DETECT II Foodborne Outbreak (FBO) Response Strategies Training

Food-Related Emergency Exercise Situation Manual

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Purpose

To protect the health of the Alabama, it is crucial that we ensure that food products are safe for consumption. Everyone involved in the food chain, from farmer through consumer, has a responsibility to keep the food supply safe.

Participants

We encourage as many of the following groups to participate in this exercise so that they can contribute to the overall understanding of the scenario, develop and/or strengthen working relationships with other organizations and benefit from the collective dialogue. Specific participant groups include private and public health clinical practitioners, hospitals, health care providers; laboratorians; local, State, Tribal, and territorial epidemiologists and regulatory agencies; school officials; and foodservice/processing industry representatives.

Goal

This tabletop exercise provides participants with an overview of actions taken at the local, tribal, and State level when a food-related incident occurs. Most of the information needed in this tabletop exercise was presented before the exercise. This tabletop exercise will help to facilitate discussion among various participating entities, such as emergency response, private sector, State and local entities.

Exercise Objectives

- Define roles in a complex and urgent food contamination incident.
- Map the process and flow of a foodborne disease investigation from the initial epidemiologic signals.
- Understand the importance of gathering and cataloging critical information needed when making decisions in rapidly developing situations.
- Coordinate your efforts with other professionals engaged in the investigation.
- Use a collaborative approach to efficiently utilize the skills of each agency and discipline and identify proactive solutions.
- Understand the importance of internal and external communications and dialogue and have ideas about how to improve both in your organization.

Exercise Structure

This exercise is designed to be an interactive, facilitated tabletop exercise. Participants are encouraged to ask questions of each other and learn from one another. It has been designed by a group of subject matter and instructional design experts to provide participants with a real-life, plausible food safety scenario. The exercise has also been developed to provide participants with

an opportunity to explore important topics like interagency collaboration and jurisdictional issues. The Alabama Department of Public Health (ADPH), Epidemiology Division (EPI), has modified the Food and Drug Administration (FDA), United States Department of Agriculture (USDA) Food Safety Inspection Service (FSIS) and Centers for Disease Control and Prevention (CDC) exercise. The series of modules includes:

- Module 1 – Onset of illness
- Module 2 – Identification of common exposure
- Module 3 – Foodservice investigation

Exercise Guidelines

This exercise is conducted in a safe learning environment, so that all participants can share and explore concepts with one another, while discussing multiple solutions and options for a given issue. This exercise will operate under the following guidelines:

- Open, low-stress and non-public learning environment and is not intended to set precedents.
- Listen to and respect the varying viewpoints of all of the other participants.
- Suspend your disbelief, and feel free to discuss differing policies and procedures during the breakout discussion.
- We will apply our findings from today's activities to our job/function and share key findings with colleagues.

Roles and Responsibilities

- Participants – Respond to the scenario based on their first-hand, experiential knowledge; current plans and procedures of their individual entity, agency or jurisdiction; and insights from training and experience.
- Evaluator(s) – Record the highlights of the discussion at each breakout table. These people do not participate in the exercise but capture the essence of the dialog for use in the After Action Report. They are chosen based on their expertise in the areas they are to observe.
- Facilitator – Generally leads the exercise, provides situation updates and moderates discussions. They also provide additional information and resolve questions as needed. Key officials may also assist with the facilitation as subject matter experts during the exercise.
- Group Leader – Representative from each table (volunteered by the group) who will lead the group as it explores discussion questions and the breakout activities.
- Group Recorder/Reporter – Representative from each table (volunteered by the group) who will ensure that the group discussions are kept on time, record the key themes discussed at the table, and will be responsible for reporting out during the large group dialogue.

Module 1 – Onset of Illness

In Montgomery County on Saturday, May 12, the Jackson Tigers Little League Baseball team ended their season and they had a team party to distribute trophies. All 15 team members, their parents, and six coaches celebrated by dining at a Mexican-style quick-service restaurant. The team mother pre-ordered chicken taco dinners for everyone. The pre-ordered meal featured chicken tacos, beans, rice, chips, green chili salsa, and ice cream sundaes.

On Monday morning, May 14, nine team members stayed home from school. They all suffered from fever and diarrhea, and three were vomiting. Not knowing about the other teammates, parents gave their children fluids and hoped for improvement. In one household, both father and son were ill.

By Tuesday morning, May 15, the nine students were still absent and eight more students from Jackson Elementary had fever and diarrhea, and did not go to school. The school nurse, called the parents to check on the children. The nurse told the parents that some other members of the Jackson Tigers were also home sick. Some of the Jackson Tiger parents called each other and others posted to Facebook the information to the other team parents. Parents decided their children should go to the doctor since they were all experiencing similar symptoms. Various physicians examined the sick children and spoke with the parents who reported other Jackson Tigers teammates were also sick. These similarities led the physicians to conclude that the children contracted a viral or bacterial infectious disease that could be transmitted person-to-person, food, or water.

On Wednesday May 16, sixteen more Jackson Elementary School students, who were not on the baseball team, visited the school nurse with gastro-intestinal (GI) illness. The nurse was alarmed at the rate of absenteeism and illness at her school and contacted the school foodservice director to inform him about the increase in gastrointestinal illness among the students. The foodservice director assessed the school's food safety records for anything that might have indicated a problem in the school cafeteria. The nurse also contacted other school nurses in the school district to see if they had observed a similar increase in absenteeism. According to Notifiable Disease Rules, physicians and school principals were required to report "Outbreaks of any kind." The nurse did not know what was causing the illness, but due to the number of affected students, she contacted the local health department who transferred the call to the Field Surveillance Staff (FSS).

The FSS contacted her county environmentalist who researched their records and saw the Mexican restaurant was most recently inspected on May 1. On May 17, the environmentalist decided to make a visit to the Mexican restaurant to complete the Environmental Assessment Report (EAR). The environmentalist told the restaurant's management of a potential outbreak that may be associated with their establishment. The restaurant manager was quite concerned and asked for as much information as possible. The manager contacted his corporate office and began gathering food safety records and information. On Thursday, the county environmentalist contacted their counterparts in other counties to inform them of the status of the preliminary association with the Mexican restaurant.

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FSS began to identify a common source of infection, stop the disease transmission, and requested stool specimens from the students. They talked with the other schools in the district and clinical professionals. FSS identified five possible cases from other schools, including two high school students and one adult from the same community as Jackson Elementary.

On Thursday, May 17, and Friday, May 18, the FSS completed five hypothesis-generating interviews with the sick students and their parents to try to determine the route of exposure. FSS also requested stool specimens from sick individuals for testing at the Bureau of Clinical Laboratories (BCL).

On Thursday, May 17, the local Montgomery TV station contacted the school system and the local Montgomery County Health Department (CHD) for information. The school superintendent and the FSS provided a brief statement that indicated the situation was under investigation.

On Saturday, May 12 in Troy County, the Community College Cafe began its annual final exam special: buy-one-get-one-free chicken enchilada dinners for one week. By Monday May 14, many students were feeling ill with fever and diarrhea, but they passed it off as nerves about exams or "stomach flu." By Wednesday afternoon, May 16, 27 students visited the campus health clinic with GI symptoms, including fever and diarrhea. The physician and the nurse practitioner grew concerned at the significant increase in ill students with the same symptoms and suspected a communicable disease. Between Thursday and Friday, 52 more students visited the infirmary with similar symptoms. On Friday, the physician contacted the CHD and the CHD contacted the Community College administration to report the situation.

Developments

- Onset of illness (illness in two counties)

- Stool samples collected
- School nurse contacts Montgomery CHD and physician contacts Troy CHD.
- Hypothesis-generating interviews begin in Montgomery County
- Local media reports Montgomery story

Questions for Participant Groups

Private and Public Health Clinical Practitioners, Hospitals, Health Care Providers

1. If you suspect a foodborne illness in one of your clinical patients, what is your standard process to follow up?
2. If you suspect *Salmonella* or pathogenic *E.coli*, do you routinely collect a stool sample? What is your threshold or decision process for specimen collection?
3. Would more information from the food safety agencies be of assistance to you in raising awareness and recognizing possible food-related illnesses?

Infection Preventionists

1. If the Emergency Room calls about multiple patients with the same symptoms, what actions would you take? Would they call you? What if it is on the weekend and you are not at work?
2. Do medical providers in the community call you when they see something unusual or an increase in patients with these symptoms or connections?
3. If you were aware of the above scenario, what actions would you take? Have you called Public Health? Who would you call?

Private and Public Laboratorians

1. Do private laboratories have processes to forward confirmed isolates to the State lab for serotyping and Pulse-field Gel Electrophoresis (PFGE) analysis? Is this routine procedure for foodborne pathogens? What influences this decision?
2. Who is responsible for monitoring significant increases in the number of samples submitted or specific tests ordered, as a possible early detection system? What happens if this type of increase is observed? Who is alerted?
3. If the number of specimens submitted exceeds the capacity of the laboratory, what actions are taken to ensure timely testing?

College healthcare, school nurses, school cafeteria directors, and administration

1. If you suspect a foodborne illness or infectious disease is affecting students or teachers in your district (or your employees), what is your standard process for follow up?

2. What are your procedures or processes for establishing the trigger or threshold levels of affected individuals in a possible communicable disease situation when a school would contact the local health authorities? Would your processes have generated a notification in this case?
3. Do you have a standard operating procedure or a crisis management plan to handle a foodborne illness outbreak in your school?

County and Area Public Health

1. What do you communicate to your local health department employees about the situation?
2. What do you say to the public when they call the health department for information?
3. How would you respond to a reporter from the local newspaper who wants an interview about the outbreak situation?

Public Health Environmentalists

1. What would you do in the early stages of this scenario, when there are clinical cases of a foodborne pathogen but no implicated food?
2. What would you do if a parent of one of the sick children brought you some of the left over food from the Mexican Restaurant to test for foodborne pathogens?
3. Are there multiple routes of dialogue for more information about possible outbreaks between the constituent groups? Do the existing mechanisms serve your needs?

Foodservice Industry

1. In a situation like this, it may be necessary to identify ill employees during the previous two-week period. In your establishment, how would you review the schedule to identify ill employees and dates they worked?
2. How would you determine which product or ingredients may be available and what to sample from your food products and ingredient lists to be tested at a laboratory?

Module 2 – Identification of Common Exposure

By Sunday May 20, FSS continued the elementary school and Community College hypothesis-generating interviews. They identified that the Little League teammates practiced and played together several times a week for at least three weeks before they became ill. The teammates shared snacks, electrolyte drinks, and water at their practices and games. During the week, school lunches were also available for purchase at the cafeteria. The shared meal at the Mexican restaurant was identified as a point of possible common exposure.

On Monday, May 21, some of the results of the students' stool were sent to their respective physicians from the private laboratories. *Salmonella* had been isolated from three of the stool specimens submitted Tuesday evening. All three specimens were sent to the BCL for PFGE patterns and serotyping. The physicians contacted the FSS at the health department to report the findings.

On Monday, May 21, the epidemiologist reviewed the food histories of the five cases, some had their stool specimens tested (3 from the Little League team) and confirmed that 3 of the 5 had eaten the chicken taco meal within 24–72 hours prior to illness onset. The epidemiologists used the analysis of the initial interviews and the laboratory information to develop a specific outbreak questionnaire. This allowed a more complete analysis to identify the common exposure point for the outbreak.

The Area/Assistant State Health Officer (SHO) updated the media with news releases, case counts, and efforts to investigate. The possible link to the restaurant was not made public at this point, as the epidemiologic investigation was not complete.

From Saturday through Monday, May 19-21, FSS after the numerous telephone calls and efforts to obtain parental permissions to contact the few college students who were minors, they conducted 5 hypothesis-generating interviews of the sick college students to try to identify the source of common exposure. This was complex because students made multiple visits to the Cafe and the students' recollection of what meals they had eaten two to four days prior to the onset of illness was fuzzy.

By Tuesday, May 22, a short list of foods consumed in common at the Cafe by the ill students was developed. The list included:

- Visits to the self-service salad bar with iceberg lettuce, onions, green peppers, mushrooms, shredded cheddar cheese, and Italian and French dressing

- Chicken enchilada dinners with chicken and cheese enchiladas topped with green chili salsa, rice and chips
- Scrambled eggs
- Roast beef sandwiches, with roast beef, iceberg lettuce and horseradish sauce

The interviews also included information on meals the students had eaten off campus or cooked themselves. No commonalities were seen to indicate an exposure outside of the school Cafe. Over the weekend of May 19-20, thirty-three more students reported to the health center with GI symptoms. Stool samples from 11 of them were obtained and sent to BCL for analysis.

On Thursday May 24, the BCL informed EPI seven stool samples from Troy County were positive for *Salmonella*, and that cultures were being serotyped and set up for PFGE analysis. FSS notified the infirmary staff about the lab results.

In the meantime, the Community College administration maintained communication with the student health clinic to monitor the situation over the weekend. The college foodservice director conducted an internal investigation, review, and evaluation of internal food safety practices and looked for any anomalies that could help with the investigation. The environmentalist called to schedule a visit to the Cafe to try to identify the possible contamination, collect food specimens, and let them know the hypothesis-generating interview results linked the illnesses to food consumed at the Cafe.

Developments

1. Analysis of Little Leaguers and other Montgomery County victims' hypothesis-generating interviews points to Mexican restaurant.
2. Doctors in Montgomery County contacts health department reported seeing an increase in patients with Salmonellosis.
3. Interviews of college students in Troy County begin. Cafe food is suspected.
4. Private lab in Montgomery County notes the unusual increase in *Salmonella* and contacts the State lab.

Questions for Participant Groups

Private and Public Health Clinical Practitioners, Hospitals, Health Care Providers

1. As more potential cases report for treatment, are your triage procedures any different?
2. With a continuing influx of cases with apparently the same symptoms that may have the same cause, are your patient care follow-up practices any different?

3. What is the impact of HIPPA on the information sharing necessary for this investigation?

Infection Preventionists

1. If you are aware of the increase in Salmonella cases within the community, what type of surveillance are you performing within your facility? Are you performing chart audits?
2. What policies, procedures, or quality assurance plans are in place to address outbreaks in the community or in the hospital?
3. How do you communicate to the other hospital employees or physician on staff about Salmonella? Do most employees have access to a work email? Do you post information in break rooms?

Private and Public Laboratorians

1. As the lab may be handling an increased workload with some possibly related cases, how are the priorities assigned?
2. If you are a private lab with multiple facilities, does your organization have a plan to address surge and workload fluctuations?
3. In Montgomery County, the management at the private clinical lab contacted the local public health lab. Is this typical procedure? Are there formal relationships between public and private labs?

College healthcare, School nurses, school foodservice directors, and administration

1. At this point, a common pathogen associated with this outbreak has been identified. What, if anything, would you communicate to the following groups at this time (as applicable)?
    a. School officials in neighboring districts
    b. Board of education/superintendent of schools
    c. Faculty, staff, and administration
    d. Parents/students
2. If you were informed that the food in your cafeteria may be linked to an outbreak, would you put food on hold and not served, close cafeteria, or serve only pre-packaged food from a trusted source? Who would make that decision?
3. Do you have a "continuity of operations" plan to see that your students are fed in the event that you shut down your cafeteria due to a foodborne illness incident?

County and Area Public Health

1. With Salmonella cases confirmed in Troy and Montgomery counties, how are you communicating between the two counties? Between the two Public Health Area? Who is the lead?
2. For the Field Surveillance Staff, have you identified others that can assist with collection of data and completing hypothesis-generating and/or outbreak specific questionnaires? How are you going to train the staff on completing the questionnaires? What modified hours are you working, if any?
3. If the community is calling or showing up at the health department for information, how is this handled? Do you have the supplies necessary to send large numbers of specimens to the BCL? How will the specimens be shipped?

Public Health Environmentalists

1. What resources do you have to research the most common food sources of salmonella?
2. What is your action plan once you receive word that there is a *Salmonella* outbreak, but the source of the *Salmonella* is not yet identified?
3. What, if anything, would you communicate to the following groups at this time?
   a. Public Health Officials
   b. Other local/State regulatory agencies
   c. CDC, FDA and USDA
   d. Consumer groups, schools, hospitality community
   e. Food industry

Foodservice/ Processing Industry

1. If you represent the college foodservice operation, what systems do you have in place to communicate when the college health center has made you aware there may be a problem associated with students who consumed food in your facility?
2. For commercial foodservice operators, what systems or procedures do you have in place to address the situation here, when you have just been informed that your facility may be implicated in a foodborne illness, but you do not yet know the food vehicle or cause?

Module 3 – Foodservice Investigation

The Montgomery County environmentalist initiated an investigation at a Mexican restaurant. In order to help identify the source of the foodborne outbreak, the environmental investigation started at the point of service.

The Mexican restaurant is part a regional restaurant chain with 14 company-owned establishments in three states with an average of 500 transactions per day per unit. The menu consists of chicken, beef, and vegetarian Tex-Mex cuisine served in a quick-service format.

The county environmentalist researched their records and saw the Mexican restaurant was most recently inspected on May 1. On May 17, the environmentalist decided to make a visit to the Mexican restaurant to complete the Environmental Assessment Report (EAR). The environmentalists first reviewed prior inspection reports and the restaurant had only minor deficiencies in the three years since it opened; its management was certified in food safety practices and the company implemented a robust employee-training program. On Monday May 21, the environmentalist conducted a follow-up visit to the restaurant related to the possible outbreak. Another complete assessment was conducted; the manager on duty accompanied the environmentalists on the assessment and was helpful and cooperative. Again, few deficiencies were noted.

After the assessment was conducted, the environmentalist spoke privately with the manager about the chicken taco meals and its possible association to the Little League team's illness. The environmentalist asked for the manager to continue cooperation by requesting access to records for food preparation: raw material sourcing, copies of any HACCP plans and other food safety standard operating procedures (SOPs), and recipes from the period a few days before illness onset.

On Tuesday, May 22, the Mexican restaurant manager talked with their corporate office, who instructed them to allow access to any records needed on-site for the environmentalist to review. The Manager gathered data relative to absenteeism and sick employees during the previous few weeks as well as the number of transactions (and day and time) for the chicken taco meals served. This information prepared them to compare the number of chicken taco meals served that were associated with illness to the number of meals served to individuals who did not become ill during the same timeframe.

The environmentalist returned to the office at the end of the day to meet with FSS. BCL reported that five additional stool samples from the school were positive for *Salmonella Newport I.6,8:eh;2*.

On May 24, the environmentalist returned to the Mexican restaurant to investigate the in-house preparation process, raw material sources, and records of any ill employees during the past two weeks, internal food safety records that document practices and behaviors, and product supplier and receiving records. The environmentalist worked with the manager to understand the restaurant procedures and product assessment, including formulations, what is prepared in-house versus what is purchased as ready-to-eat food, and the nature of the kill step, whether at the supplier or in the establishment. The environmentalist obtained the recipes and supplier information from the manager for the components of the chicken taco meal and ice cream sundaes that the team ate. They also collected food samples.

The samples were shipped through the CHD to the BCL for *Salmonella* analysis. The Mexican restaurant began to contact its suppliers to determine if they had received reports of other illnesses associated with any products.

The Area/Assistant SHO continued to respond to press inquiries, stating that *Salmonella* was the organism causing the outbreak, but transmission was unknown, while trying to explain the ongoing nature of the epidemiologic investigation and the multiple avenues of approach. Although the public message did NOT implicate the Mexican restaurant, sales did decrease due to the negative publicity.

The Montgomery CHD notified the school system of the ongoing outbreak, the possible link to the restaurant, and that the preliminary investigation indicated that their cafeteria was more than likely not implicated as the source of the exposure.

Late on Friday, May 25, the BCL informed the FSS and environmentalists that the PFGE patterns of the original 12 isolates (submitted on May 23) were completed and uploaded to the PulseNet database at the Centers for Disease Control and Prevention (CDC). The preliminary reading by the State laboratory indicated that all had a matching pattern.

On Wednesday May 23, the Troy County environmentalists reviewed the prior inspection reports for the Community College Cafe. There were some deficiencies in the past three years related to personal hygiene practices, hot holding temperatures on the buffet lines, steam table lines in the kitchen, and out-of-date or expired product on the shelves. They then visited the Community

College Cafe to investigated possible sources of foodborne contamination. The investigation focused on the factors most closely linked to foodborne outbreaks such as:

- Personal hygiene practices
- Cooking, cooling, and holding temperatures
- Sanitation and cross-contamination
- Raw material supply, focusing on the "short list" items developed thus far

The environmentalists requested various records, like recipes, supplier information, and copies of the HACCP plans, from the Cafe management to verify the food safety practices and behaviors in place. They also collected food samples.

The Community College foodservice director gathered data on internal food safety practices and procedures, records of ill employees over the last two weeks and supplier records for the last few months to provide to the public health. The Community College administration decided to serve solely pre-packaged prepared foods in the Cafe until the source of this outbreak was identified.

On Friday, May 25, the BCL contacted EPI who in turn let the FSS and Troy County environmentalists know that the PFGE results for the initial samples were a match and subsequently uploaded to the PulseNet database. The campus health center said the last case came in on May 22, with no new cases for the past three days.

Developments

1. Mexican restaurant and Community College Cafe were inspected by respective authorities.
    a. Both establishments provided product-specific information and provide food samples for analysis.
    b. Both establishments provided records of suppliers, recipes, meals served, food preparation practices, and employee absenteeism.
    c. Community College decided to serve only pre-packaged, prepared foods.
2. PFGE patterns uploaded to PulseNet appeared to match.
3. Communication with local media continued.

Questions for Participant Groups

Private and Public Health Clinical Practitioners, Hospitals, Health Care Providers

1. As the number of new cases is slowed down and the existing cases are recovering, what actions are you taking at this time?

2. Are there communication/dialogue systems in place to enable sharing of information amongst your peers in your community or jurisdiction, in an outbreak or public health emergency as the situation is proceeding, without compromising confidentiality?

Infection Preventionists

1. How has your communication changed with the hospital staff? Are you releasing different messages?
2. Have you communicated to the Emergency Room or physicians on staff about the situation? What information would a patient provide that would be of interest? How is this communicated?
3. Do you communicate to the other hospitals?

Private and Public Laboratorians

1. Are there communication channels between the laboratories, either by calling or by blast fax to make them aware of an ongoing event and to maintain dialogue during an event of this type without compromising confidentiality?
2. Understanding the resource constraints, is it possible that the laboratory analytical process could delay identification of clusters in ongoing outbreaks?
3. If you operate a public laboratory, what is the turnaround and processing time for the PFGE analysis and serotyping of Salmonella? What is your PFGE capacity, and do you typically batch them together for efficiency?

College healthcare, school nurses, school foodservice directors, and administration

1. The Community College decided to serve only pre-packaged, prepared foods. Would you have made this decision? What policies would govern this action? At this point in an evolving foodborne illness that involves your students, would you consider closing the Cafe?
2. Who would make that decision: the foodservice director or the school officials (principal, school superintendent, or school board)?
3. If you are at the school district and the health department is still reporting new cases, what, if any, actions are you taking at this point?
4. Would you be communicating with the parents in the affected communities now that the diagnosis of Salmonella is known?

County and Area Public Health

1. What coordination is being done with Environmental and Clinic staff? How are you sharing information between the different disciplines so everyone is on the same page?

2. What clinical information are you sharing with the public? How are you educating the community on Salmonella and the prevention of infection?
3. What are you communicating and sharing to outside local agencies, communities, or partners about the developments of the outbreak?

Public Health Environmentalist

1. Are there protocols in place to collaborate with other agencies/entities within your jurisdiction during a food emergency incident, including the laboratory and epidemiology organizations? Are these protocols communicated to appropriate offices and individuals? How would it work in this scenario?
2. Do you have routine periodic contact with your regulated industry to build rapport prior to a foodborne illness incident?
3. What authority do you have to collect food samples? How can regulators reach out and engage the regulated industry as soon as possible? What information sharing boundaries or constraints exist?

Foodservice/Processing Industry

1. Does your organization have a crisis management plan to handle a recall based on a foodborne illness?
2. If your organization is contacted by the regulatory agency about a possible illness that implicates your product (or a product consumed at your facility), how do you put your crisis management plan into motion? How quickly can your organization react?
3. If you were the management of Mexican restaurant, what would you be doing at this point? What conversations need to take place related to potential recalls and inventory management? What types of communication would you have with your suppliers, customers and employees? Would you have any communication with the public through the media at this point?

Wrap Up Activities

At your table, please take a few minutes to discuss the questions below as directed by the facilitator. We will then take some time as a large group to identify common themes and takeaways. At the conclusion of this discussion, we ask that you complete the feedback form that will be provided by your facilitator.

Wrap Up Discussion Questions

1. What is the most important thing you learned today in terms of managing an outbreak that impacts multiple jurisdictions?

2. What information do you need to make informed decisions during such an event? If you do not have that information, how do you get it or who makes the decision without it?
3. Do you think this exercise will prompt your organization to evaluate your protocols, policies, and procedures?
4. What top three actions should be taken to ensure proper event management based upon what you have learned from this exercise?

Appendix A: Resources

- ADPH. ADPH Notifiable Disease Rules Updated, Summary of Change, and Alabama Notifiable Diseases/Conditions, www.adph.org/epi
- ADPH. General Counsel HIPPA Letter, www.adph.org/epi, DETECT Reportable Disease
- ADPH. Foodborne Outbreak Website, www.adph.org/epi, Foodborne Outbreak
- CDC. National Outbreak Reporting System. Guidance document for NORS users. http://www.cdc.gov/outbreaknet/pdf/NORS_Guidance_5213_06232009%28compliant%29.pdf
- CIFOR. Diagnosis and Management of Foodborne Illnesses: A Primer for Physicians and Other Health Care Professionals http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5304a1.htm; http://www.cifor.us
- CIFOR. Guidelines for Foodborne Disease Outbreak Response. http://www.cifor.us/CIFORGuidelinesProjectMore.cfm
- CIFOR. Toolkit for the Guidelines for Foodborne Disease Outbreak Response. http://www.cifor.us/toolkit.cfm
- Hedberg, CW et al. 2008. Timeliness of enteric disease surveillance in 6 US states. Emerging Infectious Disease. 14(2):311-313
- CDC. Foodborne Outbreak Investigations. http://www.cdc.gov/outbreaknet/investigations/investigating.html
- Epi-Ready Foodborne Illness Response Strategies http://www.neha.org/epi_ready/
- FDA. Food Safety www.fda.gov/Food/FoodSafety/Foodborneillness/ucm235425.htm
- FDA. Foodborne Illness Environmental Assessments http://www.fda.gov/Food/FoodSafety/FoodborneIllness/ucm235425.htm
- CDC. Outbreak Surveillance Data. http://www.cdc.gov/outbreaknet/surveillance_data.html
- CDC. Foodborne Outbreak Investigations. http://www.cdc.gov/outbreaknet/investigations
- FDA. Foodborne Illness. http://www.fda.gov/Food/FoodSafety/FoodborneIllness/default.htm
- IAFP. Procedures to Investigate Foodborne Illness http://www.foodprotection.org/files/other-publications/procedures-forms.pdf

Appendix B: Acronyms Used

ADPH	Alabama Department of Public Health
BCL	Bureau of Clinical Laboratories
CDC	Centers for Disease Control and Prevention
CHD	County health department
EAR	Environmental Assessment Report
EOIR	Epidemiology Outbreak Investigation Report
EPI	Epidemiology Division
FDA	Food and Drug Administration
FSIS	Food Safety Inspection Service
FSS	ADPH Field Surveillance Staff
GI	Gastro-intestinal
PFGE	Pulsed-Field Gel Electrophoresis
SHO	State Health Officer
SITMAN	Situation Manual
USDA	United States Department of Agriculture