

Pandemic Influenza Plan - Healthcare Systems Readiness

For more information contact Paula F. Nickelson, M.Ed., CHEP at Paula.Nickelson@health.mo.gov or 573.751.5264

INTRODUCTION

The Healthcare Systems Readiness section addresses aspects of healthcare surge capacity and management during a pandemic. The goal of this plan is to prepare healthcare systems to provide medical care in the event of pandemic influenza as well as other large-scale disasters while maintaining other essential medical services in the community during and after the event. For the purposes of this annex, healthcare systems are composed of hospitals and other healthcare facilities which are defined broadly as any combination of the following: outpatient clinics and centers, inpatient facilities and centers and other entities such as emergency medical services and community health centers.

During the interpandemic and pandemic alert periods, either before influenza has been detected or has only been detected outside of the United States, the Missouri Department of Health and Senior Services (DHSS) will emphasize the evaluation or development of institutional plans, infrastructural support, policies/protocols and drills for responding to influenza pandemic. Additionally, DHSS will assist with planning for regional coordination between various components of the healthcare system and local, state, and federal governments. It is important that local healthcare systems including hospitals, primary care centers, home health agencies and long-term care facilities coordinate to allow care for the sickest patients and to maximize resources. Therefore, the development of strong local/regional healthcare coalitions will be instrumental in an effective pandemic response.

During the pandemic period, once pandemic influenza has developed within the United States, DHSS will work in close coordination with other governmental agencies involved in the Unified Command Structure and the established regional healthcare coalitions that participate in the Hospital Preparedness Program as well as other Emergency Support Function 8 (ESF-8) partners. Healthcare systems are largely community assets, thus it is once pandemic influenza has developed locally or regionally that all aspects of this plan will be fully implemented. As influenza progresses in the locality or region from 'mild' to 'moderate' to 'severe', the healthcare systems will accelerate and intensify their response accordingly.

The development of this annex involved professionals with expertise in various facets of the healthcare arena. The recommendations suggested in this annex are intended to be synergistic with those of the other pandemic influenza planning efforts. Throughout the Healthcare Systems Readiness Annex, reference has been made to other Pandemic Influenza Response Plan annexes to assure coordination. This plan does not take the place of individual facility and community planning.

Healthcare entities incorporated into this planning effort include:

- Hospitals.
- Non-hospital settings including primary care centers, outpatient clinics and community health centers.
- Emergency medical services.
- Home care agencies.
- Long-term and other residential care facilities.

OBJECTIVES

- Provide guidance on the key elements of planning for a pandemic influenza in health care settings.
- Emphasize role of infection control practices and staff education and training in reducing the impact of a pandemic.
- Understand the necessity of coordination among healthcare providers, as well as local and state health departments during a pandemic.

BACKGROUND

Originally, the Health Resource Services Administration's (HRSA) Bioterrorism Hospital Preparedness Program (BHPP) was created through Section 3191C-1 of the Public Health Services Act to enhance the ability of hospitals and supporting healthcare systems to prepare for and respond to bioterrorism and other public health emergencies. The funding opportunity subsequently moved to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR), Office of Preparedness and Emergency Operations (OPEO), Division of National Healthcare Preparedness Programs (DNHPP) and will be referred to as the Hospital Preparedness Program (HPP) in this document. This funding has allowed the DHSS, working with federal, state and local partners to build upon the planning and infrastructure efforts of Missouri's healthcare entities.

The DHSS' HPP contracts with Missouri Hospital Association (MHA), St. Louis Area Regional Response System (STARRS) through East-West Gateway Council of Governments, Mid-America Regional Council (MARC), Missouri State Emergency Management Agency (SEMA), Missouri Department of Mental Health (DMH) and the Taney County Ambulance District (TCAD) to develop and enhance preparedness capacity and capability. Collaboration efforts are ongoing within the DHSS' Division of Community and Public Health (DCPH), Division of Regulation and Licensure (DRL), the Division of Senior and Disability Services (DSDS), and the Missouri State Public Health Laboratory (MSPHL) to support preparedness capacity and capability for hospitals and other healthcare entities.

Current and prior DHSS efforts to improve all-hazards and pandemic preparedness activities include:

- Missouri is divided into three regional healthcare coalitions which encompass the Missouri State Highway Patrol's (MSHP) nine response regions resulting in full geographic state coverage.
- Missouri's three regional healthcare coalitions all have the minimum core members of hospitals, emergency medical services, local public health and emergency management, as well as other members dependent upon regional engagement.
- Missouri's three regional healthcare coalitions are all able to activate incident command structures, exercise routinely and have duty officers on call.
- Missouri is currently implementing Tier 2 of the six-tier medical surge capacity and capability model (MSCC) of healthcare coalition planning statewide.
- MHA has taken the lead to engage all hospitals statewide in one collaborative mutual aid agreement, jointly agreeing to support other hospitals within the state during critical staff or supply shortages to the extent such support can occur without resulting in hardship within their own hospital's responsibilities.

- There is also a statewide mutual aid agreement between emergency medical services (EMS), with a state and regional coordinators designated, regional EMS medical directors and a state EMS Medical Director.
- Missouri has also embraced the concept of Immediate Bed Availability (IBA), defined and supported by HHS’s Assistant Secretary for Preparedness and Response as “the ability of the healthcare coalition to provide no less than 20% of bed availability of staffed members’ beds within four hours of a disaster” as a performance measure and a metric of medical surge capacity.
- The DHSS’ Emergency Response Center (ERC) monitors the day-to-day emergency preparedness of the state. A toll-free number is available around the clock for emergencies or disease reporting. Multiple stations are activated in the ERC during a public health emergency event to assure an effective, coordinated response.
- The Medical Incident Coordination Team (M-ICT) is composed of state-level partners from DHSS, SEMA, DMH, and the three healthcare coalitions and/or their fiscal intermediaries with a purpose to provide a structure and defined process for communication, joint decision-making and coordination of deployment of resources regionally or state-wide during any emergency event that requires more than a regional healthcare response while fully recognizing the authority of the Local Emergency Operations Center (LEOC) in every response within their jurisdiction. Any member of the M-ICT may call a meeting at any time to promote situational awareness or coordinate response to an incident.
- Surge support trailers have been purchased and equipped in order to support medical surge on hospital campuses or at other locations across the state as necessary (e.g., alternate care sites) or simply to provide medical surge supplies including personal protective equipment (PPE) to the hospital or other inpatient facility.
- Missouri-1 Disaster Medical Assistance Team (MO DMAT-1) is a fully operational Disaster Medical Assistance Team that is a State asset to Missouri. The system continues to develop and enhance three (3) six-bed Regional (Divisional) Response Trailers and Teams located in three (3) strategic locations around the state: St. Louis, Kansas City and Springfield/Branson areas, as well as three (3) 24-bed mobile emergency departments.
- Ventilator Cache consisting of 247 ventilators, 26 with pediatric capability, has been purchased and a Management, Training and Deployment Plan is in place which includes a defined resource request process for hospitals wishing to access ventilators from the cache.
- In collaboration with the TCAD, DHSS, SEMA and Missouri Homeland Security, a Mobile Medical Hospital (MMH) has been designed and procured by TCAD. The MMH as well is sustained and kept in a deployment ready status by TCAD. This mobile medical hospital is a modular, scalable response package with a 60 bed capacity that can be used to support any hospital in the State of Missouri that has been disabled or destroyed by natural disaster, fire or is in need of expanded resources for surge capacity. The MMH has significant oxygen generation and storage capacity using an Expeditional Deployable Oxygen Concentration System (EDOCS). The EDOC is robust enough for bed side patient oxygen delivery and ventilator support.
- There are respiratory and pulmonary caches located regionally throughout the state with varying capabilities, including oxygen generation capability and ventilators.
- In the 2017 Annual Capacity Assessment Survey of hospitals conducted by MHA, 125/128 responding hospitals had an influenza vaccination policy. Only 12% of the responding hospitals indicated their influenza vaccination policy was voluntary, the remaining

respondents either required influenza vaccines amongst all staff or it was mandatory with potential exceptions.

- DHSS, through a contract with the SEMA, maintains Missouri's Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) known as Show-Me Response in cooperation with the Missouri Division of Professional Registration. This web-based registry of over 10,000 registered volunteers includes representatives from the 20 health care occupations prescribed by HHS. Show-Me Response is a robust database, credentialing and communication tool that is used by Medical Reserve Corps (MRC) units, local public health agencies (LPHAs), SEMA for both MO DMAT-1 and Missouri Mortuary Operations Response Team (MO MORT 1) and other response partners for the management of volunteers. The Show-Me Response registry includes over 6,000 licensed health professionals and 4,000 lay volunteers. Fifty-six percent of Show-Me Response registrants are affiliated with MRC, LPHA, or other user organizations. This system is exercised regularly and will be activated during times of emergency to assist in the coordination of additional staff.
- MHA, through a contract with DHSS, manages two web-based programs for hospitals and other healthcare providers called eICS[®] and EMResource[®].
- The first, eICS[®], is an electronic incident command system specifically customized for healthcare organizations and is used routinely by hospitals when they activate their incident command structures for exercise or a real-world event from the scene of a medical surge event through the transfer to their final destination for healthcare, and includes information about the patient's condition, medications and treatments. EMResource[®] has been used statewide by hospitals for several years to communicate information about their current emergency department status to ambulance services and other healthcare partners. Health alerts and amber alerts are examples of other information posted by the state to hospitals, public health and ambulance services and other users of EMResource[®].
- Through EMResource[®], DHSS has the ability to conduct a query of hospitals to determine bed types and bed availability, as well, as situational assessment, such as current level of operations, facility stress indicators, and ventilator availability. Standard queries are available and used routinely during influenza season to determine supply levels, staffing issues, etc.
- Hospitals, EMS, and Federally Qualified Health Centers (FQHCs) have received personal protective equipment and received hands-on training.
- Hospitals have well-established and proven supply agreements for PPE and other resources.
- Hospitals, LPHAs and FQHCs routinely exercise dispensing of antivirals within their communities and many serve as closed points of dispensing.
- In order to assure secure redundant communication systems, equipment has been received by hospitals and FQHCs through a standardized purchase ordering system to assure interoperability that includes satellite telephones, 550 Motorola HT 1250 16-channel programmable handheld radios, amateur radio systems and Motorola MTR 2000-97 channel, 100 watt base station radios and Missouri Statewide Wireless Interoperable Network (MOSWIN) radios. Regional communication hubs with interoperable and redundant communication systems have been identified in each region.
- Competency based education has been provided to hospitals and other healthcare entities through contracts with MHA, STARRS, and MARC.
- DMH staff provides behavioral health education as well as communication tools and other resources. DMH has published and trained extensively on "The Behavioral Health Emergency Plan Template for Health Care Organizations" located at

<https://dmh.mo.gov/media/pdf/behavioral-health-emergency-plan-template-health-care-organizations>.

- Educational materials, including Ready in 3 guides, have been provided for patients, family members, and the public regarding influenza, as well as disaster related events.
- DHSS MSPHL has conducted a hospital laboratory assessment and provides resources and training to hospital laboratory personnel on various topics including packaging and shipping of diagnostic and infectious materials, Rule Out/Refer of Select Agents and Risk Assessment.
- Surveillance systems allow all rural and urban hospitals, EMS and the Poison Control Center to report data that is suggestive of influenza to their local and state health departments on a 24 hours a day, seven (7) days a week basis.
- Health alerts are sent to healthcare providers on acute public health issues through the Health Alert Network.
- Hospitals, LPHAs, FQHCs and other regional/state partners conduct individual and regional exercises throughout the year.
- Pandemic exercises are conducted.
- DHSS conducts regular meetings with HPP program contractors to update them on issues of concern, including pandemic preparedness planning.

CHALLENGES

- The absence of statewide consensus on approach to crisis standards of care.
- The absence of statutory or regulatory guidance to address liability concerns regarding crisis or emergency standards of care.
- Lack of personnel to staff surge capacity needs, dependent upon the length of the pandemic.
- Potential for inadequate personal protective equipment for surge levels, dependent upon the length of the pandemic.
- Assurance of coordination between the healthcare system entities.
- ESAR-VHP (Show-Me Response) will only be effective if personal liability, institutional liability and worker's compensation for healthcare providers volunteering during an emergency are addressed.
- Willingness of healthcare providers to voluntarily receive influenza vaccinations.

PLANNING ASSUMPTIONS

- All hospitals need to be prepared as there will be no designated pandemic influenza hospitals.
- Absenteeism could rise to 40%, severely crippling critical services including first responders, healthcare workers, etc.
- Hospitals may experience shortage of beds, medications, supplies, and staff. The level of the shortages will increase with the duration and severity of the pandemic.
- Emergency medical services may be severely strained in some areas, dependent upon the duration and severity of the pandemic.
- Waiting times to primary care physicians, clinics and hospital emergency departments may become very lengthy in some areas.
- Hospitals and other healthcare entities will not be able to rely on external resources beyond what they have already prepared locally. Using the Incident Command System, additional resources, if available, will be coordinated through State Emergency Operations Center (SEOC) and DHSS' ERC.

- Basic hygiene/cough etiquette and infection control strategies may have to be reiterated and encouraged.
- The EMResource® will be used as an inquiry and data collection tool, as well as healthcare coalition communication tool, that will allow agencies to anticipate potential shortages in beds, staff, and equipment.
- Biosense and Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) will be used for syndromic data collection.
- Communication and coordination among providers at the local and regional level is ongoing.
- Pandemic influenza plans are exercised and equipment tested routinely, including periodic unannounced tests.
- Healthcare entities will assure access to EMResource® in locations throughout the organization that are easily accessible to all appropriate personnel.
- An effective healthcare response to pandemic influenza will require utilizing non-hospital based healthcare providers outside of hospital settings in order to decrease the likelihood of surges that would overwhelm hospital capability.
- Physicians in all healthcare settings must be fully integrated into plans for the healthcare response.

ROLE OF HOSPITALS:

Planning (Refer to www.hhs.gov.)

All hospitals are encouraged to establish an ongoing planning committee and develop written pandemic influenza plans (See Attachment C.), inclusive of decision-making structures (Incident Command Management System) for responding to pandemic influenza. The checklist from HHS may be useful in developing individual facility plans that encompass disease surveillance, hospital communications both internally and externally, education and training, exercises, surge capacity, infection control, security, occupational health, and mortuary issues, which are addressed respectively below.

As well, the regional healthcare coalitions may wish to consider using the “Healthcare Coalition Influenza Pandemic Checklist” as a guide to their planning with healthcare coalition partners. <https://files.asprtracie.hhs.gov/documents/aspr-tracie-hcc-pandemic-checklist-508.pdf>

Integral to the effectiveness and sustainability of the hospital during a pandemic influenza surge event, will be the local or regional healthcare system partnerships and the regional healthcare coalitions developed during non-event periods. These coalitions should include all core members of the healthcare coalition including hospitals, emergency medical services, local public health and emergency management, but should be enhanced with other healthcare system partners such as long-term care facilities, home health agencies, mental health, outpatient clinics, federally qualified health and community health centers to the extent possible.

Surveillance (Refer to Surveillance Annex.)

During the pre-pandemic period, individual health care providers and healthcare facilities play an essential role in surveillance for suspected cases of infection with novel strains of influenza and should be on the alert for such cases. Novel strains may include avian or animal influenza strains, such as avian influenza A H5N1 or novel influenza A strains, or re-emergent human viruses that cause human disease. Thus, surveillance needs will require hospitals to have systems in place

during the early pandemic period to timely identify patients at risk for infections with novel influenza strains. All patients, especially those whose primary presentation is not for influenza-like-illness (ILI), should be monitored closely for development of clinical signs of influenza during their hospital admission to detect illness and mitigate transmission of influenza throughout the hospital. Healthcare personnel involved in direct patient care should incorporate screening for the current available case definition of influenza while evaluating patients. Patients meeting these criteria should be reported immediately. These patients should receive pandemic influenza evaluation and appropriate infection control strategies should be implemented.

Hospital surveillance for pandemic influenza should include monitoring employee absenteeism, tracking emergency department visits, hospital admissions and discharges of suspected or laboratory-confirmed pandemic influenza patients, and conducting surveillance in emergency departments to detect any increase in ILI. Monitoring employee absenteeism should be implemented during the early pandemic period. All healthcare employees should be able to recognize the signs, symptoms, and risk factors of pandemic influenza and understand protocols for exclusion from work, and report their illness at the time of onset. Employees with symptoms of pandemic influenza should report to their employee health/occupational health office or similar designated offices. Hospitals should maintain a database of employees who are identified as ill and exposed from these screening programs to track staff and to direct treatment and prophylaxis. Staff surveillance during a pandemic will be critical in maintaining appropriate levels of staffing in the hospital.

Procedures should be in place to assess bed capacity and staffing needs, support local public health personnel in monitoring the progress and impact of the pandemic, detect a resurgence in pandemic influenza that might follow the first wave of cases, and antiviral treatment of healthcare workers who might be infected with the influenza virus. Hospitals should participate in the DHSS' surveillance systems including syndromic surveillance, hospitalization surveillance, and laboratory surveillance, as well as the EMResource®.

Communication (Refer to Public Communications Annex.)

Hospitals should work with the regional healthcare coalitions, public health officials, other government officials, neighboring healthcare facilities, the public and the press to ensure rapid and ongoing information sharing during an influenza pandemic. Each hospital should have a well-developed crisis communication plan fully integrated into the overall emergency response plan. Weekly or daily updates on hospital operations may improve internal, as well as external communications.

Hospitals should routinely communicate with their respective regional healthcare coalition regarding resource shortages or anticipated shortages, to include staff, and may be asked to provide updated surge capacity and resource availability via queries through EMResource®.

Health care facilities should assign responsibility for external communication about pandemic influenza. Persons responsible for updating public health reporting, a clinical spokesperson, and a media spokesperson should be identified. Providing accurate and consistent information will be critical during the pandemic.

The hospital should provide key messages regarding basic hygiene/cough etiquette, infection control, antivirals and vaccines, and general pandemic influenza updates to both their staff and

patients. With guidance from state or local health department, the healthcare facility should determine methods, frequency and scope of external communications. For example, the hospital should provide effective risk communication messages to gain the public's cooperation and trust relative to limiting hospital care to those most likely to benefit from that level of care.

Each hospital should communicate their plan to their staff and the LPHA. Policies dealing with various human resource related issues during a pandemic should be developed and clearly explained to staff, and available upon request. Hospitals should maintain up-to-date contact lists for all facility personnel including phone numbers, e-mail and home street address. Each hospital should assure redundant communication systems are available, for example to ramp up the ability to handle phone calls. Hospitals should assure systems are established to receive and distribute health alerts, ensure an ongoing system to monitor the EMResource[®] is implemented, coordinate with their LPHA to share contact information, and implement a plan regarding how communications will flow between local and regional healthcare facilities.

Education and Training

The healthcare facility's pandemic influenza plan should establish education and training goals consistent with the clinicians' and ancillary healthcare providers' needs during various stages of the pandemic. Training materials should be available in different languages and at different reading levels, as necessary. General topics for **staff education** might include prevention and control of influenza, implications of pandemic influenza, benefits of annual influenza vaccination, role of antiviral drugs in preventing disease and reducing rates of severe influenza and its complications, infection control strategies, hospital-specific work restriction policies and procedures and creating family preparedness plans. All staff should be aware of proper donning and doffing of PPE and uses for items. Clinic-specific topics might include policies and procedures for the care of pandemic influenza patients, pandemic staffing contingency plans, reporting protocols to the state or local health department, and measures to protect family and other close contacts.

As the community's experience with the influenza progresses from "mild" to "moderate" to "severe", the healthcare system may need to implement additional 'just in time' trainings specific to clinical needs at the time and based upon pandemic management planning. For instance, training on intake and triage to detect patients with influenza symptoms and to implement immediate containment measures to prevent transmission or guidance to behavioral health workers for providing psychological support to patients and hospital personnel (Refer to Mental Health Annex.). As well, it will likely be necessary to implement cross training of personnel to provide support for essential patient-care areas at times of severe staffing shortages. Health care facility staff should be educated about the importance of being immunized, vaccine safety, and the rationale for vaccine prioritization when it becomes available.

Education and training should be designed and implementation plans prepared to expand healthcare personnel capacity beyond the normal scope of practice protocols, in the event of a gubernatorial executive order allowing such expanded scopes of practice.

To **educate visitors** to the health care facility, signs and placards applicable to infection control and general influenza information should be posted in various places within the hospital and should be of varying education levels. Educational campaigns should include signage posted in

common areas (elevators, waiting areas, cafeterias, lavatories, break rooms, etc.) in appropriate languages and literacy levels to assist with infection control.

Hospitals and other health care facilities should develop plans for communication of their strategy regarding use and distribution of **vaccine and antivirals** consistent with the local and state public health agencies' recommendations.

Employees, visitors, and patients should learn and understand the proper usage of PPE through fit testing, hands-on activities, and flyers posted in common areas in appropriate language and literacy levels. Pre-made flyers describing the basics of disease transmission should also be considered. Facility staff should be informed of the protocols for visitor and patient PPE requirements.

The healthcare facilities should actively participate in pandemic influenza response exercises and drills, incorporating lessons learned into response plans.

Surge Capacity

Hospital surge planning may be enhanced by considering categories of conventional, contingency and crisis capacity. Four interdependent factors – system, space, staff, and supplies – contribute to effective surge capacity. The levels of surge capacity are defined as:

- Conventional capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.
- Contingency capacity – The spaces, staff, and supplies used are not consistent with daily practices but maintain or have minimal impact on usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources).
- Crisis capacity – Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available).

System

The pre-event healthcare planning and written pandemic influenza response plan should outline the hospital's incident command structure, indicating processes, triggers for implementation and interface with local, regional and state emergency management and public health. The hospital should monitor the EMResource[®] routinely and report to DHSS in order to coordinate requests for hospital closure, diversion or decreases in services. As well, healthcare planning should anticipate the potential necessity of implementing crisis or emergency standards of care during severe stages of a pandemic, hospitals should consult with DHSS and other regulatory agencies, prior to implementing altered standards of care.

The hospital should ensure effective triage and isolation procedures are in place to facilitate the early recognition and appropriate management of patients presenting with clinical symptoms and/or epidemiologic risk factors for influenza due to novel strains, as well as minimize the risk of transmission. This may include assigning a triage coordinator to manage patient flow, including deferring or referring patients who do not require emergency care (conventional to contingency), as well as establishing a separate triage evaluation area for

persons with respiratory symptoms. As the pandemic progresses, it may be useful to activate streamlined admission procedures, criteria and procedures for phone triage, cross-train staff from other parts of the hospital or community to assist with triage and admission, and activate external triage stations or evaluation units (contingency to crisis). Triage and admission guidelines should triage patients to the appropriate level of care including home care.

The hospital may wish to cohort patients admitted for influenza, monitor for nosocomial infections, discharge patients as soon as possible, defer elective admissions, and provide visual alerts regarding the need for patients with fever and respiratory symptoms to proceed directly to triage and adhere to respiratory and hand hygiene precautions (conventional to contingency). During moderate and severe levels of the pandemic, the hospital may need to limit admission of influenza patients to those with severe complications who can only be cared for in the hospital setting (contingency to crisis).

Space

During conventional and contingency surge, space within the hospital should be prioritized for pandemic patients by implementing plans for rapid patient discharge, canceling elective surgery, establishing separate waiting areas for persons who are symptomatic, and cohorting patients admitted with influenza. As the pandemic progresses to contingency and severe surge, the hospital should implement policies and procedures for shifting patients between nursing units to free up bed space in critical care areas, cohort patients, collaborate with home health agencies to arrange at-home follow-up care for patients who have discharged early or admission has been deferred, determine if emergency procedure patients may be transferred/referred to other hospitals, activate surge capacity trailers, and consider opening alternate care site(s). In general, the hospital should coordinate with other outpatient clinics and community health centers, hospitals, home health agencies and long-term care facilities to allow hospitals to care for the sickest patients, and to maximize resources of other healthcare facilities and home care agencies to care for those less severely ill.

Depending on the severity of the pandemic, alternate care facilities may be necessary. Health care facilities should develop plans for alternate care site(s) incorporating issues of staffing, supplies, triage, and infection control. Upon establishment of an alternate care site(s), the health care facility is obligated to notify DHSS' Division of Regulation and Licensure (DRL) which is then responsible to monitor the alternate care site(s).

Staff

Strategies to consider during conventional to contingency surge staffing include furloughing or reassigning pregnant staff and other staff at high risk for complications of influenza, reassigning non-essential staff to support critical hospital services, expanding staff shifts, and cohorting staff or assigning staff recovering from influenza to care for influenza patients. Moderate to severe levels of pandemic influenza in the community will likely result in contingency to severe surge staffing. Strategies to consider at these levels of the pandemic include activating the mutual aid agreement through MHA which is signed by Missouri hospitals to access additional staff, recruiting community volunteers (retired nurses and physicians, clinical staff working in outpatient settings), requesting DHSS to activate the ESAR-VHP or Show-Me Response, requesting assistance from MRC, requesting healthcare staffing via the Emergency Management Assistance Compact (EMAC), activating the

Missouri National Guard, requesting assistance from trainees (e.g., medical and nursing students), and requesting assistance from patients' family member in an ancillary healthcare capacity.

Supplies

The hospital should evaluate the existing system for tracking available medical supplies in the facility and determine how/when to stockpile consumable resources, considering resources for a pandemic wave of six to eight weeks' duration. The hospital should develop a strategy for acquiring additional respiratory care equipment and to maintain antibiotics to treat bacterial complications of influenza. Systems should be developed for tracking hospital supplies as well as working with vendors to ensure a continued supply of available resources. The hospital should coordinate with the LPHA to determine needed doses of vaccine and antivirals for identified high priority groups (conventional to contingency). Contingency plans for situations where medical supplies become limited should also be developed.

As the pandemic increases in severity or extends in duration, it may be necessary for the hospital to access supplies from regional surge trailers, pulmonary caches, managed inventory from the Strategic National Stockpile or other state or federal supply requests as deemed necessary. These requests should be coordinated with local EOC (Emergency Operations Center), or Health Emergency Operations Centers (HEOCs) in some jurisdictions, according to Local Incident Management System and established process (contingency to crisis).

Infection Control

It will be necessary for healthcare facilities to practice and reinforce the stringent use of infection control measures in order to prevent the spread of influenza. Strict adherence to handwashing recommendations and universal public health measures will be paramount during a pandemic. Pre-pandemic planning should ensure adequate supplies of hand hygiene products in all health care settings to anticipate possible shortages of hand antiseptics products, soap and hand towels. Hospitals should post signs for respiratory hygiene/cough etiquette. Patients with potential pandemic influenza should be identified, isolated and treated. The hospital should use triggers relative to signs/symptoms of pandemic influenza to escalate screening procedures of all persons entering the hospital to a more active level. Hospitals should accelerate the training of staff relative to infection control measures, in accordance with the clinic's pandemic influenza education and training plan, as well as consider site-specific infection control issues.

In order to reduce hospital-related transmissions, protocols to cohort staff and patients, as well as restrict new admissions (except for other pandemic influenza patients) to affected units should be considered. Cohorting patients in the designated areas of the hospital should be considered from the start of the influenza pandemic in order to contain infection within a segregated part of the hospital and thereby reduce the risk to other patients. Establishing separate entrances and exits when a dedicated area is segregated for influenza patients could be beneficial, as this would allow staff to put on PPE prior to entry to the area away from where they remove PPE after leaving that area. Hospitals should develop appropriate procedures and policies for restricting patients and staff movement within the hospital to allow proper functioning of influenza and non-influenza treatment zones. Limiting the movement of patients, including transfers within the hospital, could limit the spread of influenza within the facility.

Designated influenza areas should be cleaned at least daily, with special attention to potentially highly contaminated surfaces, such as bed rails, furniture, door handles, and bathroom fixtures. Routine cleaning procedure after patient discharge is expected to be adequate. **Visitors** should be informed when the Health Care Facility (HCF) has influenza activity. During a pandemic, visitation should be kept to a minimum, and restriction of visiting hours should be considered. Visitors with influenza symptoms should be prohibited from entering clinical areas. Visitors entering influenza treatment areas must be instructed on standard infection control principles and the wearing of protective equipment, as appropriate. Visitors' use of PPE should be determined by their level of interaction with the patients and staff.

Volunteers should report to and sign in at the area specially designated for them. Volunteers should not move between influenza designated and non-influenza areas. Instruction in standard infection control practices, including specific instruction on PPE, should be provided.

Occupational Health

The development and implementation of an occupational health plan in the healthcare setting will help maintain a healthy workforce, both to assure adequate staff capacity to provide care to their patients as well as decrease the likelihood of healthcare staff exposing their patients to the influenza. Essential components will protect healthy workers from exposures in the healthcare setting, as well as evaluate and manage symptomatic and ill healthcare personnel.

Hallmarks of an occupational health plan will include basic hygiene/cough etiquette, infection control strategies, and vaccination. All healthcare personnel, including employees with non-patient care responsibilities, should be encouraged to voluntarily receive the influenza vaccine annually, unless the healthcare worker has specific medical restrictions prohibiting use of the vaccine. The healthcare system's plan should include distribution and administration of antiviral drugs and/or vaccines to healthcare personnel as recommended, as well as a system for documenting the vaccination of healthcare personnel. Prophylaxis antivirals should be available for healthcare providers, according to HHS and DHSS guidelines.

The healthcare system should provide information to staff regarding the importance of creating family emergency preparedness plans in advance of an emergency (<http://health.mo.gov/emergencies/readyin3/>). For pandemic influenza, the family emergency preparedness plan may include provisions for alternate care for children and elderly family members, should they become ill. Basic hygiene/ cough etiquette, infection control and vaccination may be appropriate considerations.

Clear guidance and work restriction policies should be formulated and clearly communicated prior to a pandemic influenza regarding the need for staff to stay at home in the event of fever and respiratory symptoms. The healthcare system should clearly communicate what actions an employee takes if onset of illness occurs during work or at home. If possible, it may be advantageous to reassign healthcare providers that are at high risk for complications of influenza to lower risk jobs that do not involve direct care of suspected pandemic patients.

During an influenza outbreak, the healthcare system should establish regular updates for clinicians, direct patient care staff and screening/triage staff on the current status of the pandemic and any changes in the recommendations for management of influenza patients. The plan should include provisions for ‘just in time’ training and education for all healthcare personnel, as needed.

The healthcare system’s plan should also include provisions for psychosocial and mental health needs of healthcare personnel and their families. These provisions should be designed to assist healthcare workers to deal with the stress of separation from family members for extended periods which may be necessary during a pandemic, as well as the stress of dealing with very ill patients and potentially multiple fatalities.

Human Resources

During the pre-pandemic period, procedures should be developed regarding human resources policies for the pandemic period. The policies should be formulated for annual leave, sick leave, compensation, hiring, furloughing, workers’ compensation, and Family Medical Leave Act (FMLA).

Security

Security in the healthcare setting will play a pivotal role during a pandemic. Additional security may be required because of the increased demand for services and possibility of long wait times, and because triage or treatment decisions may lead to people not receiving the care they think they require.

It will be important to implement restrictions on facility access, including limiting the number of visitors to those essential for patient support, assign clinical staff to entry screening, screen visitors at the point of entry to the facility for signs and symptoms of influenza, and limit points of entry to the facility. Each health care facility should consider their unique needs for security planning. Security personnel should participate in education and exercise opportunities, upgrade security equipment as necessary, and cross-train appropriate personnel in preparation for workforce reductions due to illness.

The Missouri National Guard may be activated to provide or augment security at vaccination, distribution, quarantine or hospital treatment sites.

Mortuary Issues (Refer to Mass Fatality Management Annex.)

A planning workgroup, including the coroner/medical examiner, should develop strategies to address fatality surge. The workgroup should determine the scope and volume of supplies needed to handle an increased number of deceased persons, assess the current capacity for refrigeration, identify temporary morgue sites, and identify any regional supplies or assets for body storage.

ROLE OF NON-HOSPITAL HEALTHCARE SYSTEM PARTNERS

Emergency Medical Service and Non-Emergency Medical Transport

(Refer to Attachment C.)

Emergency medical organizations will be involved in the transport of acutely ill patients with known or suspected pandemic influenza to emergency departments. It is anticipated that some of

these patients might require mechanical ventilation for life support and/or other lifesaving interventions. Non-emergent (medical) transport organizations will be called upon to transport recovering pandemic influenza patients to their home, residential care facility, or possibly to alternative care sites.

The Missouri National Guard may be activated to provide ground or air support for medical or casualty evacuation.

Emergency and non-emergency medical transport organizations should promote occupational health principles as outlined in this plan, including promotion of basic hygiene/cough etiquette, infection control measures, vaccinations for staff, and prophylaxis antivirals as directed by HHS and DHSS. EMS may wish to use the state-wide mutual aid agreement to augment regional staffing, recognizing that all regions may be experiencing staffing shortages.

Home Healthcare Services (Refer to Attachment E.)

In addition to providing care to their existing patients, home health agencies will likely be called upon to provide care for patients who do not require hospitalization for pandemic influenza, or for whom hospitalization is not an option because hospitals have reached their capacity to admit patients. These agencies may become overburdened very quickly and shortages of personnel and supplies providing home healthcare may occur.

It is incumbent upon both the home health agency and local/regional hospital(s) or healthcare systems to plan collaboratively prior to a pandemic influenza event regarding how the home health agencies' personnel might be optimally utilized during the surge of an event. All healthcare system partners in communities are encouraged to engage in their local/regional healthcare partnership or coalition. Pre-planning will allow the systems partners to provide more seamless care at the time of the event, increase communication across systems and relieve some of the stress of providing care during patient surge for all partners.

Non-Hospital Services, Including Outpatient Clinics and Community Health Centers

Planning an effective delivery of care in outpatient settings is critical. To maintain essential medical services, careful coordination will be needed between hospitals, outpatient care clinics and community health centers. The emphasis will be on allowing hospitals to care for the sickest patients, regardless of etiology, and to maximize the resources of other healthcare facilities and home care agencies to care for those less severely ill and/or at lower risk for complications or death, as well as those less likely to survive even with critical care support. Appropriate management of outpatient influenza cases will reduce progression to severe disease and thereby reduce demand for inpatient care.

It is incumbent upon both the outpatient clinic or community health center and local/regional hospital(s) or healthcare systems to plan collaboratively prior to a pandemic influenza event regarding how the outpatient clinics' or community health centers' personnel might be optimally utilized during the surge of an event. All healthcare system partners are encouraged to engage in their local/regional healthcare partnership or coalition. Pre-planning will allow the systems partners to provide more seamless care at the time of the event, increase communication across systems and relieve some of the stress of providing care during patient surge for all partners.

Residential Care, Skilled Nursing, Assisted Living and Other Long-Term Care Facilities

(Refer to Attachment F.)

All levels of long-term care facilities should also follow the basic principles outlined within this plan within their own facility including healthcare planning, establishing occupational health policies and protocols, reinforcing basic hygiene/cough etiquette, infection control, promotion of vaccines, and antiviral prophylaxis for staff, as guided by HHS and DHSS. It is assumed long-term care facilities will have the staff, supplies and other resources to provide influenza care for their own patients.

Attachment A
Flu Surge Estimates of the Health Care Impact
from Pandemic Influenza in Missouri

Main Menu

Close

Step 1: Determine population of locale by age groups:

Age Group	Population
0-19 yrs	1,437,342
20-64 yrs	3,713,135
+ 65 yrs	838,450

Enter Data in
WHITE
boxes only!

View or
Change
Assump-
tions

Step 2: Determine basic hospital resources:

Total licensed non-ICU beds:	23,854
% licensed non-ICU beds staffed:	60%
Total staffed non-ICU beds:	14,312
Total licensed ICU beds:	2,124
% licensed ICU beds staffed:	90%
Total Staffed ICU beds:	1,912
Total number of ventilators:	2,000
% ventilators available:	10%
Total number of ventilators available:	200

Step 3: Determine duration (6, 8, or 12 weeks) and attack rate (15%, 25% or 35%) of the pandemic:

Duration: 8

Attack rate: 25%

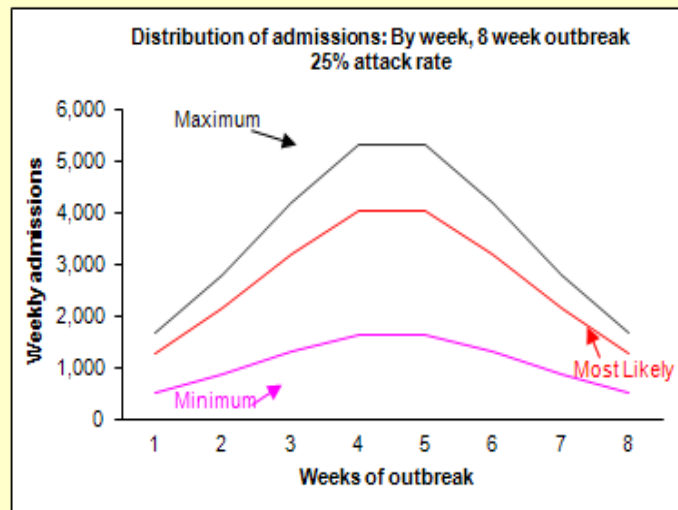
Step 4: [Click to View Results](#)

Notes: 1. Sample data are from Metropolitan Atlanta.

2. Duration (pandemic duration) refers to the number of weeks you assume the pandemic wave to last.

3. Attack rate (gross clinical attack rate) refers to the percentage of the population that became clinically ill due to pandemic influenza.

Pandemic Influenza Impact / Attack Rate	25%
Total Hospital Admissions	
Most Likely Scenario	21,204
Minimum Scenario	8,578
Maximum Scenario	27,923
Total Deaths	
Most Likely Scenario	4,265
Minimum Scenario	2,521
Maximum Scenario	6,996



Hosp Adm. / Week	1	2	3	4	5	6	7	8
Most Likely Scenario	1,272	2,120	3,181	4,029	4,029	3,181	2,120	1,272
Minimum Scenario	515	858	1,287	1,630	1,630	1,287	858	515
Maximum Scenario	1,675	2,792	4,188	5,305	5,305	4,188	2,792	1,675

Pandemic Influenza Impact / Weeks		1	2	3	4	5	6	7	8	9	10
Hospital Admission	Weekly admissions	1,272	2,120	3,181	4,029	4,029	3,181	2,120	1,272		
	Peak admissions/day				628	628					
Hospital Capacity	# of influenza patients in hospital	935	1,559	2,338	2,961	3,066	2,695	2,067	1,356		
	% of hospital capacity needed	7%	11%	16%	21%	21%	19%	14%	9%		
ICU Capacity	# of influenza patients in ICU	191	405	622	821	888	864	687	474		
	% of ICU capacity needed	10%	21%	33%	43%	46%	45%	36%	25%		
Ventilator Capacity	# of influenza patients on ventilators	95	202	311	410	444	432	343	237		
	% usage of ventilator	48%	101%	155%	205%	222%	216%	172%	119%		
Deaths	# of deaths from influenza			256	427	640	810	810	640	427	256
	# of influenza deaths in hospital			179	299	448	567	567	448	299	179

Notes: 1. All results showed in this table are based on most likely scenario.

2. Number of influenza patients in hospital, in ICU, and number of influenza patients on ventilators are based on maximum daily number in a relevant week.
3. Hospital capacity used, ICU capacity used, and % usage of ventilator are calculated as a percentage of total capacity available (see manual for details).
4. The maximum number of influenza patients in the hospital each week is lower than the number of weekly admissions because we assume a 5-day stay in general wards (see manual for details).

**Attachment B –
Hospital Checklist**

Preparedness Subject	Actions Needed
1. Structure for planning and decision making	
<ul style="list-style-type: none"> • An internal, multidisciplinary planning committee for influenza preparedness has been created. 	
<ul style="list-style-type: none"> • A person has been designated as the influenza preparedness coordinator. (Insert name) _____ 	
<ul style="list-style-type: none"> • Members of the planning committee include the following hospital staff members (insert names) <ul style="list-style-type: none"> ○ Administration _____ ○ Legal counsel _____ ○ Infection control _____ ○ Hospital disaster coordinator _____ ○ Risk management _____ ○ Facility engineering _____ ○ Nursing administration _____ ○ Medical staff _____ ○ Intensive care _____ ○ Emergency Department _____ ○ Laboratory services _____ ○ Respiratory therapy _____ ○ Psychiatry _____ ○ Environmental services _____ ○ Public relations _____ ○ Security _____ ○ Materials management _____ ○ Staff development _____ ○ Occupational health _____ ○ Diagnostic imaging _____ ○ Pharmacy _____ ○ Information technology _____ ○ Other members _____ ○ Other members _____ 	
<ul style="list-style-type: none"> • A state or local health department person has been identified as a committee liaison. (Insert name) • A linkage with local or regional emergency preparedness groups has been established. (Planning organization) 	

2. Development of a written pandemic influenza plan	
<ul style="list-style-type: none"> • A written plan has been completed or is in progress that includes the elements listed in #3 below. 	
<ul style="list-style-type: none"> • The plan specifies the circumstances under which the plan will be activated. 	
<ul style="list-style-type: none"> • The plan describes the organization structure that will be used to operationalize the plan. 	
<ul style="list-style-type: none"> • Responsibilities of key personnel related to executing the plan have been described. 	
<ul style="list-style-type: none"> • A simulation exercise has been developed to test the effectiveness of the plan. 	
<ul style="list-style-type: none"> • A simulation exercise has been performed. (Date performed _____) 	
3. Elements of an influenza pandemic plan	
<ul style="list-style-type: none"> • A surveillance plan has been developed. <ul style="list-style-type: none"> ○ Syndromic surveillance has been established in the emergency room. ○ Criteria for distinguishing pandemic influenza is part of the syndromic surveillance plan. ○ Responsibility has been assigned for reviewing global, national, regional, and local influenza activity trends and informing the pandemic influenza coordinator of evidence of an emerging problem. (Name _____) ○ Thresholds for heightened local surveillance for pandemic influenza have been established. ○ A system has been created for internal review of pandemic influenza activity in patients presenting to the emergency department. ○ A system for monitoring for nosocomial transmission of pandemic has been implemented and tested by monitoring for non-pandemic influenza. 	
<ul style="list-style-type: none"> • A communication plan has been developed. <ul style="list-style-type: none"> ○ Responsibility for external communication has been assigned. <ul style="list-style-type: none"> ▪ Person responsible for updating public health reporting _____ ▪ Clinical spokesperson for the facility _____ ▪ Media spokesperson for the facility _____ ○ Key points of contact outside the facility have been identified. <ul style="list-style-type: none"> ▪ State health department contact _____ ▪ Local health department contact _____ ▪ Newspaper contact(s) _____ ▪ Radio contact(s) _____ 	

<ul style="list-style-type: none"> ▪ Public Officials(s) _____ <ul style="list-style-type: none"> ○ A list of other healthcare facilities with whom it will be necessary to maintain communication has been established. ○ A meeting with local healthcare facilities has been held to discuss a communication strategy. ○ A plan for updating key facility personnel on a daily basis has been established. <p>The person(s) responsible for providing these updates are: _____</p> <ul style="list-style-type: none"> ○ A system to track pandemic influenza admissions and discharges has been developed and tested by monitoring non-pandemic influenza admissions and discharges in the community. ○ A strategy for regularly updating clinical, emergency department, and outpatient staff on the status of pandemic influenza, once detected, has been established. (Responsible person _____.) ○ A plan for informing patients and visitors about the level of pandemic influenza activity has been established. 	
<ul style="list-style-type: none"> • An education and training plan on pandemic influenza has been developed. <ul style="list-style-type: none"> ○ Language and reading level-appropriate materials for educating all personnel about pandemic influenza and the facility’s pandemic influenza plan, have been identified. ○ Current and potential sites for long-distance and local education of clinicians on pandemic influenza have been identified. ○ Means for accessing state and federal web-based influenza training programs have been identified. ○ A system for tracking which personnel have completed pandemic influenza training is in place. ○ A plan is in place for rapidly training non-facility staff brought in to provide patient care when the hospital reaches surge capacity. 	
<ul style="list-style-type: none"> • The following groups of healthcare personnel have received training on the facility’s influenza plan: <ul style="list-style-type: none"> ○ Attending physicians ○ House staff ○ Nursing staff ○ Laboratory staff ○ Emergency Department personnel ○ Outpatient personnel ○ Environmental Services personnel ○ Engineering and maintenance personnel ○ Security personnel ○ Nutrition personnel 	
<ul style="list-style-type: none"> • A triage and admission plan has been developed. <ul style="list-style-type: none"> ○ A specific location has been identified for triage of patients with possible pandemic influenza. 	

<ul style="list-style-type: none"> ○ The plan includes use of signage to direct and instruct patients with possible pandemic influenza on the triage process. ○ Patients with possible pandemic influenza will be physically separated from other patients seeking medical attention. ○ A system for phone triage of patients for purposes of prioritizing patients who require a medical evaluation has been developed. ○ Criteria for determining which patients need a medical evaluation are in place. ○ A method for tracking the admission and discharge of patients with pandemic influenza has been developed. ○ The tracking method has been tested with non-pandemic influenza patients. 	
<ul style="list-style-type: none"> ● A facility access plan has been developed. <ul style="list-style-type: none"> ○ Criteria and protocols for closing the facility to new admissions are in place. ○ Criteria and protocols for limiting visitors have been established. ○ Hospital security has had input into procedures for enforcing facility access controls. 	
<ul style="list-style-type: none"> ● An occupational health plan has been developed. <ul style="list-style-type: none"> ○ A system for rapidly delivering vaccine or antiviral prophylaxis to healthcare personnel has been developed. ○ The system has been tested during a non-pandemic influenza season. ○ A method for prioritizing healthcare personnel for receipt of vaccine or antiviral prophylaxis based on level of patient contact and personal risk for influenza complications has been established. ○ A system for detecting symptomatic personnel before they report for duty has been developed. ○ This system has been tested during a non-pandemic influenza period. ○ A policy for managing healthcare personnel with symptoms of or documented pandemic influenza has been established. The policy considers: <ul style="list-style-type: none"> ❖ When personnel may return to work after having pandemic influenza. ❖ When personnel who are symptomatic but well enough to work, will be permitted to continue working. ○ A method for furloughing or altering the work locations of personnel who are at high risk for influenza complications (e.g., pregnant women, immunocompromised healthcare workers) has been developed. ○ Mental health and faith-based resources who will provide counseling to personnel during a pandemic have been identified. ○ A strategy for housing healthcare personnel who may be needed on-site for prolonged periods of time is in place. ○ A strategy for accommodating and supporting personnel who have child or elder care responsibilities has been developed. 	
<ul style="list-style-type: none"> ● A vaccine and antiviral use plan has been developed. <ul style="list-style-type: none"> ○ A contact for obtaining influenza vaccine has been identified. (Name) _____ ○ A contact for obtaining antiviral prophylaxis has been identified. (Name) _____ ○ A priority list (based on HHS guidance for use of vaccines and antivirals in a pandemic when in short supply) and estimated number of patients and healthcare 	

<p>personnel who would be targeted for influenza vaccination or antiviral prophylaxis has been developed.</p> <ul style="list-style-type: none"> ▪ Number of first priority personnel _____ ▪ Number of second priority personnel _____ ▪ Number of remaining personnel _____ ▪ Number of first priority patients _____ ▪ Number of second priority patients _____ <ul style="list-style-type: none"> ○ A system for rapidly distributing vaccine and antivirals to patients has been developed. 	
<ul style="list-style-type: none"> • Issues related to surge capacity have been addressed. <ul style="list-style-type: none"> ○ A plan is in place to address unmet staffing needs in the hospital. ○ The minimum number and categories of personnel needed to care for a group of patients with pandemic influenza has been determined. ○ Responsibility for assessing day-to-day clinical staffing needs during an influenza pandemic has been assigned. <p>Persons responsible are: (names and/or titles)</p> <p>_____</p> <ul style="list-style-type: none"> ○ Legal counsel has reviewed emergency laws for using healthcare personnel with out-of-state licenses. ○ Legal counsel has made sure that any insurance and other liability concerns have been resolved. ○ Criteria for declaring a “staffing crisis” that would enable the use of emergency staffing alternatives have been defined. ○ The plan includes linking to local and regional planning and response groups to collaborate on addressing widespread healthcare staffing shortages during a crisis. ○ A priority list for reassignment and recruitment of personnel has been developed. ○ A method for rapidly credentialing newly recruited personnel has been developed. ○ Mutual AID Agreements (MAAs) and Memoranda of Understanding/Agreement (MOU/As) have been signed with other facilities that have agreed to share their staff, as needed. 	
<ul style="list-style-type: none"> • Strategies to increase bed capacity have been identified. <ul style="list-style-type: none"> ○ A threshold has been established for canceling elective admissions and surgeries. ○ Memorandum of Agreements (MOAs) have been signed with facilities that would accept non-influenza patients in order to free-up bed space. ○ Areas of the facility that could be utilized for expanded bed space have been identified. ○ The estimated patient capacity for this facility is _____. ○ Plans for expanded bed capacity have been discussed with local and regional planning groups. 	
<ul style="list-style-type: none"> • Anticipated durable and consumable resource needs have been determined. <ul style="list-style-type: none"> ○ A primary plan and contingency plan to address supply shortages has been developed. 	

<ul style="list-style-type: none"> ○ Plans for obtaining limited resources have been discussed with local and regional planning and response groups. 	
<ul style="list-style-type: none"> • A strategy for handling increased numbers of deceased persons has been developed. <ul style="list-style-type: none"> ○ Plans for expanding morgue capacity have been discussed with local and regional planning groups. ○ Local morticians have been involved in planning discussions. ○ Mortality estimates have been used to estimate the number of body bags and shrouds. ○ Supply sources for postmortem materials have been identified. 	

Attachment C – EMS Checklist

EMERGENCY MEDICAL SERVICE AND NON-EMERGENT (MEDICAL) TRANSPORT ORGANIZATIONS PANDEMIC INFLUENZA PLANNING CHECKLIST



Planning for pandemic influenza is critical for ensuring a sustainable health care response. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have developed the following checklist to help emergency medical services (EMS) and non-emergent (medical) transport organizations assess and improve their preparedness for responding to pandemic influenza. EMS organizations will be involved in the transport of acutely ill patients with known or suspected pandemic influenza to emergency departments; some of these patients might require mechanical ventilation for life support and/or other lifesaving interventions. Non-emergent (medical) transport organizations will be called upon to transport recovering pandemic influenza patients to their home, residential care facility, or possibly to alternate care sites set up by state or local health departments. This checklist is modeled after one included in the HHS Pandemic Influenza Plan (www.hhs.gov/pandemicflu/plan/sup3.html#app2). The list is comprehensive but not complete; each organization will have unique and unanticipated concerns that also will need to be addressed as part of a pandemic planning exercise. Also, some items on the checklist might not be applicable to all organizations. Collaborations among hospital, public health and public safety personnel are encouraged for the overall safety and care of the public. Further information can be found at www.pandemicflu.gov.

This checklist identifies key areas for pandemic influenza planning. EMS and non-emergent (medical) transport organizations can use this tool to self-assess and identify the strengths and weakness of current planning. Links to websites with information are provided throughout the document. However, actively seeking information that is available locally or at the state level will be necessary to complete the development of the plan. Also, for some elements of the plan (e.g., education and training programs), information may not be immediately available and monitoring of selected websites for new and updated information will be necessary.

1. Structure for planning and decision making.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pandemic influenza has been incorporated into emergency management planning and exercises for the organization.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A planning committee ¹ has been created to specifically address pandemic influenza preparedness.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A person has been assigned responsibility for coordinating pandemic influenza preparedness planning (hereafter referred to as the pandemic response coordinator) for the organization. (Insert name, title, and contact information.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Members of the planning committee include the following: (Insert below or attach a list with name title and contact information for each.)
			<input type="checkbox"/> Administration: _____
			<input type="checkbox"/> Medical staff: _____
			<input type="checkbox"/> EMS providers: _____
			<input type="checkbox"/> Phone triage personnel/dispatch center: _____
			<input type="checkbox"/> Emergency management officer: _____
			<input type="checkbox"/> State/local health official: _____
			<input type="checkbox"/> Law enforcement official (for quarantine/security): _____
			<input type="checkbox"/> Other member ² : _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A point of contact (e.g., internal staff member assigned infection control responsibility for the organization or an outside consultant) for questions/consultation on infection control has been identified. (Insert name, title, and contact information.)

1. Size of committee can vary, depending on the size and needs of the organization.

2. Some organizations may need or want to include a school official or volunteer coordinator for local civic and preparedness groups (e.g., Medical Reserve Corps, Citizen Corps, Community Emergency Response Teams, Rotary Club, Lions, Red Cross).

March 1, 2006 Version 2.1



2. Development of a written pandemic influenza plan.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Copies of relevant sections of the Department of Health and Human Services Pandemic Influenza Plan have been obtained. www.hhs.gov/pandemicflu/plan .
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Copies of available community and state pandemic plans have been obtained.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A written plan has been completed or is in progress that includes the elements listed in #3 below.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The plan describes the organizational structure (i.e., lines of authority) that will be used to operationalize the plan.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The plan complements or is part of the community response plan.

3. Elements of an influenza pandemic plan.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan is in place for surveillance and detection of pandemic influenza in the population served and the appropriate organizational response.</p> <p><input type="checkbox"/> Responsibility has been assigned for monitoring national and state public health advisories (e.g., www.cdc.gov/flu/weekly/fluactivity.htm) and informing the pandemic response coordinator and members of the pandemic influenza planning committee when cases of pandemic influenza have been reported in the United States and when they are nearing the geographic area (e.g., state or city). (Insert name, title, and contact information of person responsible.)</p> <hr/> <p><input type="checkbox"/> A system has been created to track influenza-like illness in patients transported to hospitals and among EMS staff and to report this information to the pandemic response coordinator (i.e., weekly or daily number of patients with influenza-like illness). For more information see www.cdc.gov/flu/professionals/diagnosis/. (Having a system for tracking illness trends in patients and staff during seasonal influenza will ensure that organizations can detect stressors that may affect operating capacity, such as staffing and supply needs, and hospital and emergency department capacity during a pandemic.)</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A communication plan has been developed.</p> <p><input type="checkbox"/> Key public health points of contact for pandemic influenza have been identified. (Insert below or attach a list with the name, title, and contact information for each.)</p> <p><input type="checkbox"/> Local health department contact: _____</p> <p><input type="checkbox"/> State health department contact: _____</p> <p><input type="checkbox"/> Local emergency management contact: _____</p> <p><input type="checkbox"/> State emergency management contact: _____</p> <p><input type="checkbox"/> Federal health emergency contact(s): _____</p> <p><input type="checkbox"/> The organization's point person for external communication has been assigned. (Insert name, title, and contact information.)</p> <hr/> <p>(Having one person who speaks with the health department, and if necessary, media, local politicians, etc., will help ensure consistent communication is provided by the organization.)</p> <p><input type="checkbox"/> A list of healthcare entities and their points of contact (e.g., other local EMS and non-emergent [medical] transport organizations, local hospitals and their emergency departments, community health centers, residential care facilities) has been created. (Insert location of or attach copy of contact list.) _____</p> <hr/> <p><input type="checkbox"/> The pandemic response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on communication and coordination plans, including how EMS will be represented in the planning process. (For more information on state and local planning, see www.hhs.gov/pandemicflu/plan/part2.html#overview.)</p> <p><input type="checkbox"/> The pandemic response coordinator has contacted other EMS and non-emergent (medical) transport organizations regarding pandemic influenza planning and coordination of services.</p>

3. Elements of an influenza pandemic plan. (continued)

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan is in place to ensure that education and training on pandemic influenza is provided to ensure that all personnel understand the implications of, and control measures for, pandemic influenza and the current organization and community response plans.</p> <ul style="list-style-type: none"> <input type="checkbox"/> A person has been designated to coordinate education and training (e.g., identify and facilitate access to education and training programs, ensure that staff attend, and maintain a record of attendance at education and training programs). (Insert name, title, and contact information.) <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Current and potential opportunities for long-distance (e.g., web-based) and local (e.g., health department or hospital sponsored programs, programs offered by professional organizations or federal agencies) education of EMS and medical transport personnel have been identified. (For more information see www.cdc.gov/flu/professionals/training/.) <input type="checkbox"/> Language and reading-level-appropriate materials for professional and non-professional personnel on pandemic influenza (e.g., available through state and federal public health agencies and professional organizations) have been identified and a plan is in place for obtaining these materials. <input type="checkbox"/> Education and training include information on infection control measures to prevent the spread of pandemic influenza. <input type="checkbox"/> Differences between responding to pandemic influenza and a mass casualty event have been incorporated into education and training programs.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan has been developed for triage and management of patients during a pandemic that includes the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A system for phone triage of patients calling 911 or other emergency numbers that might be used (provide/post list of appropriate numbers) that includes pre-established criteria and coordination protocols to determine who needs emergency transport. The system includes points of referral for patients who do not need emergency transport. <input type="checkbox"/> A plan for coordination with receiving facilities (e.g., hospital emergency departments), other EMS and non-emergent (medical) transport organizations, and local planning groups to manage the transportation of large numbers of patients at the height of the pandemic. <input type="checkbox"/> A policy and procedure for transporting multiple patients with pandemic influenza during a single ambulance run. <input type="checkbox"/> The plan considers the possible necessity of sharing transportation resources or using vehicles other than those designed for emergency or medical transport (e.g., buses).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>An infection control plan is in place and includes the following: (For information on infection control recommendations for pandemic influenza, see www.hhs.gov/pandemicflu/plan/sup4.html).</p> <ul style="list-style-type: none"> <input type="checkbox"/> A plan for implementing Respiratory Hygiene/Cough Etiquette for patients with a possible respiratory illness. <input type="checkbox"/> The plan includes distributing masks³ to symptomatic patients who are able to wear them (adult and pediatric sizes should be available), providing facial tissues and receptacles for their disposal, and hand hygiene materials in EMS and medical transport vehicles. <input type="checkbox"/> Implementation of Respiratory Hygiene/Cough Etiquette has been exercised during seasons when seasonal influenza and other respiratory viruses (e.g., respiratory syncytial virus, parainfluenza virus) are circulating in communities. <input type="checkbox"/> A policy that requires healthcare personnel to use Standard Precautions (www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html) and Droplet Precautions (i.e., mask for close contact) (www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html) with symptomatic patients.

3. Masks include both surgical and procedure types. Procedure masks that are affixed to the head with ear loops might be used more easily by patients and are available in pediatric and adult sizes. Either surgical or procedure masks may be used as a barrier to prevent contact with respiratory droplets.

3. Elements of an influenza pandemic plan. (continued)

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>An occupational health plan has been developed that includes the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A liberal/non-punitive sick leave policy for managing EMS and non-emergent (medical) transport personnel who have symptoms of, or documented illness with, pandemic influenza. <input type="checkbox"/> The policy considers the following: <ul style="list-style-type: none"> • Handling of staff who become ill at work. • When personnel may return to work after recovering from pandemic influenza. • When personnel who are symptomatic but well enough to work will be permitted to continue working. • Personnel who need to care for their ill family members. <input type="checkbox"/> A system for evaluating symptomatic personnel before they report for duty that has been tested during a non-pandemic influenza period. <input type="checkbox"/> A list of mental health and faith-based resources available to provide counseling to personnel during a pandemic. <input type="checkbox"/> Management of personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised healthcare workers) by placing them on administrative leave or altering their work locations. <input type="checkbox"/> The ability to monitor seasonal influenza vaccination of personnel. <input type="checkbox"/> Offering annual influenza vaccine to personnel.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A vaccine and antiviral use plan has been developed.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Websites containing current CDC and state health department recommendations for the use and availability of vaccines and antiviral medications have been identified. (For more information, see www.hhs.gov/pandemicflu/plan/sup6.html and www.hhs.gov/pandemicflu/plan/sup7.html.) <input type="checkbox"/> An estimate has been made of the number of personnel who will be targeted as first and second priority for receipt of pandemic influenza vaccine and antiviral prophylaxis, based on HHS guidance for use. (For more information, see www.hhs.gov/pandemicflu/plan/appendixd.html.) <input type="checkbox"/> Discussions have been held with the local and/or state health department regarding the role of the organization in a large-scale program to distribute vaccine and antivirals to the general population.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Concerns related to surge capacity during a pandemic have been addressed.</p> <ul style="list-style-type: none"> <input type="checkbox"/> A plan is in place for managing a staffing shortage within the organization because of illness in personnel or their family members. <input type="checkbox"/> The minimum number and categories of personnel necessary to sustain EMS and non-emergent (medical) transport services on a day-to-day basis have been determined. <input type="checkbox"/> Contingency staffing plans have been developed in collaboration with other local EMS and non-emergent (medical) transport providers. <input type="checkbox"/> Hospitals and regional planning groups have been consulted regarding contingency staffing resources. <input type="checkbox"/> Anticipated consumable resource needs (e.g., masks, gloves, hand hygiene products) have been estimated. <input type="checkbox"/> A primary plan and contingency plan to address supply shortages have been developed. These include detailed procedures for the acquisition of supplies through normal channels and requesting resources for replenishing supplies when normal channels have been exhausted. <input type="checkbox"/> Plans include stockpiling at least a week's supply of resources when evidence exists that pandemic influenza has reached the United States. <input type="checkbox"/> An understanding of the process exists for requesting and obtaining assets for the organization made available through the community response plan.

Attachment D – Non-Hospital Checklist

MEDICAL OFFICES AND CLINICS PANDEMIC INFLUENZA PLANNING CHECKLIST



Planning for pandemic influenza is critical for ensuring a sustainable healthcare response. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have developed the following checklist to help medical offices and ambulatory clinics assess and improve their preparedness for responding to pandemic influenza. This checklist is modeled after a pandemic preparedness checklist for hospitals and should be used in conjunction with guidance on healthcare preparedness planning in Supplement 3 of the HHS Pandemic Influenza Plan. Many of the issues included in the checklist are also relevant to other outpatient settings that provide episodic and chronic healthcare services (e.g., dental, podiatric, and chiropractic offices, ambulatory surgery centers, hemodialysis centers). Given the variety of healthcare settings, individual medical offices and clinics may need to adapt this checklist to meet their unique needs. Further information can be found at www.pandemicflu.gov.

This checklist identifies key areas for pandemic influenza planning. Medical offices and clinics can use this tool to identify the strengths and weaknesses of current planning efforts. Links to websites with information are provided throughout the document. However, actively seeking information that is available locally or at the state level will be necessary to complete the development of the plan. Also, for some elements of the plan (e.g., education and training programs), information may not be immediately available and it will be necessary to monitor selected websites for new and updated information.

1. Structure for planning and decision making.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pandemic influenza has been incorporated into emergency management planning for the organization.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A planning committee ¹ has been created to specifically address pandemic influenza preparedness for the medical office or clinic.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A person has been assigned responsibility for coordinating preparedness planning for the practice or organization (hereafter referred to as the pandemic influenza response coordinator). (Insert name, title and contact information) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Members of the planning committee include the following: (Insert below or attach list with name, title and contact information for each) Administration: _____ Medical staff: _____ Nursing: _____ Reception personnel: _____ Environmental services (if applicable): _____ Clinic laboratory personnel (if applicable): _____ Other member(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A point of contact (e.g., person assigned infection control responsibility for the organization or an outside consultant ²) for questions/consultation on infection control measures to prevent transmission of pandemic influenza has been identified. (Insert name, title, and contact information) _____ _____

1. The committee could be very small (e.g., two or three staff members) or very large, depending on the size and needs of the organization.
2. Formal memorandum of understanding or contract may be needed if an outside consultant is used.

March 6, 2006
Version 2.2



2. Development of a written pandemic influenza plan.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Copies of relevant sections of the Department of Health and Human Services Pandemic Influenza Plan have been obtained from www.hhs.gov/pandemicflu/plan ; copies of available state pandemic plans also should be obtained.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A written plan has been completed or is in progress that includes the elements listed in #3 below.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The plan describes the organizational structure that will be used to operationalize (i.e., lines of authority) the plan.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The plan incorporates and compliments the community response plan.

3. Elements of an influenza pandemic plan.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan is in place for surveillance and detection of pandemic influenza in the population served.</p> <p><input type="checkbox"/> Responsibility has been assigned for monitoring public health advisories (federal and state) and informing members of the pandemic influenza planning committee and/or the pandemic influenza response coordinator when pandemic influenza is in the United States and when it is nearing the geographic area (e.g., state and/or city). (For more information, see www.cdc.gov/flu/weekly/fluactivity.htm) (Insert name, title and contact information)</p> <p>_____</p> <p><input type="checkbox"/> A system has been created to monitor and review influenza activity in patients cared for by clinical staff (i.e., weekly or daily number of patients calling or presenting to the office or clinic with influenza-like illness) and among medical office or clinic staff. (For more information see www.cdc.gov/flu/professionals/diagnosis/) (Monitoring for seasonal influenza activity is performed to ensure that the monitoring system for pandemic influenza will be effective and will ensure that organizations can detect stressors that may affect organizational capacity, such as staffing and supply needs, and hospital and emergency department capacity [and supply needs] during a pandemic)</p> <p><input type="checkbox"/> A system is in place to report unusual cases of influenza-like illness and influenza to the local or state health department. (For more information see www.hhs.gov/pandemicflu/plan/sup1.html#outpat and www.hhs.gov/pandemicflu/plan/sup5.html#nov)</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A communication plan has been developed.</p> <p><input type="checkbox"/> Key public health points of contact for pandemic influenza have been identified and arrangements have been made for telephone, facsimile, or e-mail messaging.</p> <p>Local health department contact: (Insert name, title and contact information)</p> <p>_____</p> <p>State health department contact: (Insert name, title and contact information)</p> <p>_____</p> <p><input type="checkbox"/> The office or clinic's point person for external communication has been assigned. (Insert name, title and contact information)</p> <p>_____</p> <p>(Having one person who speaks with the health department, and if necessary, media, local politicians, etc., will help ensure consistent communication is provided by the organization)</p> <p><input type="checkbox"/> A list has been created of healthcare entities and their points of contact (e.g., local hospitals/health facilities, home health care agencies, social service agencies, emergency medical services, commercial and clinical laboratories, relevant community organizations [including those involved with disaster preparedness]) with whom the medical office or clinic anticipates that it will be necessary to maintain communication and coordination of care during a pandemic. (Attach or insert location of contact list)</p> <p>_____</p> <p>_____</p>

3. Elements of an influenza pandemic plan. (continued)

Completed	In Progress	Not Started	
			<input type="checkbox"/> The pandemic response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on communication and coordination plans, including notification when updated plans are created. (For more information on state and local planning, see www.hhs.gov/pandemicflu/plan/part2.html#overview) <input type="checkbox"/> A list or database has been created with contact information on patients who have regularly-scheduled visits and may need to be contacted during a pandemic for purposes of rescheduling office visits or assigning them to another point of care. (Insert location of list/database) <hr/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan is in place to provide an education and training program to ensure that all personnel understand the implications of, and control measures for, pandemic influenza.</p> <input type="checkbox"/> A person has been designated to coordinate education and training (e.g., identify and facilitate access to education and training programs, maintain a record of attendance at education and training programs). (Insert name, title and contact information) <hr/> <input type="checkbox"/> Current and potential opportunities for long-distance (e.g., web-based) and local (e.g., health department or hospital sponsored programs, programs offered by professional organizations or federal agencies) education of medical and nursing personnel have been identified. (http://www.cdc.gov/flu/professionals/training/) <input type="checkbox"/> Language and reading-level appropriate materials on pandemic influenza (e.g., available through state and federal public health agencies and professional organizations) appropriate for professional, allied and support personnel have been identified and a plan is in place for obtaining these materials. (For more information see www.cdc.gov/flu/professionals/patiented.htm) <input type="checkbox"/> Education and training includes information on infection control measures to prevent the spread of pandemic influenza. www.hhs.gov/pandemicflu/plan/sup4.html
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Informational materials for patients on pandemic influenza that are language and reading-level appropriate for the population being served have been identified, and a plan is in place to obtain these materials. (For more information see www.cdc.gov/flu/professionals/patiented.htm)</p> <input type="checkbox"/> The roles of medical and nursing personnel in providing health care guidance for patients with pandemic influenza have been established. <input type="checkbox"/> A plan for triage and management of patients during a pandemic has been developed. <input type="checkbox"/> A system is in place for phone (and e-mail, where appropriate) triage of patients to determine who requires a medical evaluation, to limit office visits to those that are medically necessary. <input type="checkbox"/> Plans have been developed to manage patient care at the height of the pandemic including the following possibilities: <ul style="list-style-type: none"> • Temporarily canceling non-essential medical visits (e.g., annual physicals). • Designating separate blocks of time for non-influenza and influenza-related patient care. <input type="checkbox"/> Local plans and criteria for the disposition of patients following a medical evaluation (e.g., hospitalization, home health care services, self- or family-based care at home) have been discussed with local hospital and health care agencies and local health department. (Flexibility will be necessary based on hospital bed capacity) <input type="checkbox"/> An infection control plan is in place and includes the following: (For information on infection control recommendations for pandemic influenza see www.hhs.gov/pandemicflu/plan/sup4.html) <input type="checkbox"/> A specific waiting room location has been designated for patients with symptoms of pandemic influenza that is segregated from other patients awaiting care. (This may not be feasible in very small waiting rooms, in which case the emphasis may be on use of masks as noted below)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Elements of an influenza pandemic plan. (continued)

Completed	In Progress	Not Started	
		<input type="checkbox"/>	<input type="checkbox"/> A plan for implementing Respiratory Hygiene/Cough Etiquette is in place. (For more information see www.cdc.gov/flu/professionals/infectioncontrol/resphgiene.htm) <ul style="list-style-type: none"> • Signage (language appropriate) directing patients and those accompanying them to notify reception personnel if they have symptoms of pandemic influenza has been developed or a source of signage (e.g., CDC website above) has been identified. • Signage (language appropriate) on Respiratory Hygiene/Cough Etiquette instructing symptomatic persons to use tissues to cover their cough to contain respiratory secretions and perform hand hygiene has been developed or a source of signage (e.g., CDC website above) has been identified. • The plan includes distributing masks to symptomatic patients who are able to wear them (adult and pediatric sizes should be available), providing facial tissues, receptacles for their disposal and hand hygiene materials in waiting areas and examination rooms. • Implementation of Respiratory Hygiene/Cough Etiquette has been exercised during seasons when influenza and other respiratory viruses (e.g., respiratory syncytial virus, parainfluenza virus) are circulating in communities. • If patients with pandemic influenza will be evaluated in the same location as patients without an influenza-like illness, separate examination rooms have been designated for evaluation of patients with symptoms of pandemic influenza. • A policy is in place that requires healthcare personnel to use Standard (www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html) and Droplet Precautions (i.e., mask for close contact) (www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html) with symptomatic patients. • The policy includes protection of reception and triage personnel at initial points of patient encounter.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A vaccine and antiviral use plan has been developed.</p> <input type="checkbox"/> Websites where current federal and/or state health department recommendations for the use and availability of pandemic influenza vaccines and antiviral medications have been identified. (for more information see www.hhs.gov/pandemicflu/plan/sup6.html)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> An estimate of the number of personnel and patients who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis, based on HHS guidance for use, has been developed. (www.dhhs.gov/nvpo/pandemicplan/annex6.pdf) (This estimate can be used for considering which patients may need to be notified first about vaccine or antiviral availability, anticipating staffing requirements for distribution of vaccines and antivirals, and for procurement purposes)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>An occupational health plan has been developed and includes the following:</p> <input type="checkbox"/> A liberal/non-punitive sick leave policy for managing personnel who have symptoms of or documented illness with pandemic influenza. <p>The policy considers:</p> <ul style="list-style-type: none"> • The handling of staff who become ill at work. • When personnel may return to work after recovering from pandemic influenza. • When personnel who are symptomatic, but well enough to work, will be permitted to continue working. • Personnel who need to care for their ill family members. <input type="checkbox"/> A system for evaluating symptomatic personnel before they report for duty and tested during a non-pandemic influenza period. <input type="checkbox"/> Mental health and faith-based resources that are available to provide counseling to personnel during a pandemic.

3. Elements of an influenza pandemic plan. (continued)

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <input type="checkbox"/> The management of personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised healthcare workers) by placing them on administrative leave or altering their work location. <input type="checkbox"/> The ability to monitor seasonal influenza vaccination of healthcare personnel. <input type="checkbox"/> The offer of annual influenza vaccine to medical office or clinic personnel. <p>Issues related to surge capacity (i.e., dealing with an influx of patients and staff and supply shortages) during a pandemic have been addressed. (For more information see www.hhs.gov/pandemicflu/plan/sup3.html#surge)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Plans for managing a staffing shortage within the organization due to illness in personnel or their family members have been addressed. <input type="checkbox"/> Staff have been encouraged to develop their own family care plans for the care of dependent minors and seniors in the event community containment measures (e.g., "snow days," school closures) are implemented. (www.pandemicflu.gov/planguide/checklist.html; www.pandemicflu.gov/planguide/familyhealthinfo.html) <input type="checkbox"/> The minimum number and categories of personnel necessary to keep the office/clinic open on a given day have been determined. <input type="checkbox"/> Plans for either closing the office/clinic or recruiting temporary personnel during a staffing crisis have been addressed. <input type="checkbox"/> Anticipated consumable resource needs (e.g., masks, gloves, hand hygiene products, medical supplies) have been estimated. <input type="checkbox"/> A primary plan and contingency plan to address supply shortages have been developed and each details procedures for acquisition of supplies through normal channels, as well as requesting resources when normal channel resources have been exhausted. <input type="checkbox"/> Plans include stockpiling at least a week's supply of consumable resources, including all necessary medical supplies, when there is evidence that pandemic influenza has reached the United States.

Attachment E– Home Health Checklist

HOME HEALTH CARE SERVICES PANDEMIC INFLUENZA PLANNING CHECKLIST



Planning for pandemic influenza is critical. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention have developed the following checklist to help public and private organizations that provide home health care services assess and improve their preparedness for responding to pandemic influenza. Home health agencies will likely be called upon to provide care for patients who do not require hospitalization for pandemic influenza, or for whom hospitalization is not an option because hospitals have reached their capacity to admit patients. These agencies may become overburdened very quickly and shortages of personnel and supplies for providing home health care may occur. This checklist is modeled after the one included in the HHS Pandemic Influenza Plan (www.hhs.gov/pandemicflu/plan/sup3.html#app2). The list is comprehensive but not complete; each home care agency will have unique and unanticipated issues that will need to be addressed as part of a pandemic planning exercise. Also, some items on the checklist may not be applicable to a given agency. Collaboration with hospitals, local pandemic planning committees and public health agencies will be essential to ensure that the affected population receives needed health care services. Further information can be found at www.pandemicflu.gov.

This checklist identifies key areas for pandemic influenza planning. Home health care organizations can use this tool to identify the strengths and weaknesses of current planning efforts. Links to websites with information are provided throughout the document. However, actively seeking information that is available locally or at the state level will be necessary to complete the development of the plan. Also, for some elements of the plan (e.g., education and training programs), information may not be immediately available and it will be necessary to monitor selected websites for new and updated information.

1. Structure for planning and decision making.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pandemic influenza has been incorporated into emergency management planning for the organization.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A planning committee has been created to specifically address pandemic influenza preparedness.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A person has been assigned responsibility for coordinating preparedness planning (hereafter referred to as the pandemic response coordinator) for the practice or organization. (Insert name, title and contact information) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Members of the planning committee ¹ include the following: (Insert name, title and contact information for each) Administration: _____ Nursing: _____ Clerical: _____ Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A point of contact has been identified for questions/consultation on infection control (e.g., hospital- or state health department-based infection control professional, healthcare epidemiologist). (Insert name, title, and contact information) _____

2. Development of a written pandemic influenza plan.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Copies of relevant sections of the Department of Health and Human Services Pandemic Influenza Plan have been obtained. (www.hhs.gov/pandemicflu/plan/)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Copies of available state and/or local pandemic influenza plans have been obtained.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A written plan has been completed or is in progress that includes the elements listed in #3 below.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The plan describes the organizational structure (i.e., lines of authority, function and assignment of responsibility) that will be used to operationalize the plan.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The plan complements ² local response plans in communities served by the home health care agency.

1. The committee could be very small (e.g., two or three staff members) or very large, depending on the size and needs of the organization. Members of the "group of professional personnel" required by CMS as one of the Home Health Agency Conditions of Participation should be included on the planning committee.

2. As communities develop their pandemic response plans, the provision of home health care will be a pivotal concern. Home health care agencies should have input into these plans to ensure there are no conflicts between what the agency can provide and what the community expects.

3. Elements of an influenza pandemic plan.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan is in place for monitoring for pandemic influenza in the population served.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Responsibility has been assigned for monitoring national and state public health advisories (e.g., www.cdc.gov/flu/weekly/fluactivity.htm) and updating members of the pandemic influenza planning committee when cases of pandemic influenza have been reported in United States and in the geographic area. (Insert name, title, and contact information) _____ <input type="checkbox"/> A system has been created to monitor influenza-like illness in patients cared for in the home (i.e., weekly or daily number of patients with influenza-like illness). www.cdc.gov/flu/professionals/diagnosis/ (Having a system for tracking illness trends during seasonal influenza will ensure that organizations can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.) <input type="checkbox"/> A system is in place to report unusual cases of influenza-like illness and influenza-related deaths to local health authorities.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A communication plan has been developed and includes the following information:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Key public health points of contact for pandemic influenza have been identified. (Insert name, title, and contact information for each) <input type="checkbox"/> Local health department _____ <input type="checkbox"/> State health department _____ <input type="checkbox"/> Local emergency management _____ <input type="checkbox"/> The organization's point person for external communication (e.g., with hospitals, nursing homes, health departments, social services agencies) has been assigned. (Insert name, title and contact information) <input type="checkbox"/> A list has been created of healthcare entities and their points of contact (e.g., other home care services providers, local hospitals, residential care facilities, social service agencies, emergency medical services providers, health centers and rural health facilities, relevant community organizations [including those involved with disaster preparedness]) with whom the home care agency anticipates that it will be necessary to maintain communication and coordination of care during a pandemic. (Insert location of contact list): _____ <input type="checkbox"/> The pandemic response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on communication and coordination of plans. <input type="checkbox"/> The pandemic response coordinator has contacted other home care services providers in the area regarding their pandemic influenza planning efforts. (Whenever possible, home care agencies should consider joint planning and coordination opportunities.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>An education and training program has been developed to ensure that all personnel understand the implications of, and control measures for, pandemic influenza and the current community response plan. (For more information on the scope of recommended education and training, see www.hhs.gov/pandemicflu/plan/sup3.html#edutrain)</p> <ul style="list-style-type: none"> <input type="checkbox"/> A person has been designated to coordinate education and training (e.g., identify and facilitate access to education and training programs, ensure that home care personnel attend, and maintain a record of attendance). (Insert name, title, and contact information): _____ <input type="checkbox"/> Current and potential sites have been identified for long-distance (e.g., web-based programs offered by professional associations or federal agencies) and local (e.g., health department or hospital sponsored programs) education of home care personnel. (www.cdc.gov/flu/professionals/training/) <input type="checkbox"/> Language and reading-level appropriate materials have been identified on pandemic influenza (e.g., available through state and federal public health agencies and professional organizations) and a plan is in place for obtaining these materials. <input type="checkbox"/> The education and training program includes information on infection control measures to prevent the spread of pandemic influenza, including information on measures home health care personnel should apply during home care of patients. (For further information on infection control recommendations for home care, see www.hhs.gov/pandemicflu/plan/sup4.html#care)

3. Most home health agencies will already have a list of healthcare organizations and points of contact that can be used for this purpose.

3. Elements of an influenza pandemic plan. (continued)

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Informational materials on pandemic influenza for patients and their families have been identified that are language and reading-level appropriate for the population being served and a plan is in place to obtain and disseminate these materials.</p> <p><input type="checkbox"/> Materials have been identified or developed to guide family members on infection control and care of patients with pandemic influenza in the home. www.pandemicflu.gov/plan/tab3.html</p> <p><input type="checkbox"/> Patients and families are encouraged to maintain a 30-day supply of medications and medical supplies as well as a two-week supply of non-perishable food and water.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan has been developed for the management of patients during a pandemic, which covers the following issues:</p> <p><input type="checkbox"/> Plans have been developed to manage patient care during the height of a pandemic to accommodate the increased number of patients who will need home care services.</p> <p><input type="checkbox"/> The scope of services that the agency will provide and those that will be denied or referred to other providers has been clearly defined.</p> <p><input type="checkbox"/> The role and responsibility of the agency regarding distribution of infection control supplies (e.g., masks, hand hygiene materials), food, medications, and other necessities in the home to patients and their families has been discussed with a local or regional pandemic influenza planning group.</p> <p><input type="checkbox"/> Plans include decision tools for determining which patients can have altered service schedules based on their health conditions, needs, and available resources.</p> <p><input type="checkbox"/> Local plans and criteria for the disposition of patients have been discussed with area hospitals and other home care agencies. (Hospitals may discharge patients to home and home health care agencies early to free-up bed space for critically ill patients.)</p> <p><input type="checkbox"/> The plan considers how social service agencies (e.g., Red Cross, Salvation Army) will help meet the needs of families in the community (e.g., by providing child- or elder-care meals, shopping services) in homes where there are patients with pandemic influenza, particularly where the primary adult support person living in the home is ill.</p> <p><input type="checkbox"/> The plan considers how the agency will maintain a database of clients who require electrically-dependent technology-driven care (e.g., ventilators, breathing treatments, suction, pumps, turning devices), oxygen, special nutrition requirements, dialysis, etc.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>An infection control plan is in place and includes the following:</p> <p><input type="checkbox"/> An infection control policy for the care of pandemic influenza patients in the home. (www.hhs.gov/pandemicflu/plan/sup4.html and www.cdc.gov/flu/professionals/infectioncontrol/)</p> <p><input type="checkbox"/> The policy requires healthcare personnel to use Standard (www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html) and Droplet Precautions (i.e., mask for close contact) (www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html) with symptomatic patients.</p> <p><input type="checkbox"/> A list has been developed of supplies (e.g., surgical masks, gloves, alcohol-based hand hygiene products) that will be used during home care of patients with pandemic influenza.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>An occupational health plan has been developed that includes the following:</p> <p><input type="checkbox"/> A liberal/non-punitive sick leave policy for managing home care personnel who have symptoms of, or documented illness with, pandemic influenza. The policy considers:</p> <ul style="list-style-type: none"> • The handling of staff who become ill at work • When personnel may return to work after recovering from pandemic influenza • When personnel who are symptomatic, but well enough to work, will be permitted to continue working <p><input type="checkbox"/> A system for evaluating symptomatic personnel before they report for duty has been developed and tested during a non-pandemic (e.g., seasonal) influenza period.</p> <p><input type="checkbox"/> Mental health and faith-based resources have been identified that are available to provide counseling to personnel during a pandemic.</p> <p><input type="checkbox"/> The management of personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised healthcare workers) has been addressed by placing them on administrative leave or altering their work location</p> <p><input type="checkbox"/> Staff have been encouraged to develop their own family care plans for the care of dependent minors and seniors in the event community containment measures (e.g., "snow days," school closures) are implemented and for possible illness in adult family members.</p> <p><input type="checkbox"/> The agency has the ability to monitor influenza vaccination of healthcare personnel.</p> <p><input type="checkbox"/> Influenza vaccine is offered or made available on an annual basis to healthcare personnel.</p>

3. Elements of an influenza pandemic plan. (continued)

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A vaccine and antiviral use plan has been developed.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Websites containing current federal and state health department recommendations for the use and availability of vaccines and antiviral medications have been identified. (www.cdc.gov/flu/professionals/vaccination/) <input type="checkbox"/> An estimate has been developed of the number of personnel who would be targeted as first and second priority for receipt of pandemic influenza vaccine and antiviral prophylaxis, based on HHS guidance for use. (www.hhs.gov/pandemicflu/plan/appendixd.html) <input type="checkbox"/> The potential role of the home health care organization in the distribution of vaccine and antivirals in the community has been discussed with the local health department and/or regional pandemic planning committee.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Issues related to surge capacity during a pandemic have been addressed.</p> <ul style="list-style-type: none"> <input type="checkbox"/> A plan is in place for managing a staffing shortage within the organization due to illness in personnel or their family members. <input type="checkbox"/> The minimum number and categories of nursing staff and other professional personnel necessary to sustain home care services for a given number of patients or on a day-to-day basis have been determined. Cross-training (where applicable) has been implemented. <input type="checkbox"/> Priorities for providing care have been established. <input type="checkbox"/> Contingency staffing plans have been developed for either limiting home care access or recruiting temporary personnel during a staffing crisis. <input type="checkbox"/> Hospitals and other appropriate healthcare service providers have been consulted regarding contingency staffing resources. <input type="checkbox"/> Anticipated consumable resource needs (e.g., masks, gloves, hand hygiene products) have been estimated. <input type="checkbox"/> A primary plan and contingency plan to address supply shortages have been developed, including detailed procedures for acquisition of supplies through normal channels as well as requesting resources for replenishing supplies when normal channels have been exhausted. <input type="checkbox"/> Plans include stockpiling at least a week's supply of resources when there is evidence that the potential for pandemic influenza has reached the United States. <input type="checkbox"/> There is an understanding of the process for requesting and obtaining assets (e.g., personal protective equipment, medical supplies) made available through the community's response plan. <input type="checkbox"/> Information has been obtained on local and regional plans and resources for dealing with mass fatalities including removal of the deceased from the home.

March 1, 2006
Version 5



Attachment F– Long Term Care Checklist

LONG-TERM CARE AND OTHER RESIDENTIAL FACILITIES PANDEMIC INFLUENZA PLANNING CHECKLIST



Planning for pandemic influenza is critical for ensuring a sustainable healthcare response. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have developed this checklist to help long-term care and other residential facilities assess and improve their preparedness for responding to pandemic influenza. Based on differences among facilities (e.g., patient/resident characteristics, facility size, scope of services, hospital affiliation), each facility will need to adapt this checklist to meet its unique needs and circumstances. This checklist should be used as one tool in developing a comprehensive pandemic influenza plan. Additional information can be found at www.pandemicflu.gov. Information from state, regional, and local health departments, emergency management agencies/authorities, and trade organizations should be incorporated into the facility's pandemic influenza plan. Comprehensive pandemic influenza planning can also help facilities plan for other emergency situations.

This checklist identifies key areas for pandemic influenza planning. Long-term care and other residential facilities can use this tool to self-assess the strengths and weaknesses of current planning efforts. Links to websites with helpful information are provided throughout this document. However, it will be necessary to actively obtain information from state and local resources to ensure that the facility's plan complements other community and regional planning efforts.

1. Structure for planning and decision making.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pandemic influenza has been incorporated into emergency management planning and exercises for the facility.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A multidisciplinary planning committee or team ¹ has been created to specifically address pandemic influenza preparedness planning. (List committee's or team's name.) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A person has been assigned responsibility for coordinating preparedness planning, hereafter referred to as the pandemic influenza response coordinator. (Insert name, title and contact information.) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Members of the planning committee include (as applicable to each setting) the following: (Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist.)
			<input type="checkbox"/> Facility administration
			<input type="checkbox"/> Medical director
			<input type="checkbox"/> Nursing administration
			<input type="checkbox"/> Infection control
			<input type="checkbox"/> Occupational health
			<input type="checkbox"/> Staff training and orientation
			<input type="checkbox"/> Engineering/maintenance services
			<input type="checkbox"/> Environmental (housekeeping) services
			<input type="checkbox"/> Dietary (food) services
			<input type="checkbox"/> Pharmacy services
			<input type="checkbox"/> Occupational/rehabilitation/physical therapy services
			<input type="checkbox"/> Transportation services
			<input type="checkbox"/> Purchasing agent
			<input type="checkbox"/> Facility staff representative
			<input type="checkbox"/> Other member(s) as appropriate (e.g., clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff, collective bargaining agreement union representatives)

1. An existing emergency or disaster preparedness team may be assigned this responsibility.
May 1, 2006 Version 1



1. Structure for planning and decision making *(continued)*.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local and state health departments and provider/trade association points of contact have been identified for information on pandemic influenza planning resources. (Insert name, title and contact information for each.) Local health department contact: _____ State health department contact: _____ State long-term care professional/trade association: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local, regional, or state emergency preparedness groups, including bioterrorism/communicable disease coordinators points of contact have been identified. (Insert name, title and contact information for each.) City: _____ County: _____ Other regional: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Area hospitals points of contact have been identified in the event that facility residents require hospitalization or facility beds are needed for hospital patients being discharged in order to free up needed hospital beds. (Attach a list with the name, title, and contact information for each hospital.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The pandemic influenza response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on coordinating the facility's plan with other influenza plans.

2. Development of a written pandemic influenza plan.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Copies have been obtained of relevant sections of the HHS Pandemic Influenza Plan (available at www.hhs.gov/pandemicflu/plan/) and available state, regional, or local plans are reviewed for incorporation into the facility's plan.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The facility plan includes the elements listed in #3 below.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.

3. Elements of an influenza pandemic plan.

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan is in place for surveillance and detection of the presence of pandemic influenza in residents and staff.</p> <ul style="list-style-type: none"> <input type="checkbox"/> A person has been assigned responsibility for monitoring public health advisories (federal and state), and updating the pandemic response coordinator and members of the pandemic influenza planning committee when pandemic influenza has been reported in the United States and is nearing the geographic area. For more information, see www.cdc.gov/flu/weekly/fluactivity.htm. (Insert name, title and contact information of person responsible.) _____ <input type="checkbox"/> A written protocol has been developed for weekly or daily monitoring of seasonal influenza-like illness in residents and staff. For more information, see www.cdc.gov/flu/professionals/diagnosis/. (Having a system for tracking illness trends during seasonal influenza will ensure that the facility can detect stressors that may affect operating capacity, including staffing and supply needs, during a pandemic.) <input type="checkbox"/> A protocol has been developed for the evaluation and diagnosis of residents and/or staff with symptoms of pandemic influenza. <input type="checkbox"/> Assessment for seasonal influenza is included in the evaluation of incoming residents. There is an admission policy or protocol to determine the appropriate placement and isolation of patients with an influenza-like illness. (The process used during periods of seasonal influenza can be applied during pandemic influenza.)

3. Elements of an influenza pandemic plan (continued).

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><input type="checkbox"/> A system is in place to monitor for, and internally review transmission of, influenza among patients and staff in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting). (This system will be necessary for assessing pandemic influenza transmission.)</p> <p><input type="checkbox"/> A facility communication plan has been developed. For more information, see www.hhs.gov/pandemicflu/plan/sup10.htm.</p> <p><input type="checkbox"/> Key public health points of contact during an influenza pandemic influenza have been identified. (Insert name, title and contact information for each.)</p> <p><input type="checkbox"/> Local health department contact: _____</p> <p><input type="checkbox"/> State health department contact: _____</p> <p><input type="checkbox"/> A person has been assigned responsibility for communications with public health authorities during a pandemic. (Insert name, title and contact information.) _____</p> <p><input type="checkbox"/> A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of pandemic influenza in the facility. (Having one voice that speaks for the facility during a pandemic will help ensure the delivery of timely and accurate information.)</p> <p><input type="checkbox"/> Contact information for family members or guardians of facility residents is up-to-date.</p> <p><input type="checkbox"/> Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., sales and delivery people) about the status of pandemic influenza in the facility.</p> <p><input type="checkbox"/> A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals' emergency medical services, relevant community organizations [including those involved with disaster preparedness]) with whom it will be necessary to maintain communication during a pandemic. (Insert location of contact list and attach a copy to the pandemic plan.) _____</p> <p><input type="checkbox"/> A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during a pandemic.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><input type="checkbox"/> A plan is in place to provide education and training to ensure that all personnel, residents, and family members of residents understand the implications of, and basic prevention and control measures for, pandemic influenza.</p> <p><input type="checkbox"/> A person has been designated with responsibility for coordinating education and training on pandemic influenza (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance). (Insert name, title, and contact information.) _____</p> <p><input type="checkbox"/> Current and potential opportunities for long-distance (e.g., web-based) and local (e.g., health department or hospital-sponsored) programs have been identified. See www.cdc.gov/flu/professionals/training/.</p> <p><input type="checkbox"/> Language and reading-level appropriate materials have been identified to supplement and support education and training programs (e.g., available through state and federal public health agencies such as www.cdc.gov/flu/groups.htm and through professional organizations), and a plan is in place for obtaining these materials.</p> <p><input type="checkbox"/> Education and training includes information on infection control measures to prevent the spread of pandemic influenza.</p> <p><input type="checkbox"/> The facility has a plan for expediting the credentialing and training of non-facility staff brought in from other locations to provide patient care when the facility reaches a staffing crisis.</p> <p><input type="checkbox"/> Informational materials (e.g., brochures, posters) on pandemic influenza and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic. For more information, see www.cdc.gov/flu/professionals/infectioncontrol/index.htm and www.cdc.gov/flu/groups.htm.</p>

3. Elements of an influenza pandemic plan (continued).

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	An infection control plan is in place for managing residents and visitors with pandemic influenza that includes the following: (For information on infection control recommendations for pandemic influenza, see www.hhs.gov/pandemicflu/plan/sup4.html .)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	An infection control policy that requires direct care staff to use Standard (www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html) and Droplet Precautions (i.e., mask for close contact) (www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html) with symptomatic residents.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A plan for implementing Respiratory Hygiene/Cough Etiquette throughout the facility. (See www.cdc.gov/flu/professionals/infectioncontrol/resphgiene.htm .)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A plan for cohorting symptomatic residents or groups using one or more of the following strategies: ² 1) confining symptomatic residents and their exposed roommates to their room, 2) placing symptomatic residents together in one area of the facility, or 3) closing units where symptomatic and asymptomatic residents reside (i.e., restricting all residents to an affected unit, regardless of symptoms). The plan includes a stipulation that, where possible, staff who are assigned to work on affected units will not work on other units.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Criteria and protocols for closing units or the entire facility to new admissions when pandemic influenza is in the facility have been developed.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Criteria and protocols for enforcing visitor limitations have been developed.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	An occupational health plan for addressing staff absences and other related occupational issues has been developed that includes the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A liberal/non-punitive sick leave policy that addresses the needs of symptomatic personnel and facility staffing needs. The policy considers: <ul style="list-style-type: none"> - The handling of personnel who develop symptoms while at work. - When personnel may return to work after having pandemic influenza. - When personnel who are symptomatic, but well enough to work, will be permitted to continue working. - Personnel who need to care for family members who become ill.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A plan to educate staff to self-assess and report symptoms of pandemic influenza before reporting for duty.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A list of mental health and faith-based resources that will be available to provide counseling to personnel during a pandemic.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A system to monitor influenza vaccination of personnel.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A plan for managing personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised workers) by placing them on administrative leave or altering their work location.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A vaccine and antiviral use plan has been developed. <ul style="list-style-type: none"> <input type="checkbox"/> CDC and state health department websites have been identified for obtaining the most current recommendations and guidance for the use, availability, access, and distribution of vaccines and antiviral medications during a pandemic. For more information, see www.hhs.gov/pandemicflu/plan/sup6.html and www.hhs.gov/pandemicflu/plan/sup7.html. <input type="checkbox"/> HHS guidance has been used to estimate the number of personnel and residents who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis. For more information, see www.hhs.gov/pandemicflu/plan/sup6.html and www.hhs.gov/pandemicflu/plan/sup7.html. <input type="checkbox"/> A plan is in place for expediting delivery of influenza vaccine or antiviral prophylaxis to residents and staff as recommended by the state health department.

2. CDC guidance on preventing and controlling influenza transmission in long-term care facilities will be a useful resource during pandemic influenza. (See www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm.)

3. Elements of an influenza pandemic plan (continued).

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Issues related to surge capacity during a pandemic have been addressed.</p> <ul style="list-style-type: none"> <input type="checkbox"/> A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations. <input type="checkbox"/> A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during an influenza pandemic. (Insert name, title and contact information.) <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law. <input type="checkbox"/> The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis. <input type="checkbox"/> Estimates have been made of the quantities of essential materials and equipment (e.g., masks, gloves, hand hygiene products, intravenous pumps) that would be needed during a six-week pandemic. <input type="checkbox"/> A plan has been developed to address likely supply shortages, including strategies for using normal and alternative channels for procuring needed resources. <input type="checkbox"/> Alternative care plans have been developed for facility residents who need acute care services when hospital beds become unavailable. <input type="checkbox"/> Surge capacity plans include strategies to help increase hospital bed capacity in the community. <ul style="list-style-type: none"> - Signed agreements have been established with area hospitals for admission to the long-term care facility of non-influenza patients to facilitate utilization of acute care resources for more seriously ill patients. - Facility space has been identified that could be adapted for use as expanded inpatient beds and information provided to local and regional planning contacts. <input type="checkbox"/> A contingency plan has been developed for managing an increased need for post mortem care and disposition of deceased residents. <input type="checkbox"/> An area in the facility that could be used as a temporary morgue has been identified. <input type="checkbox"/> Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.

References

Centers for Disease Control and Prevention. Pandemic Website

<https://www.cdc.gov/flu/pandemic-resources/index.htm>

US Department of Health and Human Services. *Pandemic Influenza Plan, 2017 Update*,

<https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>

Occupational Safety and Health Administration. *Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers*, 2009.

https://www.osha.gov/Publications/OSHA_pandemic_health.pdf

US Department of Health and Human Services. *Medical Surge Capacity and Capability: Healthcare Coalitions in Emergency Response and Recovery*, May 2009,

www.phe.gov/preparedness/planning/mscc/handbook/pages/default.aspx

Centers for Disease Control and Prevention. *FluSurge 2.0*. <https://www.cdc.gov/flu/pandemic-resources/tools/flusurge.htm>

Agency for Healthcare Research and Quality by Health Systems Research, Inc. *Altered Standards of Care*, Publication No. 05-0043, April 2005, <http://archive.ahrq.gov/research/altstand/>

Rocky Mountain Regional Care Model for Bioterrorism Events: Local Care Sites During an Emergency Final Report to the AHRQ, Alternative Care Sites, Publication No. 04-0075, August 2004, <http://archive.ahrq.gov/research/altsites/>

Department of Defense. *Modular Emergency Medical Systems*, June 1, 2002

US Department of Health and Human Services. *Long Term Care Checklist*,

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/SandC_EPChecklist_Persons_LTCFacilities_Ombudsmen.pdf

Hick, John L., MD, O’Laughlin, Daniel, MD. *Surge Capacity Triage*, 2006 by the Society for Academic Emergency Medicine, ISSN 1069-6563

Hick, John L., MC, Barbera, Joseph A., MD, and Kelen, Gabor D., MD. “Refining Surge Capacity: Conventional, Contingency, and Crisis Capacity”. *Disaster Medicine and Public Health Preparedness*, 2009.

Joint Commission on Accreditation of Healthcare Organizations. *Surge Hospital: Providing Safe Care in Emergencies*, 2006

American College of Physicians. *The Health Care Response to Pandemic Influenza*.

Philadelphia: American College of Physicians; 2006; Position Paper (available from American College of Physicians, 190 N. Independence Mall West, Philadelphia PA 19106)

DHSS. *Pandemic Influenza - Medical & Public Health Professionals*

<https://health.mo.gov/emergencies/panflu/panflu.php>