOPE 2005 EXERCISE PARTICIPANT HEALTH AND SAFETY PLAN

The following Health and Safety guidelines will be incorporated into all aspects of the Slippery Slope 2005 Bioagent Exercise.

Site Security and Safety are paramount!! Do not violate security or safety rules for the sake of exercise play!

None of the scenarios calls for testing security or safety procedures through unauthorized, illegal, or intentionally unsafe actions.

Since this is not an actual event, do not compromise safety at any time for the sake of exercise play. No shortcuts or modifications to safety procedures are authorized.

There will be an Exercise Safety Controller appointed and on-site at all exercise venues who shall report directly to the Exercise Director.

Safety Controllers will ensure all activity occurs within a safe environment.

There will be a Safety Orientation given to all exercise participants prior to conducting any exercise activity.

Weather may play a part in the safety of the exercise participants. Precautions will be taken to address cold, physical exertion, slip/trip/fall hazards, and other related factors in the planning process and in the conduct of the exercises.

Consideration will be made to ensure any of the general public that is not involved in the exercise but may observe the activities will be informed of the exercise to help prevent any undue concern on their part.

All exercise participants, staff, and observers are responsible for ensuring the exercise is conducted safely. All activities must be accomplished in accordance with standard, commonly used safety practices.

Real world emergencies take priority over exercise actions. It is possible that not all parts of the exercise will be conducted as outlined.

In the event that someone suffers a real-time medical emergency, contact the nearest Exercise Staff member and let him or her know you have a “Real-World” emergency. There will be emergency medical responders staged nearby.

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Safety in conducting the exercise is priority. Each participating hospital is responsible for ensuring safe play in their venue.

Each participating hospital will ensure that a trained Safety Officer is available for all exercise activities. This Safety Officer will be responsible for the safety of all players within his or her venue.

It is the responsibility of all participating organizations to ensure that all participants understand exercise safety; the safety phrase (Real World), how it will be used, that play will cease when this phrase is heard, and that play will only resume once permission is received from their Area Controller.

The phrase "Real World" will be used to stop play. If an unsafe situation is observed, the Safety Officer, Controller, Evaluator or Simulated Patients shall state the phrase **'Real World'** in a loud and clear voice followed by the location of the situation. If this phrase is heard, play will be stopped immediately in that area until the unsafe condition is identified and corrected. Play will resume as soon as it is safe to do so.

Exercise Controllers in each area will have the responsibility to communicate the stoppage of play to the Lead Controller who will discuss the problem with the Exercise Director who will provide direction on how to proceed.

The Exercise Controllers will also assess and be responsible for determining the extent of the unsafe situation and an exercise site-wide transmission of a stop play order if that required. This will usually be done only after consultation with the Lead Controller but may be ordered by any Exercise Controller or Safety Officer if the situation is seen to have the potential to escalate to a site-wide emergency. If a security violation or an unsafe condition exists at this level, an announcement will be made using the words "Terminate, Terminate, Terminate".

In order to maintain accountability and ensure their security and safety, observers and media shall register with each individual hospital's Media Relation's Department and with the CBPP Exercise Director.. In addition, an Exercise Staff escort must accompany observers and media when they enter the play area.

The Sim Cell will have final authority over the full termination of the exercise or the resumption of play in any area of the venue.

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EXSTAFF Controller Corrective Actions

Take the following actions when:

- An unsafe condition exists or you see an impending or potential safety hazard, stop the activity immediately and correct the situation. If possible, resolve the situation without interfering with play.
- You must stop play in a given area, transmit or loudly announce, “Real World,” followed by your call sign, location, and reason for halting play, e.g., “safety” or “security.” Report the unsafe or unsecured condition to the Master Controller and work to resolve the hazard or issue. When the situation is corrected, the Controller will announce “resume play” followed by his/her call sign and location.
- You hear the cry, “**Real World**”, stop what you are doing and hold your position until the security breach or hazardous condition has been identified and you are instructed to take action or resume play.
- Someone is injured, report it immediately to the Master Controller and take appropriate protective and first aid actions.

Possible situations and appropriate corrective actions are described below.

- **SITUATION: Someone is injured.**

ACTION: Report it immediately and take appropriate protective and first aid actions. You may need to delay or terminate play if the severity of the situation or injury warrants.

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APPENDIX E

Patient Profiles

Patient 1(chaperone): 44 y.o. male teacher cough 4 days and fever (100), diarrhea, SOB with exertion, no CP.

PHMx: HTN and smoking

VS: temp 100, 127/64 P: 90 RR:20

PEERLA, EOMI, pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ diffusely tender abdomen, ND, No organomegaly

FROM x4, no C/C/E

Dispo: isolation

Patient 2(chaperone): 41 female (patient one's wife) cough 2 days fever, runny nose and dyspnea at rest, no chest pain.

PMHx: none

Meds: OCP

VS: T: 104 BP: 130/89 P: 101 O2 sat: 96% RR:22

PEERLA, EOMI, no pharyngeal erythema, Injected conjunctiva

CTAB

S1S2 RRR, systolic ejection murmur

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

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Patient 3 (bus driver): 60 female severe dry hacking cough, fever, diarrhea, extremely SOB at rest, 8/10 headache, diaphoresis

PMH: HTN ,DM , hypercholestromlemia,

Social Hx: Smoker occ. alcohol

VS: T: 103.0 P: 94 BP:168/99 P: 110 RR:36

PEERLA, EOMI, injected sclera, pharyngeal erythema

b/l crackes at bases

S1S2 tachycardia ,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

Patient 4 (chaperone): 26 y.o. female c/o myalgias for 1 day. No other sx.

PMH: none

No meds

VS: BP: 110/78 P:99 T: 98.9 O2 : 99% RR:16

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: discharge

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Patient 5(chaperone): 38 yo male psychiatric (works at kingsbrook), generalized myalgias

PMH: none

VS: T: 98.4 112/80 P: 78 O₂ : 100% RR: 14

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

Patient 6: 16 y.o. male skier, dry cough, runny nose, fever chills, myalgias, and dry cough

PMHx: asthma

Meds: albuterol

VS: T: 101 BP: 113/89 P: 99 O₂ sat: 95% RR:18

PEERLA, EOMI, no pharyngeal erythema

Wheezing at lung bases

S1S2 tachycardic, no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

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Patient 7: 15 y.o. female smoker (1/2 ppd) skier, dry cough, runny nose, fever chills, myalgias, and dry cough

PMHx: none

VS: T: 101 BP: 125/84 P: 98 O2 sat: 98% RR:14

PEERLA, EOMI, pharyngeal erythema

CTAB

S1S2 tachycardic ,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

Patient 8: 17 y.o. male skier, dry cough, runny nose, fever chills, myalgias, and dry cough

No PMHx

VS: T: 99.6 BP: 110/76 P: 99 O2 : 96% RR:22

PEERLA, EOMI, sceral injection and pharyngeal erythema

b/l crackles at bases

S1S2 RRR,no M/R/G

BS+ NT/ND, No organomegaly

FROM x4, no C/C/E

Dispo: isolation

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Patient 9: 15 yo female skier, dry cough and headache, for 4 days.

PMHx: asthma

Meds: singulair, albuterol

VS: T: 98 BP: 110/79 P: 90 O2 sat: 98% RR:12

PEERLA, EOMI, pharyngeal erythema

Mild wheezing in b/l lung

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

Patient 10: 14 yo male skier, dry cough and headache, for 6 days.

PMHx: none

Meds: none

VS: T: 99 BP: 111/76 P: 68 O2 sat: 98% RR:20

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR, no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

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Patient 11: 18 yo female occasional smoker skier, dry cough and headache, for 5 days.

PMHx: none

Meds: none

VS: T: 99 BP: 123/67 P: 70 O2 sat: 99% RR:20

PEERLA, EOMI, injected sclera and mild pharyngeal erythema

b/l rhonchi

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

Patient 12: 15 yo male skier, dry cough and headache, for 2 days.

PMHx: none

VS: T: 104 BP: 130/89 P: 101 O2 sat: 96% RR:14

PEERLA, EOMI, pharyngeal erythema

CTAB

S1S2 tachycardia, L sternal systolic murmur

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

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Patient 13: 15 yo female skier, dry cough and headache, for 3 days.

PMHx: none

Meds: OCP

VS: T: 101 BP: 130/89 P: 101 O2 sat: 93% RR:18

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 tachycardia ,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, swollen and red leg

Dispo: isolation

Patient 14: 14 female cough dry, diaphoretic, chills

PMHx: none

VS: T: 104 O2 sat: 96% RR-38 96/56, P: 99

PEERLA, EOMI, no pharyngeal erythema

b/l decreased breath sounds and crackles diffusely

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

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Patient 15: 17 male cough dry, fever, diaphoretic, chills,

PMHx: seizure

Meds: tegretol

VS: O2 sat: 90% rr-40 103.4, rr40, 103/89, P:111

PEERLA, EOMI, pharyngeal erythema, diffuse erythema

CTAB, tachypnic

S1S2 tachycardic, no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

Patient 16: 18 yo male with sudden onset of severe headache. No fever, no SOB

PMHx: none

VS: T: 99 BP: 112/69 P: 89 O2 sat: 94% rr-16

PEERLA, EOMI, no pharyngeal erythema, photophobia

CTAB

S1S2 RRR, no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: head CT, LP

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Patient 17: 15 yo female with headache and neck pain for 1 day.

PMHx: migranes

Meds: motrin

VS: T: 98.6 BP: 122/79 P: 89 O2 sat: 100% rr-14

PEERLA, EOMI, no pharyngeal erythema, phonophobia

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: motrin and home

Patient 18: 17 male with rash on right arm for 2 days. Itchy and red.

PMHx: none

Meds: none

VS: T: 99 BP: 128/79 P: 78 O2 sat: 100% rr-14

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E, maculopapular rash 10x12x17 on forearm, no LN palpable

Dispo: home w/ derm f/u

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Patient 19: 16 female 23 weeks pregnant c/o SOB for 1 day

PMHx: none

No meds

VS: T: 98.6 BP: 122/79 P: 110 O2 sat: 86% rr-24

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

Gravid abdomen, BS+ NT/ND No organomegaly

FROM x4, tender RLE with mild erythema

Dispo: admit for PE

Patient 20: 17 male with right knee pain for 10 days (since competition)

PMHx: none

Meds: none

VS: T: 98.6 BP: 122/79 P: 89 O2 sat: 100% rr-14

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x3, decreased ROM in R knee secondary to pain, mild swelling, joint laxity noted, no C/C/E

Dispo: ortho consult and D/C home

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Patient 21: 16 female with right upper quadrant pain 12 hours, fever.

PMHx: none

Meds: none

VS: T: 99 BP: 112/79 P: 84 O2 sat: 100% rr-18

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ ND No organomegaly, no murphy's sign, no guarding, mild ruq tenderness

FROM x4, no C/C/E

Dispo: gastroenteritis and home

Patient 22: 16 male with back pain for 3 days and nausea

PMHx: none

Meds: none

VS: T: 98.6 BP: 122/79 P: 89 O2 sat: 100% rr-14

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly, suprapubic pain, +R CVA tenderness

FROM x4, no C/C/E

Dispo: home with abx for pyleo

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Patient 23: 17 male with sore throat and myalgias for 3 days

PMHx: asthma

Meds: albuterol and took motrin

VS: T: 101 BP: 112/78 P: 101 O2 sat: 100% rr-14

PEERLA, EOMI, pharyngeal erythema

CTAB

S1S2 tachycardia, no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: isolation

Patient 24: 16 female with chest pain

PMHx: none

Meds: none

VS: T: 98.6 BP: 122/79 P: 89 O2 sat: 100% rr-14

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR, no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: home

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Patient 25: 18 female with laceration over eyebrow (L)

PMHx: none

Meds: none

VS: T: 98 BP: 126/99 P: 99 O2 sat: 100% rr-16

PEERLA, EOMI, no pharyngeal erythema, 3 cm linear and superficial laceration over L eyebrow

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: home

Patient 26: 72 year old man with CP, very diaphoretic

PMHX: NIDDM, non-obese and non-smoker

VS: T: 98 BP: 168/96 P: 112 O2 sat: 100% rr-16

PEERLA, EOMI, no pharyngeal erythema

Mild crackles at bases

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Disposition: patient will crash from MI

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Patient 27: 12 year old male accompanying patient 27 (grandson) and crying

PMHX: congenital murmur

VS: T: 98 BP: 130/78 P: 100 O2 sat: 100% rr-16

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Disposition: grandson flips out b/c grandfather is sick

Patient 28: 13 year old male with fever, nausea and vomiting and abdominal pain for 12 hours.

PMHX:none

VS: T: 99 BP: 140/96 P: 106 O2 sat: 100% rr-16

PEERLA, EOMI, no pharyngeal erythema

Mild crackles at bases

S1S2 RRR,no M/R/G

BS+ RLQ tenderness ND No organomegaly

FROM x4, no C/C/E

Labs:

WBC: 11 H/H: 14/41 Platelets: 211

Na: 141 K: 4 Cl:111 Co2: 22 BUN: 12 Cr: .7 Liver enzymes nl

Disposition: appendicitis

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Patient 29: 38 yo male generalized myalgias comes in w/ daughter and 4 friends

PMH: none

VS: T: 98.4 112/80 P: 78 O2 : 100% RR: 14

PEERLA, EOMI, no pharyngeal erythema

CTAB

S1S2 RRR,no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Dispo: home

Patient Daughter 1: 17 female with sore throat and myalgias for 3 days

PMHx: asthma

Meds: albuterol and took motrin

VS: T: 101 BP: 112/78 P: 101 O2 sat: 100% rr-14

PEERLA, EOMI, pharyngeal erythema

CTAB

S1S2 tachycardia, no M/R/G

BS+ NT/ND No organomegaly

FROM x4, no C/C/E

Disposition: Asthma attack, d/c home after treatment

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APPENDIX F

Clinical Information relating to bioagent

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

SARS Fact Sheet

What is Severe Acute Respiratory Syndrome (SARS)?

SARS is a viral disease that causes respiratory (lung) symptoms and is spread by close person-to-person contact.

When was SARS first recognized?

An outbreak of an unusual pneumonia now known as SARS was first reported in the Guangdong Province of China in November 2002. But it was not until cases began to be reported in Hong Kong and Vietnam in March 2003 that SARS was officially recognized. Over the next 3 months, SARS spread to 29 countries and caused over 8,098 cases and 774 deaths.

What are the signs and symptoms of SARS?

The illness usually starts with a fever and sometimes chills, headache, fatigue, body aches, and an overall feeling of discomfort. After 3-7 days, an infected person may develop a dry cough and have trouble breathing. In severe cases, pneumonia may occur. Some patients may also experience diarrhea.

What causes SARS?

SARS is caused by a previously unknown type of virus called SARS-CoV.

Is there a laboratory test for SARS?

Yes. Tests are available that can detect both the virus itself and antibodies to the SARS-CoV. Because of the limited number of laboratories performing the tests, testing is only available for those people suspected to have SARS.

How is SARS spread?

SARS is usually spread when someone with SARS coughs or sneezes droplets of mucus into the air, and someone else breathes them in. This happens most often

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when people are in close contact, such as when a person lives in the same home as a SARS patient or a healthcare worker is caring for a SARS patient.

SARS can also be spread by touching something that has been contaminated with the secretions (from the nose or mouth) or stool of a SARS patient.

People with SARS should wear a mask when around other people, wash their hands often (especially after using the toilet or coughing), and make sure they do not share eating utensils (forks, spoons, glasses), towels and bedding with other people in the household. These items should be cleaned with soap and water before use by others. Patients with SARS should NOT share cigarettes or drinks.

How long can the SARS coronavirus survive outside the body?

Studies show that the SARS coronavirus may survive in the environment for several days, especially in the stool of an infected person.

Who is most at risk of getting sick with SARS?

SARS spreads most easily among close personal contacts, such as those who have cared for, lived with, or had direct contact with an infected person. Persons most at risk include those who live in the same home as a SARS patient or health care workers who do not strictly follow infection control procedures when providing medical care to a SARS patient. Those who have had only casual contact (such as in school or at work) with an individual with SARS do not seem to be at risk of infection.

How long does it take to get sick after being exposed to someone with SARS?

The incubation period-the period between when someone is first exposed to a SARS patient until he/she gets sick-is usually 2-7 days, but can be up to 10 days or even longer in rare cases. The illness usually begins with fever (greater than 100.4°F).

How long is a person with SARS infectious (able to spread the disease to others)?

People are most likely to be infectious when they have symptoms, such as fever and cough. It is not yet known how long after symptoms begin that people with SARS might be able to spread the disease to others or whether they are still contagious after their illness ends.

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Is SARS dangerous?

Most people who have gotten SARS have recovered, but as many as 10-15% of SARS patients have died. The disease is more severe among older persons and those with other medical problems.

Have there been any confirmed cases of SARS in New York City?

No. The New York City Department of Health and Mental Hygiene has been watching for cases since the outbreak began in early 2003. There have been no laboratory positive cases, nor has there been any evidence of spread to health care workers or household members, nor evidence of community spread of SARS in New York City.

Have there been any cases of SARS in the world recently?

There has been no documented person-to-person transmission of SARS anywhere in the world during the 2003-4 winter respiratory viral season. Only three confirmed and one probable case of SARS has been reported last winter, all from the Guangdong Province of China. There were no epidemiologic links between these three patients and the source(s) of their exposures is unknown and remains under investigation. All three patients have recovered, and investigations of their close contacts (including healthcare worker contacts) revealed no evidence of secondary spread. There has been no other evidence of SARS anywhere in the world. However, public health officials and health care providers are on alert for the possibility that SARS may return during the winter respiratory viral season, especially in areas of China where the outbreak first occurred last year.

If SARS does occur again overseas, what will be done to prevent SARS patients from coming into the United States?

For people traveling by plane, federal quarantine inspectors stationed at the airports will screen travelers returning from countries where there are outbreaks for symptoms of SARS. In addition, health alert cards will be given to air passengers asking travelers to watch their health for 10 days and to see a doctor if they become sick with a fever OR cough or difficulty breathing. These health alert cards will also be distributed by major shipping associations to people traveling on cargo ships and cruise ships into United States ports. Finally, inspectors will board any ship carrying a passenger or crewmember suspected of having SARS and take appropriate action.

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Is there a cure for SARS?

At this time, there is no known cure for SARS. Different types of treatments have been used for very ill hospitalized patients with SARS, including antibiotics, anti-virus medications and steroids, but none has been successful. Supportive treatment, such as intravenous fluids and medicines to control fever or pain, is very important.

Is there any reason to believe that SARS is linked to bioterrorism?

There is no evidence to suggest SARS is due to bioterrorism. The pattern of spread during the Spring 2003 outbreak was typical for a contagious respiratory or flu-like illness. People most at risk were health care workers taking care of sick people and family members or household contacts of people infected with SARS.

What is being done about SARS overseas?

The World Health Organization and the Centers for Disease Control and Prevention are aggressively monitoring for cases of SARS. For more information, visit the World Health Organization website at <http://www.who.int/csr/sars/en/> and the Centers for Disease Control and Prevention website at <http://www.cdc.gov/ncidod/sars/htm>.

What is being done about SARS in New York City?

The New York City Department of Health and Mental Hygiene is working closely with hospitals and medical providers to increase their knowledge of SARS and to help them identify any cases. The Department has reminded hospitals to immediately report any illnesses suspected of being SARS. If SARS does appear again, any person suspected of having SARS will be isolated at home or in a hospital until 10 days after the person is no longer sick. The Department will also follow the close contacts of a SARS patient on a daily basis to be sure they do not develop symptoms of SARS.

The New York City Department of Health and Mental Hygiene is also providing ongoing information to the public through the media, presentations to community groups, and our website, nyc.gov/health.

Who can I call if I have questions or concerns?

The public can call the New York City Department of Health and Mental Hygiene at 311.

For more information, visit the World Health Organization website at <http://www.who.int/en/> or the Centers for Disease Control and Prevention website at www.cdc.gov.

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EXERCISE IN PROGRESS

JANUARY 19, 2005

Please do not impede or distract the exercise participants, who can be identified by one of the following exercise credentials:



If you have questions or concerns regarding this exercise, please contact the Security Office for this facility, or contact an Exercise Controller, identified by a red credential, as above.

This exercise is authorized and endorsed by the New York City Department of Health and Mental Hygiene and by the management of the participating facilities.

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