## I. Executive Summary

In response to the potential use of biological agents against civilians, the Federal government has committed to upgrading preparedness, readiness, and national defenses against bio-terrorist weapons. The Centers for Disease Control and Prevention (CDC) has been designated as the lead agency for upgrading national public health capabilities for responding to biological terrorism. Many biological agents could be used to attack civilians, however, only a few, such as smallpox virus, have the ability to cause illness or panic to the extent that existing medical and public health systems would be overwhelmed. Although smallpox was globally eradicated by the late 1970's, there remains concern that stores of smallpox virus may exist in laboratories other than the two WHO designated repositories. If an outbreak of smallpox were to occur, several factors could contribute to a more rapid spread of smallpox than was routinely seen before this disease was eradicated. These factors include: 1) virtually non-existent immunity to smallpox in the absence of naturally occurring disease and the discontinuation of routine vaccination in the United States in the early 1970's, 2) potentially delayed recognition of smallpox by health personnel who are unfamiliar with the disease, and 3) increased mobility and crowding of the population. Because of these factors, a single case of smallpox would require an immediate and coordinated public health and medical response to contain the outbreak and prevent further infection of susceptible individuals.

The possibility for the use of smallpox virus as a bio-terrorism agent and the potential for its rapid spread, have prompted the updating of a response plan previously developed by the Centers for Disease Control and Prevention's (CDC) for responding to the potential importation of smallpox during the 1970's. This updated "Interim Smallpox Response Plan and Guidelines" incorporates, and extends, many of the concepts and approaches that were successfully employed 30 to 40 years ago to control smallpox outbreaks. These overall concepts for outbreak containment contributed greatly to the eventual global eradication of smallpox. Thus, while this document is an updated plan, many of the elements in the plan have been extensively and successfully utilized in prior decades. Overall, this document outlines the public health strategies and approaches that would guide the public health response to a smallpox emergency. This interim document also identifies many of the federal, state, and local public health activities that must be undertaken in a smallpox emergency. This plan, much of which has been in place for years, will be regularly updated to reflect changes in capacities and resources for responding to a smallpox emergency.

### Smallpox

Variola virus is the etiological agent of smallpox. The only known reservoir for the virus during the smallpox era was humans; there were no known animal or insect reservoirs or vectors. The most frequent mode of transmission is person-to-person spread via direct deposit of infective droplets onto the nasal, oral, or pharyngeal mucosal membranes, or the alveoli of the lungs from close, face-to-face contact with

an infectious individual. Indirect spread (not requiring face-to-face contact with an infectious individual) via fine-particle aerosols or fomites containing the virus has been reported but is less common. Fine-particle aerosol spread appears to occur more commonly with severe forms of smallpox, such as hemorrhagic smallpox, where virus titers are very high and sustained, or in cases where a significant cough (which can generate fine-particle aerosols) is present in the first week of illness (when oropharyngeal viral shedding is typically highest).

In the majority of cases, symptoms of disease usually begin within 12-14 days (range 7-17) following the exposure of a susceptible person to the virus and consists of a 2-3 day prodrome of high fever, malaise, and prostration with severe headache and backache. This pre-eruptive stage of the disease is then followed by the appearance of a maculopapular rash (eruptive stage) that progresses to papules (1-2 days after appearance of rash), vesicles (4-5$^{th}$ day), pustules (by 7$^{th}$ day), and finally scab lesions (14$^{th}$ day). The rash generally appears first on the oral mucosa, face, and forearms, then spreads to the trunk and legs. Lesions are also seen on the palms of the hands and soles of the feet. The skin lesions of smallpox are deeply embedded in the dermis and feel like firm round objects embedded in the skin. As the skin lesions heal and the scabs separate, pitted scarring gradually develops. Smallpox patients are most infectious during the first week of the rash when the oral mucosa lesions ulcerate and release the large amounts of virus into the saliva and are less infectious once the lesions have scabbed over. A patient is no longer infectious once all the scabs have separated (usually 3-4 weeks after the onset of the rash). The overall mortality rate associated with smallpox was approximately 30%. Other less common but more severe forms of smallpox include: 1) flat-type smallpox with a mortality rate >96%, characterized by severe toxemia and flat, velvety, confluent lesions that do not progress to the pustular stage, and 2) hemorrhagic-type smallpox, characterized by severe prodromal symptoms, toxemia, and a hemorrhagic rash that was almost always fatal with death usually occurring 5-6 days after the onset of the rash. (See Annex 1 – Overview of Smallpox and Medical Care of Smallpox Patients for a more complete discussion of smallpox)

**Smallpox Vaccine**

Smallpox vaccine is a highly effective immunizing agent. It is a live-virus vaccine composed of vaccinia virus, an orthopoxvirus that induces antibodies that also protect against smallpox. Its use in focused ring vaccination campaigns that utilized intensive surveillance and contact-tracing during the smallpox eradication program helped bring about the global eradication of smallpox. The last naturally-acquired case of smallpox occurred in Somalia in 1977. In May 1980, the World Health Assembly certified that the world was free of smallpox. Smallpox vaccine production ceased in the early 1980's and current supplies of smallpox vaccine are limited. However, it is expected that new cell-culture grown smallpox vaccines will become available for use within the next 2-4 years.

Although smallpox vaccine is considered a safe vaccine, post-vaccination adverse events can occur. These adverse events and their rates as determined in a 1968 10-state survey include: 1) inadvertent inoculation (529.2/million primary vaccinations), 2) generalized vaccinia (241.5/million primary vaccinations), 3) eczema vaccinatum (38.5/million vaccinations), 4) progressive vaccinia (1.5/million primary vaccinations), and 5) post-vaccinial encephalitis (12.3/million primary vaccinations). Death also occurs in about one per million primary vaccinations and is usually a result of progressive vaccinia, post-vaccinial encephalitis, or severe eczema vaccinatum.

Several groups have been identified as having a higher risk for developing post-vaccination complications. These include: 1) persons with eczema (including a history of eczema) or other forms of chronic dermatitis, and 2) persons with altered immune states (e.g. HIV, AIDS, leukemia, lymphoma, immunosuppressive drugs, etc.). In addition, because of the small risk for fetal vaccinia, vaccination is not recommended during pregnancy. Children under 1 year of age, or older adolescents or young adults receiving primary vaccination may also have a greater risk of post-vaccination complications. Vaccinia Immune Globulin (VIG) is used to treat certain vaccine adverse reactions, however supplies of the VIG are also limited.

## CDC Interim Smallpox Response Plan and Guidelines

This Interim Smallpox Response Plan is a working document that is updated regularly. Since state and local health officials are at the heart of an effective response to a smallpox emergency, their input is currently being sought, and it is anticipated that this plan will be updated frequently in the coming months. The plan is, however, operational and would be implemented should a smallpox emergency occur. The CDC Director may implement all or portions of the CDC Smallpox Response Plan under the "Criteria for Implementation" that are found in the next section.

As this plan illustrates, an effective response to a smallpox emergency will necessitate extensive involvement and coordination of CDC with state and local public health activities. This interim document thus identifies many of the federal, state, and local public health activities that must be undertaken in a smallpox emergency.

This document is organized into multiple sections. These sections outline criteria for smallpox response plan implementation, notification procedures for suspected cases, CDC and state and local responsibilities and activities —including some that should take place prior to a smallpox emergency—and CDC vaccine and personnel mobilization. This plan also provides Guidelines and Annexes to assist federal, state, and local health officials in implementing the specific activities that are essential for the management of a smallpox emergency. The general response strategy and priority activities are outlined below.

## General Strategy and Priority Activities for Smallpox Outbreak Containment

As this plan states, the first and foremost public health priority during a smallpox outbreak is control of the epidemic. The following activities would be essential to accomplishing this goal.

### Ring Vaccination

**Any vaccination strategy for containing a smallpox outbreak should utilize the ring vaccination concept. This includes isolation of confirmed and suspected smallpox cases with tracing, vaccination, and close surveillance of contacts to these cases as well as vaccination of the household contacts of the contacts.**

Vaccinating and monitoring a "ring" of people around each case and contact will help to protect those at the greatest risk for contracting the disease as well as form a buffer of immune individuals to prevent the spread of disease. This strategy would be more desirable than an indiscriminate mass vaccination campaign for the following reasons:

1. Focused contact tracing and vaccination combined with extensive surveillance and isolation of cases was successful in stopping outbreaks of smallpox during the eradication program without the need for indiscriminate vaccination.
2. Adverse events would be expected to be higher in an indiscriminate vaccination campaign due to vaccination of persons with unrecognized contraindications (e.g. undiagnosed immunosuppressive disorders such as HIV or AIDS). Careful screening for contraindications to vaccination would also be more difficult in a large scale vaccination campaign. The risks vs. benefits of vaccination ratio would be higher in such a campaign because of the inevitable vaccination of persons with high risk of adverse events and a low risk of smallpox.
3. Current supplies of VIG would not be sufficient to treat the number of expected adverse events that would occur with a large, indiscriminate vaccination campaign.
4. Current supplies of smallpox vaccine would be exhausted quickly if an indiscriminate campaign was utilized, potentially leaving no vaccine for use if smallpox cases continued to occur
5. Mass, indiscriminate vaccination of a large population would require a very large number of health-care/public health workers to perform vaccination and deal with the higher number of adverse events
6. Utilization of mass vaccination may lead to improper reliance on this strategy to control the outbreak with less focus on other essential outbreak control measure such as careful surveillance, contact tracing, and isolation of cases. This could also lead to inadequate supplies of vaccine for areas with the greatest need and potentially prolong the epidemic instead of controlling it.

Depending upon, 1) the option for outbreak control that is selected, 2) the size of the outbreak, 3) personnel resources, 4) effectiveness of other outbreak control measures, and 4) vaccine availability, the size of the vaccinated "ring" of individuals surrounding a case or contact may be modified (expanded or contracted). However, the ring vaccination concept should be maintained overall. The determination of the initial vaccination ring size or alteration of subsequent vaccination ring sizes will be made jointly by Federal and State health officials.

**Identification of Priority Groups**

The following are considered high risk groups and should be prioritized for vaccination in a smallpox outbreak:

1. Face-to-face close contacts ($\leq$ 6.5 feet or 2 meters), or household contacts to smallpox patients after the onset of the smallpox patient's fever.[¶]
2. Persons exposed to the initial release of the virus (if the release was discovered during the first generation of cases and vaccination may still provide benefit)
3. Household members (without contraindications to vaccination) of contacts to smallpox patients[†] (to protect household contacts should smallpox case contacts develop disease while under fever surveillance at home)
4. Persons involved in the direct medical care, public health evaluation[*], or transportation of confirmed or suspected smallpox patients
5. Laboratory personnel involved in the collection and/or processing of clinical specimens from suspected or confirmed smallpox patients
6. Other persons who have a high likelihood of exposure to infectious materials (e.g. personnel responsible for hospital waste disposal and disinfection)
7. Personnel involved in contact tracing and vaccination, or quarantine/isolation or enforcement, or law-enforcement interviews of suspected smallpox patients[*]
8. Persons permitted to enter any facilities designated for the evaluation, treatment, or isolation of confirmed or suspected smallpox patients[‡] (only essential personnel should be allowed to enter such facilities)
9. Persons present in a facility or conveyance with a smallpox case <u>if</u> fine-particle aerosol transmission was likely during the time the case was present (e.g. hemorrhagic smallpox case and/or case with active coughing)[§]

[¶] Although individuals with smallpox are not infectious until the onset of rash, vaccinating contacts from the time of the onset of fever helps provide a buffer and assures that contacts who may have been exposed at the early onset of rash, when the rash may have been faint and unrecognized, have been vaccinated.

* Includes personnel whose public health activities involve direct patient contact such as case interviewing

[†] Household members of contacts who have contraindications to vaccination should be housed separately from the other vaccinated household members until the vaccination site scab has separated (~ 2 weeks) to prevent inadvertent transmission of vaccinia virus. They should be also

be housed separately from the contact until the incubation period for smallpox has passed and the contact is released from surveillance.

‡ Only personnel without contraindications to vaccination should be chosen for activities that would require vaccination for their protection. Personnel with contraindications should not perform duties that would place them at risk for smallpox exposure and should otherwise only be vaccinated if an exposure has already occurred.

§ Evaluation of the potential risk for aerosol transmission and initiation of vaccination for non-direct contacts will be done by CDC, state, and local public health personnel. The decision to offer vaccination to non-direct contacts of smallpox cases will be made jointly by Federal and the State health officials.

## Additional Groups that Would Be Considered for Voluntary Vaccination

Federal, State, and Local response personnel not involved in direct patient or contact evaluation or care but whose uninterrupted support of response activities is deemed essential may be considered for voluntary vaccination. Vaccination of these personnel will be dependent upon the size of the outbreak, availability of vaccine, the assessed risk for unintentional or unrecognized contact with smallpox cases, and a careful assessment of the benefits vs. the risks of vaccination. Only personnel within these non- patient contact groups who have no contraindications will be considered for vaccination. Persons within these groups with contraindications should not be vaccinated. **The decision to offer voluntary vaccination non-patient contact personnel will be made by the Director, CDC.** These groups include, but are not limited to:

1. Public health personnel in the area involved in surveillance and epidemiological data analysis and reporting whose support of these public health activities must remain unhindered
2. Logistics/resource/emergency management personnel whose continued support of response activities must remain unhindered
3. Law enforcement, fire, and other personnel involved in other non-direct patient care response support activities such as crowd control, security, law enforcement, and firefighting/rescue operations

## Overview: Activities and Guidelines

This Interim Smallpox Response Plan and Guidelines document outlines, and in some cases, describes in detail, many of the pre- and post-event activities that need to be, or would be undertaken, in response to a smallpox emergency. These include:

Surveillance and Epidemiological Investigations:

- Pre-event rash surveillance
- Smallpox clinical presentations and differential diagnosis guidelines
- Smallpox case definitions
- Notification procedures for suspected smallpox cases

- Case and outbreak investigations

General Vaccination activities:

- CDC vaccine deployment
- Clinic vaccination procedures and adverse event reporting
- Rapid identification and vaccination of all priority groups (non-contact and contact)
- Education and evaluation of vaccine responses with revaccination when needed
- Education, recognition, and treatment of vaccine adverse events
- Decontamination guidelines
- Monitoring of vaccine utilization and supplies

Quarantine/Isolation related activities:

- Fever/rash surveillance and education of contacts (vaccinated and unvaccinated)
- Isolation and care of smallpox patients during the infectious period

Surveillance activities:

- Identification and reporting of suspected smallpox cases through active surveillance at the local, state, national, and international levels
- Surveillance of vaccine adverse events

Epidemiology:

- Epidemiological investigation of the outbreak to determine at-risk populations (contacts), source of outbreak, and risk factors for illness
- Specimen collection and transportation guidelines

Public/Media Communications:

- Communications principles and guidelines
- Pre-event communication education and information
- Smallpox emergency communication operations and activities

These inter-related, multifaceted activities are discussed in the Guides and Annexes that follow. In addition, this Interim Smallpox Plan identifies, and provides examples, of many of the specific activities, forms, and procedures that should be followed in preparation for, and in response to, a smallpox emergency.

**The CDC Interim Smallpox Response Plan and Guidelines is a draft document that will be updated as needed to reflect changes in capacities and resources for responding to a smallpox emergency. Public health authorities will be notified when updated drafts are available.**

## II. Criteria for Release of Smallpox Vaccine and Implementation of the CDC Smallpox Response Plan

The CDC Director may authorize the release* of all or portions of the smallpox vaccine stockpile and implement all or portions of the CDC Smallpox Response Plan if one or more of the following occur:

1. Confirmation of the presence of smallpox virus, antigen, or nucleic material in clinical specimens by CDC or another laboratory qualified to evaluate specimens for the presence of smallpox virus.
2. Credible reports of clinically compatible cases with pending laboratory confirmation, once an outbreak of smallpox has been previously identified.
3. A large outbreak of a clinically compatible illness as determined by CDC with pending etiological confirmation.
4. Confirmation of smallpox virus in an environmental sample, package, distribution device, or other device associated with potential human exposure.

In addition, the CDC Director may authorize release of a portion of the smallpox vaccine stockpile and implementation of all or portions of the CDC Smallpox Response Plan if a threat of a smallpox virus release has been received, evaluated, and deemed highly credible by federal law enforcement or intelligence authorities.

*The CDC Director will notify the Surgeon General and other federal agencies (HHS, FBI, NSC, etc.) prior to the release of smallpox vaccine.

## III. Notification Procedures for Suspected Smallpox Cases

State and local public health authorities should notify CDC for any of the following:

1. A suspected case of smallpox with request for clinical specimen testing
2. An outbreak of illness that is clinically compatible with smallpox
3. A request to test an environmental sample, package, distribution device, or other device associated with potential human exposure for smallpox virus

The following CDC offices should be notified by state and local public health authorities immediately for any of the above events:

1. Bioterrorism Preparedness and Response Program

2. Poxvirus Section, Division of Viral and Rickettsial Diseases, NCID, CDC

3. Emergency Preparedness and Response Branch

The telephone contact numbers for these offices and copies of the CDC Interim Smallpox Response Plan and Guidelines have been distributed to each State's Health Department. If you need these telephone numbers, please contact the Bioterrorism Preparedness Coordinator at your State Health Department.

*Medical personnel should notify their state and local public health authorities for suspected cases of smallpox.

## IV. CDC and State/Local Responsibilities and Actions in the Event of a Smallpox Outbreak

**Any large-scale outbreak of smallpox would quickly overwhelm federal public health capabilities to provide personnel resources sufficient for federal implementation of public health control measures at the local level. Therefore, local and state health and emergency authorities must be prepared to mobilize resources to initiate and sustain the necessary outbreak control measures. Federal resources will be available to assist local and state authorities in the implementation of these measures.**

### CDC Responsibilities and Actions

In the event of a confirmed or suspected smallpox outbreak, or a highly credible threat of a smallpox release as determined by federal law enforcement or intelligence agencies, CDC will immediately mobilize for the following activities/responsibilities:

1. Delivery or standby readiness for delivery of smallpox vaccine and vaccination components
2. Initial laboratory confirmation of smallpox infection and establishment of laboratory protocols for confirmation in surge capacity laboratories.
3. Coordination with state/local health officials to establish communications and implement federal-state response plans
4. Immediate mobilization and deployment of CDC personnel to assist local and state public health officials with epidemiologic investigations, surveillance, implementation of case isolation protocols, contact identification, vaccine administration, adverse events monitoring, and vaccine inventory monitoring
5. Development of vaccination strategies and prioritization
6. Distribution of guidelines for surveillance, contact identification and tracing, vaccination, isolation strategies, specimen collection and transport, public/media communications, decontamination, and smallpox patient medical care guidelines
7. Provision of technical assistance to the national authority responsible for coordinating the overall federal efforts for managing the event
8. Coordination with federal law enforcement agencies conducting the criminal investigation
9. Provide recommendations on quarantine needs that supercede the capabilities of local/state authorities/statutes
10. Coordination with state/local authorities for public and media communications
11. Tracking and reporting of national surveillance information regarding outbreak
12. Coordinate between states for contact tracing and monitoring

### State/Local Public Health Responsibilities and Actions

1. Activation of local/state emergency response plans for bioterrorism and/or smallpox outbreaks

2. Designation of state/local leads to coordinate local case surveillance and isolation, contact tracing and monitoring, epidemiologic investigation, and vaccine administration
3. Mobilization of local and state public health resources to conduct epidemiological investigations, surveillance, implementation of case isolation protocols, contact identification, vaccine administration, and adverse events monitoring
4. Designation and activation of sites/clinics for vaccine administration
5. Designation and activation of sites for patient isolation
6. Designation and activation of sites for contact isolation if initiated
7. Utilization of local/state public health statues and resources for implementation and enforcement of isolation and quarantine within the local/state jurisdiction
8. Coordination with local/state/federal law enforcement agencies conducting the criminal investigation
9. Coordination with federal authorities for public and media communications

## V. Vaccine Mobilization and Deployment

### Deployment of Vaccine

Initial deployment of smallpox vaccine and vaccine components will occur once approval for release has been obtained from the Director, CDC.

**Vaccine delivery will be prioritized for areas/states with confirmed cases of smallpox, and/or confirmed contacts to smallpox cases. States with probable cases will also have priority over states with no cases.**

The amount of initial vaccine delivered to an area/state will be determined by the CDC Director and will be based upon an assessment of:

1. Known or estimated of number of confirmed or suspected smallpox cases
2. Known or estimated of number of contacts
3. Known or estimated number of areas/states potentially effected
4. Number of public health, medical, and response personnel requiring vaccination
5. Vaccination strategy implemented

Supplemental vaccine deployments to an area/state will be based on:

1. Federal assessment of continued vaccine needs to support federally-approved vaccination campaigns initiated in an area/state
2. Vaccine availability

## VI. CDC Personnel Mobilization and Deployment

Once an outbreak of smallpox has been identified, the Director, CDC will initiate mobilization of personnel for the following functions:

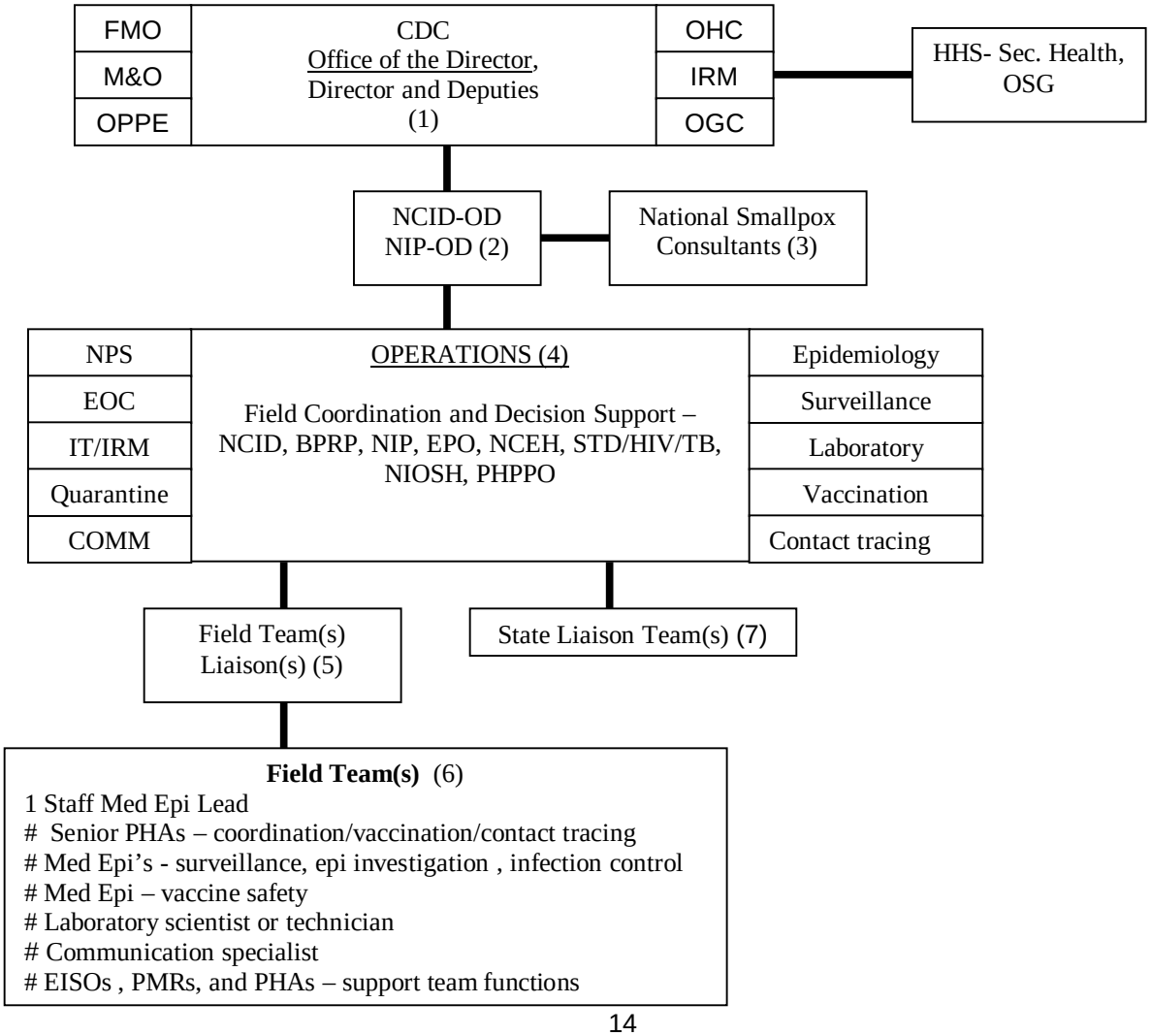
1. Laboratory:
    a. Perform initial laboratory confirmation of disease to confirm smallpox outbreak
    b. Enact protocol for receiving and processing large numbers of specimens at CDC
    c. Initiate protocols in "surge capacity" state labs for smallpox diagnostics once initial outbreak has been confirmed at CDC
    d. Provide reagents and consultation as needed to surge capacity state labs
2. Vaccination:
    a. Deliver vaccine and vaccine components to public health officials in areas with confirmed smallpox outbreaks
    b. Work with state and local health officials to refine and initiate strategies for vaccine administration based upon initial and ongoing analysis of the outbreak
    c. Assist in establishing vaccination sites
    d. Provide instruction on vaccination techniques
    e. Assist with monitoring of vaccine utilization, take rates, and adverse events
3. Isolation and Quarantine:
    a. Assist with the development and implementation of protocols for isolation of smallpox cases
    b. Assist with public health decisions regarding implementation of local quarantine and travel restrictions as needed
    c. Enact federal statutes for quarantine as needed
4. Surveillance:
    a. Assist in the development of case definitions and active surveillance for additional cases
    b. Assist in surveillance for smallpox cases in states/areas where cases have not yet been identified
    c. Coordinate and track national surveillance activities
5. Contact identification and tracing:
    a. Assist in the development and implementation of protocols for contact identification and tracing
    b. Assist in the development and implementation of protocols for contact vaccination and monitoring
    c. Assist in the development and implementation of protocols for isolation of symptomatic contacts
6. Epidemiology
    a. Assist with the epidemiological investigation of cases to determine source of infection and characterize outbreak

b. Coordinate national epidemiological activities

7. Coordination:
   a. Coordinate CDC mobilization and response efforts with State/Local health authorities
   b. Serve as liaisons with other Federal agencies (FBI, HHS, OEP, etc.) involved in the response
8. Provide technical expertise and assistance to state/local public health authorities and the national authority responsible for coordinating the overall federal emergency response

The number of initial CDC personnel mobilized will be contingent upon the anticipated size of the outbreak and the extent of response estimated for control of the outbreak. The size of field teams mobilized to specific states may vary depending upon the extent of the outbreak within the state and/or the resource needs of the state. Mobilization of personnel will be initiated by the Director, CDC and coordinated through the CDC Operations Group (see page 2). If personnel needs extend beyond CDC staffing capabilities, the Director, CDC will seek the assistance of other Federal agencies.

**Fig. 1 – Flow Chart of CDC Personnel Organization/Mobilization**



**(1) Office of the Director, CDC**

a. Coordinates overall CDC activities
b. Direct liaison with Secretary of Health and Human Services and Office of Surgeon General

**(2) NCID/NIP OD**

a. Consultants to the Director, CDC for agency policy decisions
b. Act as liaisons to other Federal agencies (FBI, HHS, OEP, DoD, etc.) or assign personnel to act as liaisons
c. Designate personnel within their divisions for response activities
d. Act as liaisons or assign personnel to act as liaisons to international organizations such as WHO

(3) **National Smallpox Consultants** – Consists of non-CDC smallpox expert consultants from list of national experts maintained at CDC

a. Provide additional smallpox expert ise consultation for CDC Director and NCID/NIP OD

(4) **Central Operations Group** – Consists of personnel from NCID, BPRP, NIP, EPO, NCEH, STD/HIV/TB, NIOSH, PHPPO, and other CDC C/I/Os

a. Coordinate overall the CDC epidemiology, surveillance, and stockpile activities, serve as central location for tracking nationwide surveillance, epidemiology, and vaccination activities, maintain national surveillance database
b. Provide guidance to CDC field teams regarding surveillance, contact tracing, vaccination, and epidemiological investigation, and epidemic containment issues
c. Mobilize vaccine stockpile as directed by CDC Director
d. Address resource needs of personnel in field
e. Provide technical expertise and assistance to state/local public health and medical authorities and federal agencies involved in response
f. Coordinate interstate and international tracing and notification of contacts
g. Coordinate internal CDC diagnostic laboratory activities
h. Liaise for external CDC diagnostic laboratory activities (USAMRIID)
i. Coordinate specimen collection and transportation strategies
j. Mobilize smallpox vaccine to states where cases have been identified

**(5) CDC Field Team Liaisons** – provide direct CDC communications and support to assigned field teams

**(6) CDC Field Teams** – Work directly with state and local authorities for outbreak control activities. Consists of the following personnel:

1. Senior level Physician/Medical Epidemiologist – Team Leader

2. Senior Public Health Advisors (number to be determined) – coordination and management of team, assist with implementation of vaccination strategies
3. Medical epidemiologists (number to be determined) – assist with coordination of surveillance, epi investigation, infection control activities
4. Medical Epidemiologist (number to be determined) – coordinates activities for diagnosing, monitoring, analyzing vaccine safety data
5. Laboratory Scientist or Technician (number to be determined) – advise local laboratories on specimen collection, handling, shipping, laboratory safety, diagnostic protocols once initial case confirmed at CDC
6. Communications specialist – liaison between team and communications specialist at CDC and HHS, assist local health department press officers draft statements, materials, etc.
7. EISO/PMR/PHA – additional staffing resources as needed

**(7) State Liaison Teams** – Assigned as CDC liaison and contact for states without CDC field teams to provide general overall support to states