**HID Seminar Transcript**

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**Kelly Nadeau:** Hello. I am Kelly Nadeau. I’m the director of the healthcare preparedness program for the Georgia Department of Public Health, and we thank you for joining us for this overview of the Department of Public Health’s Highly Infectious Disease Plan.

The purpose of this plan, this seminar, is for a high-level review of the plan, The Highly Infectious Disease Plan. So as we go forward and you see that acronym on the slides, “HID”, just remember that that’s what it stands for: Highly Infectious Disease. There will be a lot of information on each slide, we’re not going to cover everything in detail, but we do want to provide an overview of the plan for you today.

So, first of all, let’s talk about how we got to this point. Let’s review the planning process. So, the Georgia Department of Public Health commissioned the writing of this plan to the University of Georgia Institute for Disaster Management, IDM, when you see that acronym.

We helped identify potential members of the planning committee to be invited to participate. There were several members from both DPH’s various sections and The University of Georgia. The IDM compiled research material for us and we met several times together with that core planning team using a website portal.

The IDM drafted sections of the plan and distributed them to the planning team for review. We met eleven times via Zoom used to have an overview of each section of the plan and then the full draft was presented to DPH on the 30th of June, 2021.

**Dr. Patrick O’Neal:** Hello, I’m Doctor Patrick O’Neal, clinical professor here at the Institute for Disaster Management in the College of Public Health at the University of Georgia. It’s a real pleasure to be here today to talk to about the Highly Infectious Disease Plan. And I’m sure you, like many others, have asked yourself: Why did we do this? What purpose was creating a highly infectious disease plan? What was the purpose of it? And basically, what we wanted to do was to create a framework for highly infectious disease incidents. So that they would be recognized and that we would be able to know when to activate a plan and respond to that particular incident.

We also wanted to define the state’s command and control operations. That’s really key. Knowing who’s in charge is really important as far as command and control goes. We have seen incidences where different people thought that they were, at the same time, in control. That created a lot of friction and problems, so our plan designates very specifically that whole aspect of command and control.

There are department roles that are identified and responsibilities that are identified in the plan, and there is a concept of operations during highly infectious disease incidents. It’s really, really important. We also wanted, through this plan, to be able to inform stakeholders of Georgia’s public health preparedness and response procedures for a highly infectious disease incident. Our stakeholders are key participants with us, so we want our plan to basically give us a way of being sure that they were going to be informed.

Now, with a plan of this magnitude, what really is the scope of it? The Highly Infectious Disease Plan includes the anticipated actions of not only at what we do at the lower level, at the state level, but even at the federal level, and even at local agencies. As well as the private sector which very often is left out in response plans, but we had it in this particular plan. The desired outcome, really, of this plan is to identify, mitigate (that is to reduce the impact of) whatever the highly infectious disease incident is on the state of Georgia.

So, essentially, with the situational overview I think we need to address that to help you understand what the nature of the plan may really look like. A highly infectious disease is a disease that is transmitted through direct contact with an infected individual sometimes. Sometimes just with a vector. Sometimes with contaminated surfaces or supplies or something in the environment that is contaminated that we come in contact with and can catch the agent from that. And it may cause serious illness or even death. We’re talking about really highly infectious, very dangerous diseases.

Georgia faces several potential highly infectious disease hazards, and we’ve seen many of these. Now, fortunately we haven’t seen the one I’m going to mention first so far, knock on wood. We have not seen any type of really bad agent escape from one of our labs. In Georgia we have a host of different labs, but the ones that handle really bad agents are BSL 3 and BSL 4. Particularly BSL 4, where they work with really bad agents on a regular basis. So far, we’ve never seen any type of agent escape from one of those. But it could happen. Just because it hasn’t happened so far, is no reason that we should not address it. The other thing we want to do is recognize the fact that Georgia truly is an agricultural state. You know, I’ve heard it said that, just in terms of our poultry industry in the state of Georgia, if in fact we were a country, with our poultry industry, we would have probably somewhere between the fifth and the seventh largest in the world. So we have a huge poultry industry. But we also have many other aspects of agriculture too, but the poultry industry is one that we need to pay particular attention to. And I think many of you probably know that we had the Atlantic Fly Way, which goes right over the state of Georgia. Now, why would that matter? Those birds, those wild birds that are flying over Georgia, are going to be dropping things along the way. If in fact, those wild birds are harboring some type of bad agent, like an avian influenza agent – a virus – then birds in our poultry area, if in fact they are outside, (that’s not often the case, but it’s part of the time the case) those birds can contract that disease. And, in fact, if we get even a low pathogenic avian influenza in our poultry industry, that’s not really good news for Georgia. And if that particularly happens to be a highly potent infection and it mutates so that it becomes transmissible person to – I’m sorry – bird to person, then we’re really in trouble. And for years – actually since about 1997 – we have been particularly concerned about the possibility of a bird flu that could have a death rate much higher actually than what we see right now with COVID-19. So, the fact that we have this migratory bird pathway, the fact that we have this industry – this huge industry – of poultry, those are hazards that we need to pay particular attention to.

Then the other thing to recognize is that, you know, in terms of transportation, many years – in fact most years – the Atlanta airport is number one in the world in terms of the number of folks that go through there. We also have another airport that gets some international traffic in Savannah. So we have the possibility, just in air traffic, of things being introduced into our country that could conceivably be very dangerous to us. And it’s not just the air. We have sea ports too, in Brunswick and in Savannah. And we have these interstate highways that crisscross our state. And goodness knows what could be coming in through those highways. So, that’s really the area of hazard that I think we need to pay particular attention to as we think about why we needed to write this highly infectious disease plan.

Now as we did this, you know, you always have to make certain assumptions when you do planning. Sometimes those assumptions are right, sometimes they’re not as good as they should be, but I think these are pretty clear cut. Essentially we wanted full information about a highly infectious disease that may not be immediately available and may take time to unfold. We wanted that to be a message that got out to our stakeholders and to the public. Now we’ve seen situations before where – and I’m thinking about several years ago with Ebola – CDC put out information in the beginning that suggested that our personal protective equipment could just be basically what we normally have in hospitals. But then they changed their recommendations based on what Emory had to do when they actually treated an Ebola patient. So, in essence, we’re planning – we’re assuming – as we did this plan that things may change based on new information that comes along. And I realize that that’s hard for the public to understand, but certainly if we do a good job with our risk communication plan, it’ll be easier for the public to understand and most importantly, for our stakeholders, our partners, and even within public health to understand. So that assumption is that things may change.

The other assumption is that public health will lead a highly infectious disease response in Georgia until the incident has been elevated to the point of activating the State Operations Center and/or the designation of a different Incident Commander by the Governor. The Governor obviously can decide who he or she – if we have a female governor in the future – may want to have as the Incident Commander. I can tell you, in general, people that are not in the health arena really don’t want to be involved to the degree of really a lot of activity and participating to a strong degree when there is a bug or germ that they are not familiar with. I’ve talked to law enforcement folks in the past, and as soon as we talk about a highly infectious disease: “oh no, that’s your job doc”. So, I think in most instances, if we have a strong public health leader, that the Governor would want that person to be the leader in terms of responding.

That changes though when we have a host of other partners that are involved. And actually, with a major highly infectious disease outbreak that might become an epidemic, conceivably even a pandemic, the Governor has almost every single state agency involved. And when that happens, Public Health really needs a government leader, like the Governor, to be the Incident Commander or whoever is at his level that interacts with all those agencies on a regular basis because Public Health doesn’t interact. So at that point I think it will very often fall to the Governor. But I think the important assumption here is that until we get directions from the Governor to do otherwise – and that will happen at the opening of the SOC, potentially, the State Operations Center – until that happens, the assumption is that the Commissioner of Public Health, the leader of Public Health, would basically be the Incident Commander for whatever the situation might be.

A highly infectious disease incident – and this is another assumption – will require significant communication and information sharing, as well as robust data management and reporting systems. I cannot emphasize that enough. If you look back over all the situations that have been catastrophic and emergencies that became disasters in Georgia, the one area that we always had an opportunity for improvement was what? It was communications. So in this plan we wanted to make it very clear whose responsibility to share what information with whom was the piece. So our assumption here was that we better have a really strong focus on significant communication and information sharing, as well as robust data management and reporting systems. So essentially those are the pieces that I think are important assumptions.

Now, another thing that has been problematic over the years as we have seen disasters in Georgia – not necessarily public health disasters but all disasters – is that we have issues with roles and responsibilities. There will be situations where one person will assume that John Doe is responsible for it. John Doe will assume that Jane Doe is responsible for it, and it doesn’t get done. So knowing roles and responsibilities is really critical.

And in terms of the individuals that have probably the single greatest responsibility in a highly infectious disease – in terms of role and responsibility – it’s going to be the section of epidemiology. They basically deal with this on a regular basis for diseases that are not necessarily highly infectious. They are experts at this. They’re also often called what? Disease detectives. So they’re the perfect section for dealing with this. They support public health district epidemiologists from the state level. We have many epidemiologists at the state level and in every district we have at least one. So, the state epidemiologists support the epidemiologists in all of our public health districts. And they do this in conducting epidemiological investigations – remember disease detectives, they investigate. Exactly what Epi does. They do risk assessments. They do contact tracing and that is absolutely critical. Now most of the contact tracing is actually being done at the district level, wherever the disease outbreak is occurring. Whether it’s over here in this county or whether it’s down south near the border with Florida – wherever – the epidemiologists are going to be responsible for contact tracing. They’re also responsible for laboratory specimen collection and sometimes testing. But generally they don’t do the test, they arrange for the testing to be done usually at our state public health labs of which we have two. One in Waycross which covers the southern part of the state. We have one outside of Atlanta on Claremont. That’s the largest one – over 130 employees at that one – so that’s a big lab.

The epidemiologists are responsible for seeing that the necessary specimens are taken to one of those labs. And if that lab can’t do it, typically what happens is that the state level will forward it on to the CDC. There are some other government labs that may also be involved sometimes but in general it’s going to be going to the CDC if our state labs don’t have the ability to do that particular type of testing. Other duties as needed or are requested often go directly to Epi rather than going to any other section of public health because Epi has had such a strong history of being involved in disease investigations and response.

Epi also ensures rapid and safe medical transport and medical evaluation of suspected or confirmed HID cases through coordination with Georgia Infectious Disease Network, also often called the IDN – Infectious Disease Network. Which we actually set up back at the time that we were treating Ebola cases here in Georgia. I think it’s also important to emphasize that Epi generally doesn’t do the testing, as I’ve said before, but as I just mentioned, they ensure that that testing can be done rapidly. And that means working with organizations – and actually we have very few in Georgia – that have the capacity to transport highly infectious agents. And you can’t do this with just any service. It takes a service that has been specially trained because that type of transport is dangerous. So, it’s really important that we use those transport networks that are trained to do this. Now, unfortunately, they’re not always available at the time that we need them. They may be on other calls and because we have a limited supply of that type of transport network we often have to resort to what? The Georgia State Patrol. We have a wonderful relationship with GSP – Georgia State Patrol. And they will…we will package, the epis will usually do the packaging of the agent and Georgia State Patrol will carry it from the trunk of their vehicle and will rush it to one of the state labs, whichever one is closer whether it’s Waycross or whether it’s the one here in Atlanta.

The other thing that Epi does is they conduct exposure risk assessments. That’s really critical too because we have to know essentially who has been exposed, how high that risk is, and we have to identify potential contacts that can be, essentially, traced and determine what type of decontamination needs may occur as well. So providing and disseminating scientific expertise is part of the role as well. They provide guidance. Typically, all the other sections of Public Health very often turn to Epi for advice and guidance. But, so does the public. The information that goes out through our Communications Section very often stimulates questions coming from the public, and who does the public call for the information? They call Epi. Usually the medical epidemiologist on call.

The other thing that Epi does – and they do it so very well – they provide scientific expertise. Our epidemiologist – actually I will tell you that the state epidemiologist some years ago was a veterinarian. And we had a legislator who was very snarky and faulted public health because we had a veterinarian for our state epidemiologist. Well, I can tell you that that veterinarian was smarter in terms of epi than any MD that I know of, and did a fantastic job. She had a Master’s of Science as well as her Doctorate in Veterinarian Medicine. And she was superb. Fortunately, that legislator ultimately got pulled out of the Assembly. Which was good from our perspective because he really did not appreciate the value of our state epi.

So they do – the epidemiologists do – disseminate excellent scientific expertise information to stakeholders and through communications – through the communications section of DPH – Department of Public Health – to the public also. The other thing they do is they establish and maintain hospital designation for the IDN – Infectious Disease Network. Now what do we mean by that? Establish and maintain? Back at the time of Ebola was when we really fine-tuned a lot of our work related to highly infectious diseases. And we went around the state and identified hospitals that had the capability of treating highly infectious diseases. We identified five major hospitals geographically well spread throughout the state of Georgia. We also identified nine hospitals that would not, basically, have the ability for any long-term treatment – which highly infectious disease patients may require. We identified nine of those hospitals that could actually test individuals for a highly infectious disease and then make arrangements to transfer that patient to a higher level treatment center. Epi says it’s not good enough – what we did in 2014 – to just identify those because things change. You have to maintain proficiency. So, Epi on a regular basis – I think it’s every three years roughly – goes back to those hospitals to see if they still have their expertise at doing either the testing piece or the treating piece. And if so, they re-designate them. And we see that in all of our specialties centers, like even our trauma centers, we designated them starting back in 1981. But we have to re-designate every three years because abilities change, they lose personnel that might be key for doing certain things. So, re-designation is part of what Epi does and they do a very good job with it.

I think also that it’s important to recognize the value of an area that I really specialized in when I was working in Public Health and that was Emergency Preparedness and Response or EPR. Essentially, their role is to activate and staff the Department of Public Health’s EOC – Emergency Operations Center – in the event that activation is deemed necessary. Now that EOC – that Emergency Operations Center – has a low level of activation 24/7. Not necessarily with people there, but people on call who have situational awareness of what’s going on. And if something does happen they have the ability to upgrade the level of activation, bring people in to the different sections that may be necessary. So Emergency Preparedness and Response has a key role in doing that.

They also coordinate the overall planning and response efforts with state and district agencies as well as community partners. They have an important role with community partners, as does epidemiology. The EPR – or Emergency Preparedness folks – assist in fulfilling resource requests. And those resources requests typically come into the state operations center. And at the state operations center, Public Health has a separate room that they staff with different individuals, but most importantly, they staff it with Emergency Preparedness and Response folks. So if in fact there is a request coming from one part of the state that needs something that they’ve run out of – say some personal protective equipment that they no longer have available – and they’ve got sick people where they feel that their staff needs that. That request will go up to the state operations center and EPR – Emergency Preparedness and Response – will basically work to fulfill that request.

The other thing that is important, EPR – Emergency Preparedness and Response – basically is a unit of The Department of Public Health that primarily works with CDC. They’re all about public health preparedness and response, but that’s only, not even really, half of the battle that we’re dealing with when we face a highly infectious disease. What we also have to deal with is the actual treating community – all the hospitals and practitioners across the State of Georgia. That section of the Department of Public Health is called the Healthcare Preparedness Program, HPP. Originally that was funded under a grant that started back in, gosh, right after 9/11 through HRSA – Health Resources Services Administration. That changed and it’s now funded through ASPR – Assistant Secretary for Preparedness and Response. That section deals just with the hospital community initially, but they changed it to healthcare community. So they deal with EMS. They deal with long-term care. They deal with home health nurses. They deal with renal patients – renal failure. They have a host of activates that encompass the entire healthcare system. It’s not just hospitals, but certainly hospitals are right at the top and that’s what they have the greatest responsibility for. They coordinate with Georgia’s fourteen regional healthcare coalitions, and that’s important. I’m sure you’re probably aware of what a coalition is. It is basically in our so-called regional coordinating hospitals, 14 major hospitals around the State of Georgia, there is a coalition made up of public health, made up of physicians, made up sometimes of law enforcement, made up of mental health providers, made up sometimes of even the private sector. Georgia Power sits on one of the coalitions, for example. The coalition is responsible for planning and orchestrating what would happen if in fact we had some type of major catastrophe, disaster, emergency, or highly infectious disease – which would fall into one of those categories too.

So the folks in Healthcare Preparedness in that program they deal with, essentially, the 14 regional coalitions who have emergency plans, not just for that hospital where they sit, but for all the satellite hospitals that work with that regional hospital. So, the coalition has a very important role and the Healthcare Preparedness Program really does a wonderful job in working with them. Healthcare Preparedness also communicates with treatment centers to determine bed and staff availability. And in crises, what’s more important than knowing whether or not you have beds available. That’s really critical. And in many instances, for example, when we had the Ebola issues here in Georgia, we knew that one of our major hospitals that was treating Ebola patients, they had 11 rooms that were available to treat those patients. But it took about 30 staff members per patient, and they had 60 staff members, so what could they do? They could treat two patients. So 9 of those 11 rooms couldn’t be used because they didn’t have the staff. Well, this program – Healthcare Preparedness Program – has the responsibility to know that, so that if there was a call saying “where can we take this patient?” that person who is covering for Healthcare Preparedness can answer. So they maintain that awareness at all times.

Now another really critical section of the Department of Public Health that deals with many things, but certainly also with highly infectious diseases is Environmental Health. They are excellent scientists as well. They provide guidance, agency notification, legal support for community/facility decontamination. If in fact we have a situation where there is a contaminated area – say we have a patient and in medical terms we would often refer a patient who is wet (that is a patient who may be vomiting or having diarrhea) so that they contaminate an area potentially with germs. Potentially a highly infectious germ. So Environmental Health is really key in order to oversee what’s needed in terms of that decontamination piece.

The other area in Public Health – and many people don’t realize that this is in Public Health – but that’s EMS. Officially it is called the Office of EMS and Trauma. And obviously if we have a highly infectious disease and multi-patients are involved, they’re having to go to different places either to be tested or to be treated. Who’s going to take them? You don’t want to ask the family, perhaps increase their exposure, to take them by car. They’d be too sick to go by car anyway. So they call EMS. And we have a specially trained group of EMS providers that only do these transports for highly infectious diseases. We started that during Ebola. We basically have experts in all counties of Georgia. All of 159 counties we have covered with EMS services that were willing to train EMTs and paramedics as to how they can safely transport these patients. So that group is called the IDTN – Infectious Disease Transport Network. Now remember the other acronym IDN – Infectious Disease Network – that’s the hospitals. The IDTN the T is for transport. That’s the one that has just specialized EMS units to do those transports. And it’s The Office of EMS and Trauma that coordinates that.

They also, essentially, update guidance as necessary for EMS personnel. You know, as we said at the very beginning of this, things change as we learn more about a highly infectious disease. So what we may initially tell EMS is the appropriate PPE – personal protective equipment – may change as we learn more about the particular agent that is causing this disease. So we have to change our recommendations for EMS providers too. And it’s the Office of EMS and Trauma that does this for us. They also arrange transport through coordination with Epi - it’s actually the medical epidemiologists that they work most closely with – and with hospitals who are part of the IDN. They actually also further information on the IDN and IDTN in numerous ways, but for anyone who is really interested in our plan we have really expanded on what we have said here in Appendix G – which is an additional section that talks more specifically about the IDN and the IDTN. So for those that want more specific information of how that was formed, how that works, who activates it, and so forth, it’s Appendix G that will tell that.

Now another role – and I’m sorry we didn’t mention them earlier because this is really an extraordinarily important role. And I would say next to Epidemiology, if I had to choose the section of Public Health that is next in importance for highly infectious diseases, it’s going to be the Laboratory. That’s the area that’s going to make the diagnosis for us, in most instances. Now in some situations you can make a clinical diagnosis, but with highly infectious diseases, even when you can make it clinically, you generally have to confirm it with laboratory findings. So the Georgia Public Health Lab, the one on Claremont is the big one – that’s the 130 employees as I said. The one in Waycross, it’s a lovely facility, much newer than the one on Claremont here in the Atlanta area, but they only have 12 employees. So, although they can do most of the same tests that the one on Claremont here in Atlanta can do, they can’t do as many of the tests because they don’t have the added staff. But that laboratory system, whether it’s in Atlanta or whether it’s in Waycross, is extraordinarily important in performing testing on specimens. And I talked to you earlier about how those specimens get there. Generally it’s worked through the medical epidemiologist, and in rare instances that specimen will be taken not by one of our identified services that can actually move so called Class A Agents (those are agents that are extraordinarily dangerous) and we have those specialized services that have been approved to carry those serious types of organisms – specimens that have those organisms, potentially. But also remember that if in fact you can’t get one of those individuals – one of those services – who do we turn to? The Georgia State Patrol. And I cannot say how much we value that relationship that we have between Public Health and Public Safety – Georgia State Patrol. They have done such fabulous work for us through the years. It’s like they’re just apart of us in a sense – part of us in Public Health.

Another role that the Lab has that is really important because state labs will be able to do a host of things that hospital labs can’t do. But there are things that can’t be tested in our state lab that can be tested at CDC. Or in some instances, not even at CDC. Perhaps military testing in USAMRIID may have to occur. But it is our Public Health Labs that actually do that collaboration with the CDC and refer specimens to CDC for further testing or for referral even up the chain from there.

Another thing that the state lab does is they provide or disseminate scientific expertise. They are you know of all the parts of Public Health, I think that the area with the strongest expertise in science is our Laboratorians. Second, I think, Epidemiology. Third, I think, Environmental Health. Now we’ve got a host of other sections but those three are the areas where we see the highest amount of scientific expertise. So providing and disseminating scientific expertise is one of the roles that the Georgia Public Health Labs certainly do. They provide guidance and they also provide resources to some of the stakeholders. Very often in terms of what is needed to collect a specimen that somebody may want to send to the lab, but they don’t have that type of material that’s needed for that specimen to be put upon to be transported. So the state lab will arrange that they get that. So that’s important.

Now, another area that you can never overlook – and it’s really an important area, and I hate to that it’s this late in the discussion – that’s the Office of Nursing. Now at the state, we have maybe about 5 RNs all with advanced degrees and really, really sharp. In fact, the leader of that group is actually, she has her doctorate degree in nursing, and she is a nurse practitioner as well. They are bright people, and they work with each of our public health district nurses because that’s where the patients are, out in the districts. And those district nurses, for the most part, don’t have the high-level of training that the state nurses have. There are some exceptions. There is a nurse in Savannah, for example, who also has her doctorate, but in general, in many of the districts, the public health nurses need a higher level of expertise to advise them and provide guidance for them. And that’s what the State Office of Nursing does.

They maintain a bidirectional – that’s important – line of communication between the State Health Nursing Office and the districts, the public health nurses in the districts. Interestingly, it’s kind of a strange situation in a way, it’s not that the nurse in the district reports to anybody at the state level directly. Who do they report to? They report to the District Health Director – the physician over that district. And that district may encompass as few as six counties or it may have as many as 16 counties. We have two districts that have that larger number. So you can imagine in one of those big areas, you got to have quite a few district nurses. And they very often are calling the state for information, for expertise, for guidance on a regular basis, and The Office of Nursing provides that. But, it’s actually up to the District Health Director to be their supervisor. Now the District Health Directors report to The Commissioner of Public Health, and they are also state employees. So, the Office of Nursing which comes also under the Commissioner – really although they don’t directly tell the District Nurses what to do – they have strong influence because their doctor is taking orders from the State Commissioner.

So another area that, again, is showing up late in our discussion, but it’s an area that I think is so critically important, and that’s Communications. If you look back at disasters that have struck Georgia over time, as we do after action reports and review what happened in the response to that particular disaster, every single event where there is an after action report you will see there are opportunities for improvement in what? Communications. It is the single most difficult part of response. So there are key roles and responsibilities at the state level with our Section of Communications. They coordinate with partner agencies, stakeholders, also with the media outside to determine talking points and assess the need for a Joint Information Center – JIC – often referred to as the JIC. Because we have multiple agencies that are going to be responding. Not just Public Health. Remember if this escalates all the way to opening the State Operations Center, certainly GEMA – Georgia Emergency Management Agency and Homeland Security – are going to have a key responsibility here. So, coordinating information so that one agency is not putting out this information which is 180 degrees different from this agency. There has to be that coordination. And if we have that multi-agency approach, very often there’s a recommendation that we form a Joint Information Center so that there is coordination and consistency in the messaging that is going out. One of the very worst things that can happen in a disaster is for the public to get conflicting information as to what is happening and what should be done. So in the formation of the Joint Information Center – which once again, Communications makes a recommendation for that – that’s important.

They also work with the media, and again it’s through the media that much of our information gets out to the public, obviously. They update the Department of Public Health’s electronic media properties. DPH – Department of Public Health – does have certain electronic properties that are also available to get information out. So the Communications Section is basically involved in putting the most frequent information into that network as they possibly can. And they also create news releases which very often it’s more frequent that we see news releases than we see actual commissioners getting up and standing and giving a press conference. The people are so busy during crises like this that top-level officials don’t really have a lot of time to do press conferences, so the Communications Section will prepare news releases in lieu of that. Now periodically, the Governor may want to do one with the Commissioner of Public Health, and that happens not infrequently. We certainly have seen it with COVID.

The other thing that they do is communicate and coordinate with the healthcare coalitions. Once again, remember every part of the state is covered with a regional coordinating hospital – there are 14 of them – and every one of them has a coalition that is made up of multiple different areas of expertise. So, very often at the coalition level questions are coming to the coalition of “what are we dealing with?”, “can we tell the public in our community what’s going on?” What is important is that Communications provide that information to all the coalitions so that any information that’s going out – whether it’s going out from the coalition or from the regional coordinating hospital – that it’s consistent with the information that has been gathered at the state level. So tremendous importance with the Communications Section and what they can get out there, not just to the public but to key stakeholders. The business community very often has a key role to play here too.

So how about in the district – you know I talked a little bit about state Epidemiology and how critical they are – but every one of our health districts actually has a district epidemiologist or more. And those are the epis that are doing the footwork on the ground. They’re out there with the patients. They coordinate with internal and external partners regarding overall response activities. They may get a lot of requests coming to them from elected officials, from commissioners, wanting to know how many cases of this have you seen and what are the recommendations that you’re telling the families of these people? That all basically goes to the district epi. And in most circumstances the district epis have already gotten their talking points from the state epidemiologist. Sometime routed through Communications, sometimes direct communication between state Epi and district epi.

The district epidemiologists also conduct exposure risk assessments to identify patient contacts – that’s really important – if any, that may need to be monitored and to determine if there is a need for community, environmental, or facility decontamination. Remember what I said about so-called “wet patients”? If we have patients that are having any type of fluid that is coming off of their body, possible vomiting, it could even be sweat, it could be diarrhea. That may contaminate an area that has to be cleaned up. The district epi will coordinate that.

They also begin notification of multiple levels – federal, state, and local – stakeholders in the event of a suspected or confirmed highly infectious disease case. A lot of times, even before the confirmation’s been made, there will be questions coming to the district epidemiologist because somebody in the community has heard that something bad has happened, and it’s the district epi that basically responds to that. Sometimes they don’t do it directly. Sometimes they do it through the PIO – the individual that, at the district level, is responsible for communications. Sometimes it goes through them, but very often it goes directly from the district epi.

They manage also highly infectious disease case investigations. Once again, as I said, one of the commonest ways of defining epidemiologists is that they are what? Disease detectives. They investigate like detectives do. So that investigation is not only being held at the state level, but its occurring where the patients are at the district level. They coordinate laboratory information, specimen collection, and transport and then subsequently what comes of that. They coordinate all that information as well. So, terribly important role. Once again, key in highly infectious disease. Epidemiology, whether it’s at the top state level or whether it’s boots-on-the-ground level at the district – terribly important.

All of our districts in Public Health in Georgia have a district environmentalist. Those individuals are, just like at the state, they are responsible for decontamination. And in fact, really more responsibility in some ways, than the state. The state will give recommendations as to how to do it, perhaps depending upon the nature of the organism, but it’s actually the environmentalist who are out there in the field with the individuals - perhaps at a facility, at the community level, wherever it might be – that are actually going to be instructing people or participating directly in the decontamination procedure.

They also will provide surge support for highly infectious disease testing, as needed. Now what do we mean by surge support? Well, if we have a really bad situation, we may run out of our normal staff to handle things, we may run out of hospital beds, we may run out of any number of things. And we get into a surge situation where hospitals, healthcare communities have to surge to provide care. It’s sometimes not as comfortable as the care is ordinarily when you have everything that you need because you’re having to do without. So surge care is really important, and very often environmentalists may involve himself or herself in helping in a hospital where they are having a real hard, they don’t have anybody in their environmental section of the hospital who can do the decontamination. So they will step in and actually do it for them. That’s important.

The district emergency preparedness person is also important. Now, this person – once again – is on the CDC side of preparedness. We have two sides, we have healthcare community preparedness. We have, basically, public health preparedness. The EPR person in the district is on the CDC side. This person activates and staffs the District Operations Center – Emergency Operations Center – in the event that activation is deemed necessary. Now for some lower level things there may not be a need to activate the Emergency Operations Center – EOC, but if we’re talking about a really bad germ, it’s going to be activated. And it will be the EPR, the emergency preparedness coordinator, who actually does that.

They coordinate the overall planning and response activities as well, with state and district agencies and with community partners. And that community partner piece is really important because at the state level the partnerships that are developed are at a very high-level. They’re not down here where boots meet the ground. But in the districts, it’s down here *(gestures to ground)*. So those partnerships are really key and it’s the district emergency preparedness coordinator who is responsible for creating those partnerships and keeping those partnerships open. You’ve heard the expression “you don’t want to be exchanging business cards at the time of a disaster”. You want to – basically those preparedness activities – to already have been addressed with partners who know each other. So, that’s really important and it’s the District EPR – emergency preparedness person on the Public Health side – that does that.

They also assist in fulfilling resource requests. Remember we talked a little bit about that in terms of what happens at the state level – in the state SOC. It is the emergency preparedness director at the state level, who is in the state operations center, getting those requests that are usually coming up from the district saying “my hospital, Hospital X, we’ve run out of blood type A, B, run out of blood type O. We’ve run out of blood type whatever. We need that”. That comes up from the district, and it very often is through the emergency preparedness coordinator that funnels up to the emergency preparedness director at the state operations center. So, that chain of connectivity is really important, and it basically is important too in maintaining situational awareness overall of response activities. And what we ask is that that person at the district be thinking ahead of time. Not just at the moment that, all of a sudden, the hospital’s out of O type blood – O negative blood – for example. We want to know early on that they are running short, so that we can begin at the state level to find out where we can get certain types of blood that we can send down to the district when the need becomes obvious. So, it’s important that the district folks not do a last-minute announcement of “we’ve got to have this”. They try to maintain situational awareness so that they know ahead of time what the needs are going to be, and the state can already be working on it so that when the need becomes obvious – boom – it can go right away. And with that we need to switch to my colleague, Kelly Nadeau.

**Kelly Nadeau:** Alright, our next section is to talk about the Concept of Operations for the plan. So management of a highly infectious disease incident is categorized into three separate phases. There’s the pre-incident phase. There’s the response phase, and then there’s the recovery phase. And we’re going to talk about each of them in a little bit more detail. Overlap may occur between the phases of the incident. In other words, it doesn’t start with this section, and immediately go to this section, and go to the next section nice and neatly. It’s more of a continuum of how we move through the phases of the response. And the decision-making authority for escalating two different phases of the response, activation, or de-escalation rest with the state health officer or their designee.

So, with the graduating intensity of the response, I want you to sort of look at the colors here for green, yellow, orange, and red to kind of give you an idea of intensity of the response. So let’s first talk about green. Green is our level one pre-incident or preparedness phase. This is where we live every day. Emergency managers, preparedness managers, coordinators – this is what we do all the time. We’re always thinking ahead. We’re working on planning. We’re working on preparedness activities. This is where we are with pre-incident.

The next three color phases – yellow, orange, and red – all have to do with phases of the response. And so we’re going to talk now about those particular phases. So, again, pre-incident is just talking about the day-to-day regular activities. These are our normal preparedness activities. We’re always being on the lookout for something that might popup that’s unexpected that might trigger a response. In level two – which is an outbreak – the actions in this response phase – first response phase – are focused on identifying and treating individual cases and mitigating the risk of a larger outbreak. So we’re trying to focus on the few first individual cases, making sure we have a handle on those, and seeing what those symptoms are, and being very interested in those particular first patients. Level three moving onto an epidemic. This phase is when there are many more patients that actually have the disease. Our focus here is trying to limit the spread of the highly infectious disease, and mitigate further disease. So, we’re trying to contain it as much as possible. And then level 4 is actually a pandemic, and so we’ve all now had experience with living in a pandemic, haven’t we? So here we are and we know then that the disease is widespread across every state, every country, and so our efforts then are to implement broad mitigation efforts and coordinate with our federal partners. So be thinking about things like vaccine and therapeutic administration. Things like that that are across the whole country really to try to mitigate this pandemic. The plan also has potential triggers identified throughout that talk about which phases should be activated and what might trigger response and recovery then of the plan itself.

Moving on, Communications, Data Management, and Transitional Planning. Now emergency managers, you know, that the number one focus on every response is – you can say it with me – communications, right. It’s the most important thing. It’s what we do all the time, every day. Make sure that the right message gets to the right population in a timely manner, and certainly we operate with that communications plan in DPH every day, but we’re going to make sure that we’re doubly focused on great communications with any kind of a highly infectious disease. Different communication and information sharing procedures might be developed during a highly infectious disease that might be different than day-to-day activities. And our risk communicators and public information officers will certainly coordinate and communicate with all of our stakeholders. Not only our employees but the general public, our media, all of our stakeholders – local, state, federal – with everyone. So there’s lots of communication efforts throughout.

Alright so Data Management and Reporting. We certainly know in this response with COVID that data has been the number one focus for everyone, right? Everyone wants to know “what are the case counts?” and “how many patients are in the hospital” and so many things that everyone wants to know all the time. So it really puts a focus on how important data is. What do we capture? Is it the right data? Are we putting it together in the right way? Analyzing it, interpreting it, and then communicating that data – incredibly important – to all of our partners so that we have some awareness of the situation and know where we are in the response for this particular pandemic.

It’s the responsibility of each of the DPH Programs to manage their own data. So different Programs are going to be looking at different things. For example, the Epidemiology Program is going to be looking at different data than the Vaccine Program than our environmental health partners or our healthcare partners – different pieces of data but they’re all equally important and they all need to work together to provide a great situational awareness for where we are with this particular response.

And then DPH also works with external stakeholders, not only with our various state partners, but our federal partners. And many of our federal partners have reporting requirements, for example, our hospitals and our long term care facilities have had to report a variety of metrics to them on a regular basis, and those reporting requirements do change over time as the incident progresses.

Transitional Planning. There will at some point be a time that we are finished with COVID – I know it seems like forever – but it’s going to happen. So the thing is, we need to be starting to think about “how do we get out of this?”, “What is that transitional planning?”, “what does that demobilization look like and when do we need to start thinking about that”? Well, we’ve already started thinking about that while we were in response. So, as we respond, we start thinking about now how does that deescalate and how do we get things back to that level one, pre-incident preparedness level of our day-to-day operations – we’re longing for that, right. But it’s going to take a while. Recovery should be planned during the response phase and that response phase then becomes more predominant as the incident is declared controlled or more under control. So the scale is going to depend. Remember I talked about different phases of the response are not cut and dry, one ends the other begins, one ends the other begins, but it’s a continuum of that response. Same thing is true for the response planning. Transitional and demobilization planning won’t be complete until the evaluation has occurred, after action reports are completed, and those improvement plans have been completed.

And now, we’ll turn it back to Dr. O’Neal to talk about Mitigation and Infection Control Practices.

**Dr. Patrick O’Neal:** Okay, we’ve already talked a lot about the Georgia Highly Infectious Disease Plan, but now I think it’s really important to talk about what are we going to do if we have that infectious agent that is a really bad one. What are we going to do about it? Mitigation and Infection Control Practices are an extraordinarily important part of our plan. There are pharmaceutical interventions and there are non-pharmaceutical interventions. Let’s talk first about pharmaceutical interventions.

These are for highly infectious diseases that involve using medications to either cure, prevent, or mitigate – if we have them. Now in some instances we don’t have a drug or a vaccine and we don’t have this opportunity, but if we do have drugs or vaccines that can have some impact on at least mitigating the impact of this highly infectious disease, we want to use it.

The other thing DPH may want to coordinate the receipt, staging, storage, and distribution of pharmaceutical resources needed during a highly infectious disease event. Now, you’ve probably heard those words before – receipt, staging, storage particularly – where? From the Strategic National Stockpile. We have – in the United States – we have a really amazing system that was thought out by CDC where they have some seven tractor trailer loads of drugs, vaccines, medical supplies like ventilators, any number of things. Seven tractor trailer loads. And if you are in one of the contiguous states of the US, you can expect delivery of those seven tractor trailer loads within twelve hours. So if in fact we need to get certain drugs, but we also need ventilators, we will ask the Strategic National Stockpile to ship them to us. And that’s where the terminology staging, storing, and so forth comes in is with SNS – Strategic National Stockpile. And we, in Georgia, have an ability to distribute those throughout the entire state within a matter of hours, which is important. If we’re dealing with some types of organism where you only have like 48 hours to get prophylactic antibiotics in a patient. For example, anthrax. Then you need to get that drug out there to the entire state in a hurry. And that’s what happens with part of our pharmaceutical activities, and that’s coordinated by the state pharmacist.

Now in many instances, however, there are highly infectious diseases that we won’t even know what the disease is at the beginning. So we don’t know what the necessary drugs may be and if we’re going to have them or not. And we may find out that there’s no drug available for whatever this particular agent is. So we also have to look at non-pharmaceutical interventions, and this is really important. You’ve heard a lot about this during the COVID pandemic, particularly early on before we had vaccines, before we had any antivirals that we knew would be effective. We really depended upon non-pharmaceutical interventions. And these are basic principles of Public Health.

Isolation and quarantine, and people confuse that a lot. If in fact the patient is already sick with whatever this highly infectious disease is, what do we put them into? Isolation. If their family members have been exposed to them and this is a contagious disease, those family members don’t go into isolation, they go into quarantine. So the sick are in isolation, the well but exposed individuals are in quarantine, that’s the difference. The Department of Public Health and the Georgia County Boards of Health both have concurrent authority – and this is kind of confusing. It’s not this way in all states, but this is true for Georgia. They have concurrent authority to require the isolation of persons – isolation underscore, that’s for the sick people – showing symptoms of highly infectious diseases or conditions likely to endanger the health of others. For example, tuberculosis. Not one of our really rare types of disease but very prevalent. And both the Boards of Health at the county level as well as the Department of Public Health (i.e. the Commissioner of Public Health) and she may delegate that authority to each of the district health directors, and she has in many instances in the past. So, Department of Public Health Commissioner has that responsibility, that authority, as does – or as do – the Boards of Health. And remember, every county in Georgia has a Board of Health, so that’s important.

Department of Public Health only, not the Boards of Health, is granted the authority to order the quarantine of persons exposed to, or suspected of being exposed to – or infected – with, a highly infectious disease. And that’s a difference in the law. Kind of strange, I’m not sure why the law was written like that, but it’s only the Commissioner of Public Health who has that authority with the exposed persons.

Community-based activities and venue interventions are also a part of this whole non-pharmaceutical intervention process. Essentially, the Department of Public Health will provide guidance as recommended usually by CDC but it can be coming from other authorities as well – issued by an appropriate authority, whatever that might be – it could be NIH for example – concerning community-based activities and venue interventions like closing down sporting events or closing movie theaters. Anything that is thought to be a site where the disease would spread more readily. There is authority at DPH – at the Department of Public Health Commissioner’s level – to provide guidance. Usually that guidance is recommended by CDC, and the Commissioner passes it on.

The other thing that is really important is personal protective equipment. And I don’t know if you recall the issues we had at the beginning of Ebola, where CDC came out with recommendations initially that just standard gloves and mask and gowns were sufficient for dealing with Ebola patients. And as we learned a lot more about the way that particular virus was spread, the PPE – the personal protective equipment – was changed. So, those recommendations are extremely important and they’re difficult when they change as knowledge changes. So it’s really important on the part of Public Health to prepare the community for the fact that there may be changes in these recommendations as more knowledge is gained about the particular agent causing this highly infectious disease. So, essentially, DPH – Department of Public Health – will be working with certainly all of our state partners, but most importantly with our federal partners particularly the CDC. And we’re really fortunate here in Georgia because that’s where the bulk of CDC is located, so we have a really tight relationship there.

The Department of Public Health will collate and disseminate a list of recommended personal protective equipment for persons within the State of Georgia. And that’s the important part of the non-pharmaceutical interventions that really is key and that may change depending on what we hear from CDC or other authorities. Also, known information about a highly infectious disease or personal protective equipment may change – as I mentioned – and necessitate amending recommendations. And, when that happened before with Ebola, it created a lot of issues even in the physician community because they saw this changing recommendation. So there were some people who said “well, CDC doesn’t know what it’s doing. You know they said this one time and then they say this the next time”. And that caused a real problem because CDC has amazing expertise, and the reason for the change was obvious. But it’s inherent I think in humanity that we don’t like to see changing recommendations coming from experts. We think that if they know what they’re doing, that aught to be the same every time that they talk about it. But the reality is that, as we learn more about a highly infectious agent, we very often have to make changes. So it’s important that, again, our communications folk work to educate not only the public at large, but also the medical community, the hospital community, the nursing community, that there may be changes afoot.

The other thing that’s really important with non-pharmaceutical interventions is disinfection techniques. And the Department of Public Health will basically distribute disinfection guidance based on recommendations usually from the CDC, but often it comes from other federal agencies like EPA sometimes. So, that guidance is put throughout the State of Georgia so that, at the local level, there’s ability to deal with whatever is needed to disinfect a given area. Really a key part of our non-pharmaceutical interventions. So, once again, remember we have isolation/quarantine that is keeping sick people isolated so that they’re not in contact, keeping possibly individuals who may be exposed in a separate area – again, separate from the population at large – until we know that they’re not going to get sick. Those are key. Then also we have other methods that I’m sure that everybody who has dealt with COVID has heard about our masking issues and all of the different recommendations that have come down about that.

The other thing that we have as a strategy, basically, that’s not pharmaceutical, and I think there’s a lot of question about the value of this nowadays quite frankly, but it’s travel restrictions. And if you notice, again I go back to the Ebola time, what did we do with travel restrictions back then? We said that any individual who was flying out of West Africa into The United States could only fly into one of five airports, one of which was Hartsfield-Jackson in Atlanta. Because those five airports had the ability to test people when they got off the plane to see if they had a fever or any signs of illness and then also had referral patterns worked out so if they were sick they could go into isolation. If they’d been exposed because they were within a few seats of that person on the plane, they could go into quarantine. So that travel restriction seemed to make a lot of sense. And you know that people might go from West Africa to Paris before they came to the US, but the people at passport control could tell exactly where they initiated their trip from. So it might be a flight from Paris that we were getting John Doe who was actually originally from West Africa, and that John Doe had to come through one of the five airports. So those types of travel restrictions, I think, make pretty good sense.

The travel restrictions that we have not seen – at least from the standpoint of concrete evidence that really helped us that much – and we saw this a lot with COVID with countries that just stopped allowing people from wherever – like for example when we had the new variant of COVID that was frightening a lot of people because of the increased transmissibility – they stopped people from coming out of where? South Africa because that’s where that variant was initially found. The Omicron variant. The problem is that there is so much international travel now, and I will quote the state epidemiologist in Georgia who says that a major highly infectious disease is at the most twelve hours away by flight. So, I think that’s really key to understand. If in fact we have such transport through the world, diseases that when I was trained as a physician a long time ago, I never thought we’d see in the United States. We see them now because of international travel being as prevalent as it is. So those travel restrictions can, under certain circumstances, be helpful as a non-pharmaceutical intervention. But in some instances, it’s like closing the barn door after the horse is out. So, just take that as you may.

Contact tracing is also part of the non-pharmaceutical intervention piece. And this is Epi’s role predominately that is so important. If in fact – and we have seen this going way, way back to how we really worked on eliminating small pox for example – being able to trace in a fashion, all the people that were around the infected person and pulling them out from the population until we knew that they were not going to get infected too. Tracing all those contacts and being sure that we separated them was really, really important.

So how about Resource Management, Laboratory Testing, and Medical Surge. Really another important area, and I think it’s important also to look at the diagram that we have – or the graph that we have – on this that’s color coded. Essentially, the severity level one, it’s a green. Everything is just like normal in Public Health. We’re functioning the way we do every day. Nothing special is going on. But when we get to level two, which is a yellow, there has been an outbreak of something. Now, it’s just right now it’s an outbreak. If in fact it starts involving multiple individuals, it moves from being an outbreak to being an epidemic. And that is the orange level of this particular diagram. It’s level three, and that means that there are multiple individuals that are involved. If it goes beyond that, and it’s not just multiple individuals here but in geographical areas, like on two different continents, the World Health Organization will then proclaim a pandemic. And we certainly have seen that with what happened with COVID. Initially, just certain areas were involved and then wide spread everywhere.

Laboratory Testing, as I mentioned, is extraordinarily important and our lab people don’t get all the credit they deserve for the really great work that they do. They are basically able, at the Georgia lab, to diagnose a lot of things that you can’t do in a hospital lab. And we have a special program in Georgia called the Biowatch program where there are secret air collectors around major cities that really, essentially, force air through those collectors. Those collectors are analyzed daily at the Georgia Public Health Lab. And if one of the so-called Class A organisms – like plague, like small pox, like a viral hemorrhagic fever, like tularemia – rabbit fever. There are six of those agents that fall into that category. If that’s diagnosed, that’s going to be a major highly infectious event. And it could be natural or it could be bioterrorism. So, Laboratory has an important role here in Georgia in terms of what they do with highly infectious disease. And it doesn’t necessarily have to be a novel agent. We are seeing a return of germs that we thought we had eliminated. I’m thinking particularly right now we were pretty sure we have eliminated small pox, but we know that there is small pox growing in laboratories in two parts of the world: US has it, Russia has it. And we suspect that Russia has shared it with other nations as well. So we think it’s somewhere out there. So, those are issues that are really important from the stand point of risk to communities.

Frontline facilities. What are frontline facilities, any idea? It could be the doctor’s office. It could be the nurse at CVS or Walgreens, and the nurse’s clinic. It could be the school clinic, the university clinic. Any of those could be frontline facilities. We don’t expect the frontline facilities in general to be able to do more than what we call the Three I’s. We want them to Identify that there is possibly a highly infectious disease. We want them to Isolate the individual who comes into their facility that they think they have that highly infectious disease. We tell them that if they can find a bathroom that nobody else is using, that that individual can have access to, and that that patient or individual can be kept right close to that bathroom, but away from anybody else. That’s what we want them to do, to isolate that patient until that patient can be transferred to a center that can do testing which is generally the next level of center that we will talk about in a second.

And then we want them to Inform. Inform who? We want them to inform the medical epidemiologist. We have 24/7 on call medical epidemiologists in Georgia that coordinate the beginning of response to a highly infectious disease. So that’s what we ask all of the frontline facilities to be able to do. Identify a possible, not a confirmed diagnosis, just identify a possible. Then what do they do next? They isolate that person that they’ve identified that possible case. And then what do they do? They inform or they call the medical epidemiologist so that we can jet up and begin whatever may be necessary if it turns out, after testing, that this is a highly infectious disease.

Now, the frontline staff or the frontline facilities – I shouldn’t say staff – the facilities, are not expected to do any testing on a possible viral hemorrhagic fever like Ebola because that testing is so involved, no frontline facility would have the capability to do that. There are certain hospitals that do have that capability, and essentially, in the infectious disease network, the level two – not the treatment hospitals, but the assessment hospitals of which we original had 9, those numbers change from time to time. Those hospitals are the ones that receive from the frontline facilities those possible cases and they do the testing if in fact there is suspicion of a viral hemorrhagic fever. No if it’s not a viral hemorrhagic fever suspicion, many of those frontline facilities will have the ability to do certain lab testing, and they can do it. But we ask them not to do it if there’s any suspicion of a viral hemorrhagic fever because the risk of contamination within their laboratory is so great, that it’s not worth them taking the risk. And they typically don’t have preparations that provide the degree of safety necessary to do that.

Laboratory testing for a novel pathogen will likely involve newly developed tests by CDC and very often our state lab will not have those, but because we basically are so close to CDC, we can get that specimen to CDC very quickly and CDC will run that test. And if it’s something the CDC can’t do, then they get it up to someplace like USAMRIID military lab to do the testing. The availability of testing reagents also may be variable across the state. And very often, particularly we saw this with COVID, we run out of testing reagents when we have a large number of individuals that are patients. So, that availability basically can be a real problem and the lab has a responsibility to be aware of what their capacity and their capability is in terms of being able to have those reagents and if in fact that don’t then just like the districts are calling up to EPR – Emergency Preparedness – at the State Operations Center, the lab has a lab network that they can call other laboratories to see if they can get specimen or reagents as well. Additional laboratory testing may only be available through the state public health lab – usually is – and sometimes it’s only available through CDC. But typically, that may be just in the beginning, and after a period of time, testing and reagents are made available to other labs throughout the state so that the Public Health Lab is not getting inundated with all the testing that has to be done.

Now, we mentioned the word earlier on: Medical Surge. Basically, this is where the number of patients is great enough to exceed basically what a hospital has in the way of supplies and in the way of staff to take care of them. And we go into what is referred to as a crisis care environment, and that’s a really difficult situation because a lot of people think that that is equivalent to rationing your supplies, rationing your care to patients. Determining who gets something and who doesn’t. Maybe you only have two ventilators at a given hospital. All of a sudden, you’ve got four patients that need to be on a vent. What do you do? How do you, in an ethical way, distribute those two vents to which of those two patients of the four? We have a special plan in Georgia that we’ve crafted which addresses that, and gives some recommendations as to how to do that from a medical ethical perspective.

So the other thing with medical surge is that it can be localized just to one area – it doesn’t have to be the whole state. It could be just that one hospital. And sometimes that hospital can reach out for the network of other hospitals within Georgia to get more vents. So that’s possible, and then they don’t have to go into this crisis standard type of situation. The Department of Public Health and other state agencies should maintain situational awareness about capacity and capability of the healthcare community throughout Georgia. That’s important. You don’t want to get the call at the last minute that Hospital X has four patients needing vents and that hospital only has two. It’s up to Public Health to be in contact through the so-called HPP – the Healthcare Preparedness Person – of what’s out there already and where the needs may occur. They want that total situational awareness all the time. Not just at the moment that the need becomes absolutely necessary.

In order to properly mitigate and or respond to medical surge incidents, the Department of Public Health may implement various functions and programs such as going into the crisis care plan. And there is obviously awareness across the medical community that there are times when that may become necessary. It’s not a pleasant situation, I have not heard of it happening in Georgia lately, but you may recall that early on in the COVID situation there was a situation in California where they had to go into crisis care, crisis standards.

Now with this plan, we wanted to try to keep the plan as brief as we possibly could. It turned out being a lot more voluminous than we really wanted it to be, but we tried to keep it brief and we thought that, rather than going down into the weeds with so many subjects of the plan, that we would create appendices for the plan. And we would go into the weeds with those appendices. Some here that we are going to talk about today. Appendix A is just for acronyms and abbreviations. Public Health, like so many other areas of expertise, are really bad about abbreviating things, and that’s problematic because sometimes an abbreviation in Public Health will be the same abbreviation somebody in another expertise uses, has an entirely different meaning. So we have this Appendix A which identifies all the major acronyms that we use in healthcare here in Georgia, and the abbreviations as well.

Appendix B identifies the authorities that may be involved at different levels. It identifies the federal level that we communicate with on a regular basis. It identifies state regulations that basically control what people can do, and that are pertinent to the highly infectious disease plan. Remember that, again, if we have a highly infectious agent and we have hospitals that run out of the ability to take care of those folks, they’re going to move into the crisis care type of environment, and that may mean that some of those regulations that pertain to hospitals, like having to do an evaluation of any patient that shows up on their doorstep as part of EMTALA – that regulation. We need to be aware of what those requirements are, so that the state can in many instances, through the Department of Community Health, relax those standards so that we do the most good for the most number of people. But it does involve relaxing certain federal standards and state standards.

Appendix C is about notifiable diseases. And these are over 70 different types of diseases in Georgia that we’ve identified, where public health needs to know if there’s a single case in the state. There are some that require notification within 24 hours, there are others that the lab or the doctor or the nurse has up to seven days to make the notification. So in Appendix C, we have a list of all of those notifiable diseases and whether or not they are the 24 hour rule or the 7 day rule.

Appendix D is surveillance data management. And that’s really a difficult one. Newly developed graphics concerning what surveillance data is and how it is being collected and disseminated is part of that appendix. Again, any time that you’re talking about healthcare information and aggregating it, there’s always the issue of what has to be kept private, what can be shared. Public Health has certain abilities to release data that private person may not have under certain circumstances. So that is addressed in that Appendix D.

Appendix E is the next appendix that we are going to talk about, and basically this is related to disinfection techniques. And that’s critically important because what may kill one type of germ doesn’t necessarily kill another. So, we have an appendix which describes the different types of agents that can be used to disinfect depending on the nature of the organism that they are trying to disinfect. So that’s very helpful to the providers of the community.

Appendix F is Department of Public Health guidance on management and contact tracing for a confirmed case of a highly infectious disease. And remember, this is one of the key roles of public health epidemiology, is that contact tracing. We have seen that work historically for years. If, in fact, we can identify those contacts, separate them from the public, we can diminish spread of the disease to the public, if in fact the disease is transmissible from person to person. So, that’s terribly important and is really a role primarily of Epi – Epidemiology. Also, in this Appendix F there is, essentially, the ability to use it for contacts that have been identified in Georgia regardless of the pathogens present and whether the case-patient is alive or deceased. And that’s an important piece too because, in some instances, this will actually not be diagnosed or suspected by a practitioner – a physician, a nurse, whatever. It may be diagnosed or suspected after an autopsy on a deceased person. So, this is important and this is addresses also in Appendix F.

Appendix G: Infectious Disease Network. We’ve mentioned this already, IDN – Infectious Disease Network – that’s the network of hospitals. The treatment hospitals, the testing hospitals, and then everybody else in healthcare is called what? Frontline. So there is further explanation of the IDN – the Infectious Disease Network – and the IDTN – the Infectious Disease Transport Network – which is that specialized group of EMS trucks and personnel that had been trained to deal with highly infectious diseases.

So, at this point, I would like to thank all of you for listening to what we put together – or sort of an overview of what we put together in the Highly Infectious Disease Plan for Georgia. I think it was a very challenging effort to do this, but I am convinced that the Department of Public Health, and the community at large, will be better off because we have this plan. And because I think that all of our folks in Public Health are becoming very familiar with it, and it’s going to end up saving lives. And now I’d like to switch back to my very dear colleague, Kelly Nadeau.

**Kelly Nadeau**: Thank you so much for your attention to this presentation about our Highly Infectious Disease Plan. We hope that it’s answered lots of questions that you may have had. If you have any further questions, you can always contact us at DPH and we are happy to help you in any way that we can. Thank you so much.