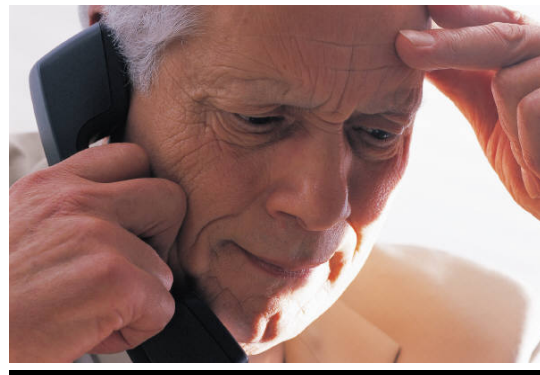
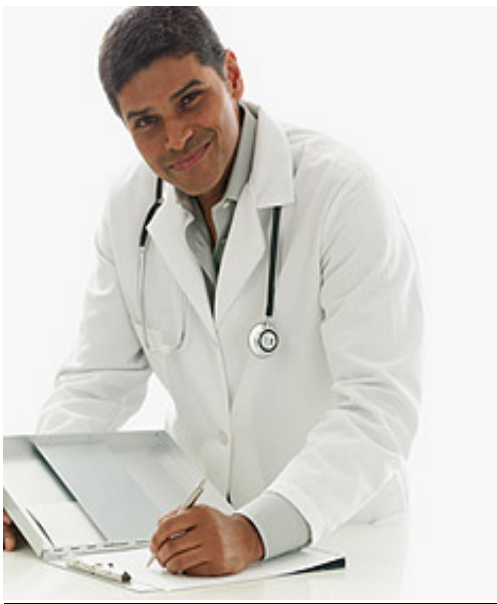


State of Georgia Pandemic Influenza Planning Kit for Outpatient Providers



Prepared for

the

Georgia Hospital Community Bioterrorism Preparedness Program

Georgia Division of Public Health

by

Clarity Healthcare, Inc.

April 2007



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Pandemic Influenza Planning Kit for Outpatient Providers

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Goals of This Planning Kit

The Georgia Division of Public Health developed this planning kit to provide information that will help you prepare for an influenza pandemic so that you can:

- Help public health with the surveillance that will determine when the pandemic reaches your community
- Help limit the spread of the disease once a pandemic starts,
- Prepare your practice through planning and staff education

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Background on Influenza Pandemics

A pandemic is a worldwide outbreak of a disease. An influenza (or flu) pandemic occurs when a new flu virus appears or “emerges” in the human population, causes serious illness, and then spreads easily from person to person worldwide.

Pandemics are different from seasonal outbreaks or “epidemics” of the flu.

- **Seasonal outbreaks** are caused by subtypes of flu viruses that already exist among people.
- **Pandemic outbreaks** are caused by new subtypes or by subtypes that have never circulated among people, or that have not circulated among people for a long time.

In a typical flu season, approximately 36,000 people die of the flu in the United States, mostly the elderly. Past influenza pandemics have led to high levels of illness, death, social disruption, and economic loss.

How New Subtypes of Flu Viruses Emerge

There are many different subtypes of flu viruses. The subtypes differ based upon certain proteins on the surface of the virus. Pandemic viruses emerge when there is a sudden, major change in flu viruses. These changes are caused by new combinations of the proteins on the surface of the virus. This change results in a new flu virus subtype.

The appearance of a new flu virus subtype is the first step toward a pandemic. But the new virus subtype also must spread easily from person to person to cause a pandemic. Once a new pandemic flu virus emerges and spreads, it normally becomes established among people and circulates for many years as seasonal epidemics of flu.

The U.S. Centers for Disease Control and Prevention and the World Health Organization monitor flu activity around the world, and look for new strains of flu virus to emerge that might cause a pandemic.

Flu Pandemics During the 20th Century

During the 20th century, the emergence of new flu virus subtypes caused three pandemics, all of which spread around the world within 1 year of being detected.

- In 1918-19, the "**Spanish flu**," caused the highest number of known flu deaths. More than 500,000 people died in the United States. Up to 50 million people may have died worldwide. Many people died within the first few days after infection, and others died of complications later. Nearly half of those who died were young, healthy adults. For every 1,000 people who got the Spanish flu, 20 died.
- In 1957-58, "**Asian flu**," caused about 70,000 deaths in the United States. First identified in China in late February 1957, the Asian flu spread to the United States by June 1957.
- In 1968-69, "**Hong Kong flu**," caused about 34,000 deaths in the United States. This virus was first detected in Hong Kong in early 1968 and spread to the United States later that year. For every 1,000 people who got the Hong Kong flu, 5 died.

Both the Asian flu and the Hong Kong flu pandemics were caused by new viruses created when a human flu virus and an avian (bird) flu virus combined. It is now believed that the 1918-19 pandemic virus was also caused by an avian flu virus, with similarities to the H5N1 strain of the avian flu virus that is currently circulating in Asia and other parts of the world.

Stages of a Pandemic

The World Health Organization (WHO) has defined the phases of a pandemic:

Interpandemic period (between pandemics)

Phase 1: No new flu virus subtypes have been detected in humans. A flu virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.

Phase 2: No new flu virus subtypes have been detected in humans. However, a circulating animal flu virus subtype poses a substantial risk of human disease.

The difference between phase 1 and phase 2 is based on scientists' judgment of the risk of humans becoming infected by the subtypes that are infecting animals.

Pandemic alert period

Phase 3: Humans have become infected with a new subtype, but there has been no spreading of the virus from human-to-human.

Phase 4: There has been some human-to-human transmission, but it has been limited to small, highly localized cluster(s), suggesting that the virus is not well adapted to humans.

Phase 5: Human-to-human spread is still localized, but now in larger cluster(s), suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).

The distinction between phase 3, phase 4 and phase 5 is based on scientists' judgment of whether the virus is well-adapted to humans, how quickly it will spread, and how sick people will get when they have the virus.

Pandemic period

Phase 6: Human to human spread has increased and is sustained in the general population.

For more information on influenza pandemics, see the list of links in the reference section.

Vaccines to Protect Against Pandemic Flu Viruses

A vaccine probably will not be available in the early stages of a pandemic. Current vaccine production techniques require several months to produce a vaccine that is generally effective only for the specific strain(s) used in the production process. The CDC is working with the WHO and vaccine manufacturers on shortening the time needed to produce an effective vaccine.

Antiviral Medications to Prevent and Treat Pandemic Flu

Four different flu antiviral medications (amantadine (Symmetrel), rimantadine (Flumadine), oseltamivir (Tamiflu), and zanamivir (Relenza)) are approved by the U.S. Food and Drug Administration (FDA) for the treatment and/or prevention of flu. However, the flu viruses identified

in human patients in Asia in 2004 and 2005 have been resistant to amantadine and rimantadine. Monitoring of avian viruses for resistance to flu antiviral medications is continuing.

The References section includes links to the CDC and WHO websites, where you can find information on anti-viral medications, vaccines, vaccine research, and the current status of efforts to speed vaccine development. There is also a link to the recommendations of a joint working group of the Advisory Committee on Immunization Practices (ACIP) and the National Vaccine Advisory Committee (NVAC) regarding priorities for vaccine and anti-viral distribution during a pandemic when these resources are in short supply.

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Introduction

Preparing for the Next Pandemic

Preparing for a pandemic involves taking steps to limit, as much as possible, the number of people who get sick, preparing to take care of possibly large numbers of people who do get sick, and planning how to minimize the disruption to society. Even a mild pandemic will challenge the ability of the health care system because demand will go up even as resources are limited by staff absenteeism due to illness and the need to care for ill family members. (See the Health Care System Surge Capacity section for information on preparing the health care system for a pandemic.) High absentee rates will also make it more difficult to maintain other essential services. Therefore, a cornerstone of the government's plan to minimize the impact of the pandemic is to limit the number of people who get sick.

Non-pharmaceutical interventions (NPIs) will be the primary strategies for limiting the number of people who get sick in the early stages of the pandemic because:

- A vaccine probably will not be available for several months,
- Antibiotics don't work against viruses,
- Antiviral medications will be in short supply, and may not work if the virus becomes resistant.

Non-pharmaceutical interventions include:

- Voluntary isolation of the sick,
- Voluntary quarantine of exposed individuals,
- Child social distancing, *including school closures*, and
- Adult social distancing.

How aggressively these interventions are implemented will depend on the severity of the pandemic as it unfolds. If, as expected, the pandemic begins overseas, we may have some information on how severe it will be as we are implementing our pandemic response. How much information we have and how quickly we have it will depend on how rapidly the pandemic spreads, in what country it starts, and how quickly it reaches our shores.

The CDC has developed a Pandemic Severity Index that is based on the case fatality rate (the percentage of the people who get the disease who die). This Index is designed to facilitate the development of response plans that are contingent upon the severity of the pandemic. Table 1 below shows the expected impact on Georgia of pandemics of various severities using the Pandemic Severity Index. The numbers of deaths expected assumes a 30% illness rate during the pandemic. The three pandemics that occurred in the last century are shown for reference purposes.

Voluntary Isolation of the Sick

This is the only intervention recommended by CDC for all severities of a pandemic. It is always advisable for people who are sick with an infectious disease to stay home and away from other people. However, whether because of the lack of sick benefits or just a desire to "tough it out", in our culture it is the norm for people to go to work when they are sick. In a pandemic, it will be necessary to override this cultural norm and create strong community-based pressure to stay at home when ill.

Table 1: Pandemic Severity Index

Category	Case Fatality Rate	Expected Number of Deaths in Georgia	20 th Century U.S. Experience
1	<0.1%	< 2,722	*
2	0.1 - <0.5%	2,722 - 13,609	1957, 1968
3	0.5 - <1.0%	13,609 - 27,218	None
4	1.0 - <2.0%	27,218 - 54,435	None
5	=> 2.0%	=> 54,435	1918 Pandemic

* Seasonal influenza has approximately this case fatality rate, but an illness rate of only 5 – 20% because of the existence of immunity in some individuals from prior exposure to the specific influenza virus circulating in any given year.

Voluntary Quarantine of Exposed Individuals

What this intervention means is that all members of a household should stay home when any member of the household is ill with flu-like symptoms. Because people with the flu are contagious before they have symptoms, family members of those who are ill could infect classmates or co-workers before they themselves get sick.

The CDC Interim Pre-Pandemic Planning Guidance recommends that this intervention be used in a Category 4 or 5 pandemic, and that it be considered for a Category 2 or 3 pandemic. The Guidance indicates that it is not recommended in a Category 1 pandemic for broad application across communities, but it may be advisable in a particular community or for a particular group of people.

Child Social Distancing

The CDC Planning Guidance uses a three-tiered strategy for planning for the dismissal of children from schools, colleges and universities, and childcare programs:

- No dismissal of students from schools or closure of childcare facilities in a Category 1 pandemic
- Short-term (up to 4 weeks) dismissal of students and closure of childcare facilities during a Category 2 or Category 3 pandemic
- Prolonged (up to 12 weeks) dismissal of students and closure of childcare facilities during a severe influenza pandemic (Category 4 or Category 5 pandemic)

Research shows that it is important that these measures be implemented *before* extensive spread of the virus has occurred in a specific community. **It is not recommended that communities wait to implement school closures until a threshold level of absenteeism in the schools is reached.** In all but the mildest category of pandemic, it is expected that schools will be closed for some period of

¹ Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States – Early, Targeted, Layered Use of Non-pharmaceutical Interventions, Centers for Disease Control and Prevention, February 2007

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time. If schools are not closed, pandemic response activities will focus on infection control in the schools.

Adult Social Distancing

Adult social distancing covers a range of measures including

- Canceling public gatherings, (for example, closing theatres or canceling sporting events),
- Increasing the distance between people by modifying work schedules to reduce the number of people in a particular space so that people can spread out more, and
- Decreasing social contacts (reducing face-to-face meetings in favor of teleconferences, teleworking for those able, replacing attendance at religious services with video services or home prayers).

As with voluntary quarantine of exposed individuals, the CDC Pandemic Planning Guidance recommends that this intervention be used in a Category 4 or 5 pandemic, and that it be considered for a Category 2 or 3 pandemic. It is not recommended in a Category 1 pandemic for broad application across communities, but it may be advisable in a particular community or for a particular group of people.

Community Responsibility for Non-Pharmaceutical Interventions

Discussion of non-pharmaceutical interventions often focuses on official decisions to close schools or cancel public events. But as Table 2 shows, these official actions to close facilities in support of social distancing measures are a small part of any community's toolbox for protecting its community during a pandemic.

Responsibility for successfully implementing non-pharmaceutical interventions must be shared across your community. In fact, successful implementation of *voluntary* isolation of the sick and *voluntary* quarantine of exposed individuals depends on individuals and families making the choice to stay at home when sick, or when a family member is sick. In order for them to be able to make that choice, employers must support that decision through liberalized sick leave policies that do not penalize employees who want to make the right choice for the community. Other members of the community must be willing to support affected households that are voluntarily staying away from the rest of the community by delivering food, medicine, or other supplies that might otherwise cause someone in the household to go to a store, possibly infecting others.

The first task of community leaders and public officials is providing accurate and timely information, as it is available. Just as importantly, they must coordinate these efforts of the various organizations in their community to maximize their effectiveness.

Table 2: Suggested Actions by Pandemic Severity and Type of Non-pharmaceutical Intervention

Category 1 Pandemic (case fatality rate = < 0.1%)			
	Isolation and Quarantine	Child Social Distancing	Adult Social Distancing
Official Actions	Encourage individuals and organizations in voluntary isolation of the sick. Coordinate systems that support affected households.	Encourage cough etiquette and hand hygiene.	Encourage cough etiquette and hand hygiene; encourage alternatives to handshaking.
Community Leadership (e.g., Segment Task Forces) Actions	Encourage individuals and organizations in voluntary isolation of the sick. Coordinate systems that support affected households.	Encourage cough etiquette and hand hygiene.	Encourage cough etiquette and hand hygiene; encourage alternatives to handshaking.
Organizational Actions	Support individual decisions to isolate sick through liberal sick leave policies. Support affected households.	Supports individual decisions to isolate sick through sick leave policies. Screen children and staff for illness and send ill home. Provide supplies for cough etiquette and hand hygiene. Actively encourage cough etiquette and hand hygiene.	Supports individual decisions to isolate sick through sick leave policies. Provide supplies for cough etiquette and hand hygiene. Actively encourage cough etiquette and hand hygiene; encourage alternatives to handshaking.
Individual Actions	Have <i>primary responsibility</i> for voluntary isolation of the sick.	Keep sick children home from school or day care. Practice cough etiquette and hand hygiene; teach and encourage children to do so.	Stay home from work when sick. Practice cough etiquette and hand hygiene; use alternatives to handshaking.

Table 2: Suggested Actions by Pandemic Severity and Type of Non-pharmaceutical Intervention

Category 2 or 3 Pandemic (case fatality rate = 0.1% to < 1.0%)			
	Isolation and Quarantine	Child Social Distancing	Adult Social Distancing
Official Actions	Encourage voluntary isolation of the sick and voluntary quarantine of household members. Coordinate systems that support affected households with deliveries and moral support.	Cancel some extracurricular school activities. Encourage individuals and organizations to suspend low priority activities that involve social contact. Encourage cough etiquette and hand hygiene. [Close schools and day care facilities for up to 4 weeks.]	Encourage individuals and organizations to suspend low priority activities that involve social contact. Encourage cough etiquette and hand hygiene; encourage alternatives to handshaking. [Cancel public gatherings.] [Close recreational and entertainment facilities.]
Community Leadership (e.g., Segment Task Forces) Actions	Encourage voluntary isolation of the sick and voluntary quarantine of household members. Coordinate systems that support affected households with deliveries and moral support.	Encourage individuals and organizations to suspend low priority activities that involve social contact. Encourage cough etiquette and hand hygiene.	Encourage individuals and organizations to suspend low priority activities that involve social contact. Encourage cough etiquette and hand hygiene; encourage alternatives to handshaking.
Organizational Actions	Support individual decisions to isolate sick and quarantine household members through liberal sick leave policies. Support affected households with deliveries and moral support.	Suspend low priority extracurricular activities. Support individual decisions to isolate sick through sick leave policies. Screen children and staff for illness and send ill home. Provide supplies for cough etiquette and hand hygiene; actively encourage cough etiquette and hand hygiene. Support home learning for households that choose it.	Suspend low priority activities. Support individual decisions to isolate sick through sick leave policies. Screen employees for illness and send ill home. Provide supplies for cough etiquette and hand hygiene; actively encourage cough etiquette and hand hygiene; encourage alternatives to handshaking. Support working from home or modifications to work schedules, especially if there are essential workers or vulnerable individuals in the household.
Individual Actions	Have <i>primary responsibility</i> for voluntary isolation of the sick. Households that can may choose to voluntarily quarantine household members when someone in the household is ill.	Keep sick children home from school or day care. Practice cough etiquette and hand hygiene; teach and encourage children to do so. Suspend low priority extracurricular activities. Households that are able may choose to implement a home learning plan, especially if there is an essential worker or vulnerable individual in the household.	Stay home when ill. Practice cough etiquette and hand hygiene; use alternatives to handshaking. Suspend low priority extracurricular activities. Households that are able may choose to work from home or modify work schedules, especially if there is an essential worker or vulnerable individual in the household.

Table 2: Suggested Actions by Pandemic Severity and Type of Non-pharmaceutical Intervention

Category 4 or 5 Pandemic (case fatality rate = > 1.0%)			
	Isolation and Quarantine	Child Social Distancing	Adult Social Distancing
Official Actions	Encourage voluntary isolation of the sick and voluntary quarantine of household members. Coordinate systems that support affected households with deliveries and moral support.	Close schools and day care facilities for up to 12 weeks. Cancel extracurricular school activities. Encourage individuals and organizations to suspend non-essential activities that involve social contact. Encourage cough etiquette and hand hygiene.	Cancel public gatherings. Close recreational and entertainment facilities.
Community Leadership (e.g., Segment Task Forces) Actions	Encourage voluntary isolation of the sick and voluntary quarantine of household members. Coordinate systems that support affected households with deliveries and moral support.	Coordinate systems that support continued student learning while schools are closed. Encourage individuals and organizations to suspend non-essential activities that involve social contact. Encourage cough etiquette and hand hygiene.	Encourage individuals and organizations to suspend non-essential activities that involve social contact. Encourage cough etiquette and hand hygiene.
Organizational Actions	Support individual decisions to isolate sick and quarantine household members through liberal sick leave policies. Support affected households.	Suspend non-essential activities. Support those with school age children at home through sick leave policies. Implement plans for continuing student learning while schools are closed. Actively encourage cough etiquette and hand hygiene.	Modify workplace and work schedules to increase distances between people. Allow working from home, if possible. Suspend non-essential activities. Support individual decisions to isolate sick through sick leave policies. Screen employees for illness and send ill home. Provide supplies for cough etiquette and hand hygiene. Actively encourage cough etiquette and hand hygiene.
Individual Actions	Have <i>primary responsibility</i> for voluntary isolation of the sick. Have <i>primary responsibility</i> for voluntary quarantine of household members.	Implement home learning plan. Limit children's exposure to other children. Suspend non-essential activities. Practice cough etiquette and hand hygiene; teach and encourage children to do so.	Stay home when ill. Work from home or modify work schedule, if possible. Practice cough etiquette and hand hygiene. Suspend non-essential activities.

Introduction

Response Steps

The steps between recognition that a pandemic is imminent and the decision to activate specific response plans are critical. CDC has defined three response steps to reflect the escalation of response action given specific triggers:

- *Alert* includes notification of critical systems and personnel of the impending activation of response plans,
- *Standby* includes initiation of decision-making processes for imminent activation, including mobilization of resources and personnel, and
- *Activate* refers to implementation of the specified pandemic mitigation measures.

Table 3 shows what events trigger each of these response steps.

Table 3: Triggers for Response Steps

Pandemic Severity Index	Response Steps		
	Alert Notification of critical systems and personnel	Standby Initiation of decision-making processes; mobilization of resources and personnel	Activate Implementation
1	Widespread human outbreaks in multiple locations overseas	First human case in North America	First laboratory confirmed cluster in a state or region*
2 and 3	Widespread human outbreaks in multiple locations overseas	First human case in North America	First laboratory confirmed cluster in a state or region*
4 and 5	Confirmed human outbreak overseas	Widespread human outbreaks in multiple locations overseas	First laboratory confirmed cluster in a state or region* (may be the first human case in North America)

* In metropolitan areas that cross state boundaries, the first cluster in the region would trigger activation, even if the cluster is in another state encompassed by the metropolitan area.

As part of your pandemic planning, we are asking you to identify what specific personnel should do during each of these response steps, what critical resources they will need, and the processes that they will follow, so that the transition time between *Alert*, *Standby*, and *Activate* can be minimized. Plans should be developed to address all pandemic severities.

Preparing Georgia

The effect of a pandemic will be very widespread. Every community will be affected. Even people who do not get sick will feel the effects of the pandemic because some activities will be cancelled and some businesses will close temporarily.

Georgia’s pandemic flu community preparedness activities have the following goals:

1. Every resident of Georgia knows how to protect themselves and their families when a pandemic strikes.
2. Every resident of Georgia knows who to call/where to go if someone in their family gets sick during the pandemic.
3. Services and systems are in place to care for large numbers of flu patients.
4. Essential services continue, with modifications planned in advance to minimize the impact of the pandemic.
5. Economic disruption is limited/controlled/managed through pre-planning and community-wide cooperation.

100% participation in pandemic flu preparation is important!

Each county has been asked to create a County Pandemic Flu Planning Committee to help achieve these goals. (Smaller, rural counties may wish to join with a neighbor to ensure sufficient resources for planning.)

The Division of Public Health and the Georgia Emergency Management Agency is providing guidance and assistance to the County Pandemic Flu Planning Committees, but leaders in each community know best how to muster resources, and organize local government, businesses, schools, churches and other organizations.

To help communities plan for a pandemic, we have identified nine community segments that should be actively involved in planning:

- | | |
|-----------------------|------------------------------------|
| 1. Government | 6. Schools |
| 2. Public Health | 7. Transportation |
| 3. Health Care System | 8. Volunteer/Service Organizations |
| 4. Media | 9. Faith-Based Organizations |
| 5. Business | 10. General Public |

Each of these segments has a somewhat different role in planning, and when the pandemic arrives. The role of organizations in the Health Care System segment are shown on the next page. Planning materials being prepared to assist health care providers in pandemic planning are also shown.

The Role of the Health Care System in Pandemic Planning and Response

Planning:

- Develop surge capacity plans using planning kits provided by the Division of Public Health (see below)
- Develop pandemic influenza plans
- Plan and place caches of critical equipment and supplies
- Ensure that patient care protocols to be used during health emergencies with resource shortages (personnel, supplies, and equipment) are consistent with state and Centers for Disease Control guidelines
- Coordinate with public health and other segments of community

When pandemic arrives:

- Implement surge capacity plans
- Implement pandemic influenza plans
- Deploy caches, as necessary
- Implement altered standards, as necessary
- Coordinate with public health and other segments of community

Resources:

- [Healthcare Segment Task Force Worksheet \(included in County Pandemic Influenza Planning Committee Planning Kit\)](#)
- Hospital Surge Capacity Planning Kit
- EMS Surge Capacity Planning Kit (Draft 4)
- Emergent Care Surge Capacity Planning Kit
- Pandemic Influenza Planning Kit for Outpatient Providers (this document)

Infection Control During a Pandemic

Despite the prevalence of influenza year after year, most information on the modes of influenza transmission from person to person is indirect and largely obtained through observations during outbreaks in healthcare facilities and other settings; the amount of direct scientific information is very limited. However, the epidemiologic pattern observed is generally consistent with spread through close contact (i.e., exposure to large respiratory droplets, direct contact, or near-range exposure to aerosols). While some observational and animal studies support airborne transmission through small particle aerosols, there is little evidence of airborne transmission over long distances or prolonged periods of time (as is seen with *M. tuberculosis*). The relative contributions and clinical importance of the possible modes of transmission of influenza remains unclear and may depend on the strain of virus ultimately responsible for a pandemic.

It is important to follow all standard precautions such as hand hygiene before and after all patient contact or contact with items that may be contaminated with respiratory secretions of infected persons. Persons who must be in contact with patients should:

- ✓ Wear a surgical or procedure mask for close contact with infectious patients.
- ✓ Use contact and airborne precautions.
- ✓ Wear gloves (gown if necessary) for contact with respiratory secretions.
- ✓ Perform hand hygiene after contact with infectious patients.

The addition of airborne precautions, including respiratory protection (an N95 filtering face piece respirator or other appropriate particulate respirator), may be considered for strains of influenza exhibiting increased transmissibility, during initial stages of an outbreak of an emerging or novel strain of influenza, and as determined by other factors such as vaccination/immune status of personnel and availability of antivirals.

The prioritization of respirator use during a pandemic remains unchanged: N-95 (or higher) respirators should be worn during medical activities that have a high likelihood of generating infectious respiratory aerosols, for which respirators (not surgical masks) offer the most appropriate protection for health care personnel. Use of N-95 respirators is also prudent for health care personnel during other direct patient care activities (e.g., examination, bathing, feeding) and for support staff who may have direct contact with pandemic influenza patients. If N-95 or other types of respirators are not available, surgical masks provide benefit against large-droplet exposure and should be worn for all health care activities involving patients with confirmed or suspected pandemic influenza. Measures should be employed to minimize the number of personnel required to come in contact with suspected or confirmed pandemic influenza patients.

References

A link to CDC's Interim Guidance on Planning for the Use of Surgical Masks and Respirators in Health Care Settings during an Influenza Pandemic, from which this section was derived, can be found in the References section, beginning on page 18. The use of surgical masks by hospitalized patients and other symptomatic persons ("source control") is covered in the CDC's Interim Guidance for the Use of Masks to Control Influenza Transmission, also included in the Reference section.

The World Health Organization (WHO) publication, Infection Control Recommendations for Avian Influenza in Health-Care Facilities, has been reproduced on the next pages. You can check for the

most up-to-date version at

http://www.who.int/csr/disease/avian_influenza/guidelines/EPR_AM_final.pdf

More detailed infection control guidance can be found on the websites of the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), and the Department of Health and Human Services (DHHS). Links to these websites are provided in the References section. As the epidemiologic characteristics of the pandemic virus are more clearly defined, CDC will provide updated infection control guidance, as needed.

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Infection control recommendations for avian influenza in health-care facilities

Health-care facility infection control recommendations for avian influenza (AI)

The current avian influenza A (H5N1) epidemic in birds began in south-east Asia in 2003 and has since spread to other parts of the world. Human cases have been reported in several countries since December 2003 and health-care facilities in several countries now face the challenge of providing care for patients infected with avian influenza (AI). It is critical that health-care workers use appropriate infection control precautions when providing care for these patients to minimize the possibility of transmission of infection to themselves, other health-care workers, patients, and visitors.

As of the date of this document, no efficient human-to-human transmission of AI A (H5N1) is known to have occurred, and there is no evidence to suggest airborne transmission from humans to humans. However, enhanced infection control precautions for patients with suspected or confirmed AI infection appear to be warranted because of the uncertainty about the modes of human-to-human AI transmission, the high lethality of human AI A (H5N1) infection to date, and the possibility that the virus could mutate or reassort at any time into a strain capable of efficient human-to-human transmission.

Important advice

- Use standard and droplet precautions when providing care for patients with acute, febrile, respiratory illness, regardless of whether AI infection is suspected. Facial protection and hand hygiene are the most critical elements of these precautions and should be prioritized.
- Full barrier precautions (standard, contact, and airborne precautions) should be used, when possible, when working in direct contact with suspected or confirmed AI-infected patients.
- Because the use of airborne precautions may not be feasible in all health-care facilities, minimal requirements when providing care for AI-infected patients should include standard, contact, and droplet precautions, plus eye protection. Elements of airborne precautions should be prioritized and pursued when resources permit.

✓ Personal protective equipment (PPE) and hand hygiene checklist

- Before entering the AI patient room or area, put on PPE including:
 - Clean, non-sterile long-sleeved gowns.
 - If cloth gowns are used, a plastic apron should also be used if splashing of blood, body fluids, excretions, or secretions is anticipated.
 - Clean, nonsterile, ambidextrous gloves, which cover the cuffs of the gown.
 - Face shield, visor, or goggles.
 - A particulate respirator that is at least as protective as a US NIOSH-certified N95, EU FFP2, or equivalent respirator. If particulate respirators are not available, use surgical or procedure masks.
- Put on PPE carefully before patient contact to avoid the need for adjustments and to reduce the risk of self-contamination/inoculation.
- Remove PPE carefully to avoid self-contamination/inoculation.
- Perform hand hygiene before and after any patient contact and after contact with contaminated items, whether or not gloves are worn.
 - Perform hand hygiene before putting on PPE, immediately after glove removal, and after taking off all PPE items.
 - Hand hygiene includes either hand washing with soap and water, followed by drying with a clean towel or, preferably, the use of an alcohol-based hand rub.
 - Wash hands with soap and water when they are visibly soiled.

For more details, see **Avian Influenza, including Influenza A (H5N1), in Humans: WHO Interim Infection Control Guideline for Health-care Facilities** available at http://www.who.int/csr/disease/avian_influenza/guidelines/infectioncontrol1/en/index.html



World Health Organization

Health-care facility infection control recommendations for avian influenza (AI)

KEY ELEMENTS AT A GLANCE

1. Basic infection control recommendations for all health-care facilities

Standard and droplet precautions when caring for patients with acute, febrile, respiratory illness

2. Respiratory hygiene/cough etiquette

Individuals with respiratory symptoms should cover cough with mask or tissue and perform hand hygiene

3. Early recognition and reporting of AI cases

Consider AI in patients with acute, febrile, respiratory illness who have been in an AI-affected region within the 2 weeks prior to symptom onset and who have had exposure to birds or to a human AI case in the region

4. Isolation precautions for suspected and confirmed AI cases

Place patient in negative pressure room (if available). Full barrier precautions (standard, contact, and airborne) for all persons entering the isolation room

5. Additional measures to reduce nosocomial AI transmission

Limit numbers of health-care workers/family members/visitors exposed to AI patient

6. Specimen collection/transport/handling within health-care facilities

Use full barrier precautions for specimen collection. Use standard precautions for specimen transport to the laboratory. Health-care facility laboratories should follow best biosafety practices

7. Family member/visitor recommendations

Family members/visitors should be limited to those essential for patient support and should use full barrier precautions

8. Patient transport within health-care facilities

AI patient should wear surgical mask. Health-care workers doing transport should wear gowns and gloves

9. Pre-hospital care

Full barrier precautions for all involved with suspected AI patients

10. Waste disposal

Treat waste possibly contaminated with AI virus as clinical waste following local regulations

11. Dishes/eating utensils

Use standard precautions

12. Linen and laundry

Use standard precautions; avoid shaking linen/laundry

13. Environmental cleaning and disinfection

AI virus can survive in the environment for variable periods of time (hours to days), and is inactivated by standard hospital disinfectants. Clean and disinfect AI patient room at least once a day; frequently touched surfaces should be cleaned more often

14. Patient care equipment

Dedicate to AI patient. If not possible, clean and disinfect before reuse

15. Duration of AI infection control precautions

Adults >12 years: 7 days after resolution of fever
Children <12 years: 21 days after symptom onset

16. Patient discharge

If AI patient is still infectious (i.e. discharged within the period of AI infection control precautions: see box above), instruct family members on appropriate infection control precautions in the home

17. Occupational health recommendations

Monitor health of health-care workers exposed to AI patients. Antiviral prophylaxis should follow local policy. Use of seasonal influenza vaccine should be promoted

18. Health-care facility administrative controls

Health-care worker AI education, training, and risk communication. Adequate staffing and PPE

19. Prioritization of PPE when supplies are limited

Facial protection (eyes, nose, and mouth) and hand hygiene are priorities

20. Health-care facility engineering controls

If single rooms for AI patients are not possible, cohort patients in isolation wards keeping at least 1 m between beds. Negative pressure rooms for AI patients, if available

Health Care System Surge Capacity

An Overview of Georgia's Statewide Integrated Surge Capacity Plan is included as Appendix A. The plan addresses inpatient care, emergent and ambulatory care, and patient transportation. Surge capacity for each of these three components consists of surge capacity within existing organizations, and temporary capacity that can be set up when needed, but must be planned in advance.

Hospitals completed their surge capacity planning kits during 2005. The Division of Public Health is providing funding to each hospital to purchase supplies and equipment to be stockpiled for use when surge capacity is activated in an emergency. **All** of the state's 150 acute care hospitals completed the Surge Capacity Planning Kit for Hospitals, reporting a total of:

- 2,276 ISC1 beds (equipped, but NOT staffed),
- 4,357 ISC2 beds (in day treatment and procedure units), and
- 6,952 ISC3 beds (spaces in hallways, classrooms).

These 13,585 beds represent a surge capacity of 77% over and above the approximately 17,642 normally equipped and staffed beds in Georgia's acute care hospitals.

Stockpiles of supplies and pharmaceuticals have been placed in individual hospitals to support the ISC1 and ISC2 capacity they reported. Public Health District stockpiles to support ISC3 beds include 7,000 disaster hospital beds, other equipment, supplies, and pharmaceuticals. The ISC beds, and the stockpiles to support them, give Georgia a surge capacity of 332% of the federal requirement.

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The final component of Georgia's Integrated Surge Capacity Plan will be extremely important during a pandemic: Home Patient Care Management. The goal of this program is to keep people at home as long as they can be safely cared for by family or friends. The benefits of home management of patients include:

- Hospitals can concentrate on, and provide better care to, the sickest patients.
- Reduction in the exposure of flu patients to other infections that they would not be exposed to at home.
- Limiting the number of people with whom flu patients come in contact.

We will be asking people to stay at home and away from others as long as anyone in their household is sick with the flu (voluntary quarantine).

Home Patient Care Management (HPCM) will include:

- Information on how to care for a flu patient will be available in brochures, videos, and television broadcasts. These materials will also include information on how to protect the caregiver and other family members.
- An 800 number for people to call when someone in their family gets the flu. Public health nurses will coach them in how to care for their loved one, and will continue to follow-up with them until everyone in their family is well again. They will also help them to decide when they do need to go to a doctor's office or the hospital. Households with influenza patients will be enrolled in the Home Patient Care Management system, and provided with support services.
- Kits of medical supplies not normally found in homes will be delivered to patients' homes.

Outpatient Providers

- ▶ Health care workers may visit homes if the nurse managing the patient's care feels that she needs an evaluation by a trained health care worker.
- ▶ Support services such as grocery, medication, and prepared meal delivery are being organized to help facilitate the voluntary quarantine.

We are hoping that outpatient providers will choose to integrate their own telephone triage efforts with the Home Patient Care Management System. Your nurses will be able to access the HPCM triage protocols online, and enroll your patients in the HPCM so that they can receive support services and supplies. Your staff can continue to manage your patients, while making the services of the HPCM available to them.

Planning for the HPCM is taking place at the state, public health district, and community level. The State Division of Public Health is developing the care management protocols based on CDC guidelines. Planning kits are being developed for each public health district to use in developing the Home Patient Care Management System in its district, and for Community Organizations that are willing to help provide support services to affected households.

The Role of Outpatient Providers in Georgia's Pandemic Influenza and Health Care System Surge Capacity Planning

If every outpatient provider in the state plans in advance what they will do when an influenza pandemic strikes, we will be better prepared to meet the needs of the people of Georgia. If those plans are coordinated within each community and across communities, and between the health care system and public health, we will be as prepared as we can be when the time comes. The purpose of this planning kit is to facilitate this planning process.

Outpatient providers can help to prepare for a pandemic in the following ways:

1. Participate in the Sentinel Provider network. Data from sentinel providers are critical for monitoring the impact of influenza and are used to help guide prevention and control activities, vaccine strain selection, and patient care (see box on the Sentinel Provider network).
2. If you are a primary care provider or are in a specialty that treats influenza patients, plan for surge capacity in your own practice to meet the substantial increase in the demand for health care services that will occur in a pandemic,

OR

If you are in a specialty that treats patients with chronic diseases, provide management of influenza for these patients to reduce the burden on primary care providers and ensure that the specialized needs of your patients are not overlooked in care environments stretched to accommodate higher than normal volumes,

OR

If you are in a specialty that will likely experience a decrease in volume during a pandemic, support the surge capacity plans of other providers and your community by offering your services and those of your staff for phone triage, staffing of temporary facilities, etc.

Now You Can Help With...

Influenza Sentinel Provider Surveillance

...In Only a Few Minutes a Week!

What is an influenza sentinel provider?

Influenza sentinel providers conduct surveillance for influenza-like illness (ILI) in collaboration with state health departments and the Centers for Disease Control and Prevention. Data reported by sentinel providers provide a picture of ILI activity in the U.S. Approximately 1600 providers in 49 states were enrolled in this network during the 2002-03 influenza season.

What data do sentinel providers collect? How and to whom are data reported?

Sentinel providers report the total number of patient visits each week and the number of patient visits for influenza-like illness by age group (0-4 years, 5-24 years, 25-64 years, ≥ 65 years). These data are transmitted once a week via the Internet, a touch-tone telephone, or fax to a central data repository at CDC. Most providers report that it takes them **less than 30 minutes a week** to compile and report their data. In addition, sentinel providers can submit specimens from a subset of patients for virus isolation **free of charge**.

Who can be an Influenza Sentinel Provider?

Providers of any specialty (e.g., family practice, internal medicine, pediatrics, infectious diseases) in any type of practice (e.g., private practice, public health clinic, urgent care center, emergency room, university student health center) are eligible to be sentinel providers.

Why Volunteer?

Influenza viruses are constantly evolving and cause substantial morbidity and mortality (approximately 36,000 deaths) almost every winter. Data from sentinel providers are critical for monitoring the impact of influenza and, in combination with other influenza surveillance data, can be used to guide prevention and control activities, vaccine strain selection, and patient care. Sentinel providers receive feedback on the data submitted, summaries of regional and national influenza data, and a free subscription to CDC's Morbidity and Mortality Weekly Report and Emerging Infectious Diseases journal. The most important consideration is that the data provided are critical for protecting the public's health.

For more information on Influenza Sentinel Provider Surveillance, please contact the Georgia Division of Public Health at 404-657-2588.



Outpatient Providers

Our model for handling the increased demand for outpatient care during a pandemic can be briefly described as follows:

- Outpatient providers who can will increase the number of staff fielding phone calls. As many patients as possible will be provided with phone support in caring for their loved ones at home.
- Information on how to care for a patient at home will be provided via continuous television broadcasts, the internet, and print materials.
- Patients being managed at home that need support services will be enrolled in the public health Home Patient Care Management system.
- Patients that need to be seen will visit their own physicians, who will have modified patient flow patterns to segregate flu patients and will have instituted procedures to limit transmission.
- If a patient requires hospitalization, the provider will call the Regional Coordinating Hospital Operations Center for bed assignment and to arrange transportation, if necessary. The RCH will alter normal referral patterns only if resource management requires it.
- Patients being discharged will be referred back to the Home Patient Care Management System for support services, if necessary.

Planning Your Surge Capacity

As discussed in more detail in the Integrated Surge Capacity Plan in the Appendix, three types of resources are necessary in order to implement surge capacity: Physical facilities and equipment, personnel, and training. As you think about how you can increase your capacity during an influenza pandemic, you should address each of these types of resources.

Surge capacity planning for **physical facilities and equipment** involves identifying how you can modify patient flow or use space differently to increase capacity. This may include converting non-patient care space for patient care in an emergency. It also involves evaluating equipment and supply needs and increasing inventory or establishing stockpiles for critical items.

In a health emergency that affects only a limited geographic area (e.g., explosion, natural disaster, or localized bioterrorist attack), health care **personnel** can be moved to the affected area from other areas of the state, and even from other parts of the country. Planning to accomplish this movement of personnel efficiently is a key component of our emergency staffing plan. However, in a pandemic, the increased demand for health care personnel will be universal, and each community will have to manage with the personnel resources it can muster from within its own borders.

In the 8 to 12 weeks that the first wave of an influenza pandemic is expected to last, the demand for some health care services will likely decrease. Elective procedures will not take place, and patients will likely not seek specialist care for non-urgent conditions. Health care personnel involved in these areas of reduced demand can be reassigned to assist with the care of flu patients.

Retired staff may be asked to return to work in some capacity. Clinical staff who normally work in an administrative capacity may also be able to assist in the care of flu patients.

Part of your planning for a pandemic should be to think about how you can increase your staff in these ways, how you might best use staff in areas outside of their primary expertise, and how you might use retired staff whose skills may have gotten a little rusty.

Outpatient Providers

Training is the third resource required in creating health care surge capacity. In the case of outpatient care in an influenza pandemic, this training will need to be focused on providing refresher courses for retired health care personnel, and influenza-focused primary care refreshers for personnel normally working in specialty care or administrative areas. The GDPH will be making this type of training available.

Coordination of Medical Resources

In a pandemic, the expected demand on the healthcare system will challenge even the most prepared facilities, and will likely overwhelm the medical care system in some areas. It will be the job of public health to coordinate resources in short supply, and facilitate the deployment of resources from federal and state stockpiles.

GDPH has been working for four years with the Georgia Hospital Association (GHA) on hospital surge capacity planning. A statewide Mutual Aid Group that includes all hospitals in the state, and is coordinated by GHA, has been planning and developing systems of cooperation to be used in any emergency that puts unusual demands on the healthcare system. Discussion at meetings of the Mutual Aid Group led to the designation of thirteen Regional Coordinating Hospitals who have volunteered to assist with the coordination of resources and movement of patients in an emergency. The overview of Georgia's Statewide Integrated Surge Capacity Plan in Appendix A includes an Emergency Response Model that elaborates on the role of the Regional Coordinating Hospitals.

Individual providers can help to develop plans for their community by participating in the Health Care Task Force of your County Pandemic Influenza Planning Committee. You can get more information on the specific plans for your community by contacting your local hospital's emergency preparedness coordinator, your county health department or your district public health office. It is especially important that you know how important information will be communicated to providers during a pandemic, and how you can communicate your issues and resource needs to the emergency medical command structure.

Outpatient Providers

Planning Steps:

We are asking every outpatient provider in the state to develop a pandemic flu plan. Planning steps vary somewhat depending on whether you are a primary care provider or are in a specialty that treats influenza patients (e.g., infectious diseases or pulmonology), or whether you are in a specialty that will likely experience a decrease in volume during a pandemic.

Primary Care and Specialties that treat influenza patients:

- 1) Estimate the increase in demand. (An Excel worksheet is provided that will automatically calculate the demand over an 8 week pandemic once you enter the number of active patients in your practice. The case fatality rate, a projected admission rate, and a projected ratio of outpatient visits to the number sick is provided for each Pandemic Severity.)
- 2) Develop a staffing plan that includes:
 - a) Monitoring of staff for signs of illness and assigning staff with minor symptoms to areas that do not involve contact with patients who may not have the pandemic strain.
 - b) Contacting retired staff in advance to determine their willingness to assist in a pandemic and helping them to obtain refresher training.
 - c) Asking specialists and their staffs to assist in treating flu patients during a pandemic.
- 3) Develop a triage/patient flow plan that includes:
 - a) Pre-screening patients before an appointment is given to reduce visits by the “worried well”, reducing their exposure to flu patients and the demand for office visits. Providing some basic education and referral to additional sources of information will help to minimize their seeking care elsewhere (e.g., the emergency room).
 - b) Triage incoming patients at the entrance to your office and separating patients with respiratory symptoms from other patients (e.g., separate waiting areas). You may also want to consider the use of guest pagers to allow patients to wait in their cars (weather permitting).
 - c) Offering a mask to patients who are coughing or sneezing.
 - d) Planning how you might use non-patient care space.

Specialties that treat patients with chronic diseases:

- 1) Estimate the increase in demand. (An Excel worksheet is provided that will automatically calculate the demand over an 8 week pandemic once you enter the number of active patients in your practice. The case fatality rate, a projected admission rate, and a projected ratio of outpatient visits to the number sick is provided for each Pandemic Severity. These projections are for the general population, not for individuals with chronic diseases, so you may want to modify them somewhat.)
- 2) Develop a staffing plan that includes:
 - a) Monitoring of staff for signs of illness and assigning staff with minor symptoms to areas that do not involve contact with patients who may not have the pandemic strain,
 - b) Contacting retired staff in advance to determine their willingness to assist in a pandemic and helping them to obtain refresher training,
 - c) Asking other specialists and their staffs to assist in treating flu patients during a pandemic.

Outpatient Providers

- 2) Develop a triage/patient flow plan that includes:
 - a) Ongoing management of patients with chronic conditions, including influenza care (coordinate in advance with their primary care providers),
 - b) Pre-screening patients before an appointment is given to reduce visits by the “worried well”, reducing their exposure to flu patients and the demand for office visits. Providing some basic education and referral to additional sources of information will help to minimize their seeking care elsewhere (e.g., their primary care physician or the emergency room).
 - c) Triage incoming patients at the entrance to your office and separating patients with respiratory symptoms from other patients (e.g., separate waiting areas). You may also want to consider the use of guest pagers to allow patients to wait in their cars (weather permitting).
 - d) Offering a mask to patients who are coughing or sneezing.
 - e) Planning how you might use non-patient care space.

Specialties that will likely experience a decrease in volume during a pandemic:

- 1) Estimate the effect of a pandemic on demand.
- 2) Develop a staffing plan that includes:
 - a) Estimating the effect of any decrease in demand on your staffing needs.
 - b) Monitoring of staff for signs of illness and assigning staff with minor symptoms to areas that do not involve contact with patients who may not have the pandemic strain.
 - c) Identifying staff that are willing to support the community response by assisting primary care providers or by working at temporary facilities.
 - d) Contacting retired staff in advance to determine their willingness to assist in a pandemic and helping them to obtain refresher training.
- 3) Develop a triage/patient flow plan that includes:
 - a) Pre-screening patients before appointments to reduce visits by patients with symptoms of influenza like illness.
 - b) Triage incoming patients at the entrance to your office and separating patients with respiratory symptoms from other patients (e.g., separate waiting areas). You may also want to consider the use of guest pagers to allow patients to wait in their cars (weather permitting).
 - c) Offering a mask to patients who are coughing or sneezing.
 - d) Planning how you might use non-patient care space.

Ideally, all health care providers in a community will work together on this planning. Once you have estimated your increased demand, and developed staffing and triage plans, you will be able to assess, as a community, how well you can meet the demand for the various pandemic scenarios. This will help public health officials plan for temporary capacity during a pandemic and identify community-wide and statewide resource needs.

The Centers for Disease Control and Prevention (CDC) have developed a Medical Offices and Clinics Pandemic Influenza Planning Checklist which you may find useful as an adjunct to this planning kit. It is reproduced on [page 18](#) of this kit. You can check for the most up-to-date version at www.pandemicflu.gov/plan/medical.html.

Outpatient Providers

This planning kit was designed to guide your pandemic planning activities, and help you coordinate your efforts with others in your community. It is a work-in-progress. It will be improved by your experiences in using it. Your comments on the usefulness of the kit, or suggestions for its improvement are welcome and should be sent to:

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kathleen.lysak@clarityhealthcare.com

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Projected Effect of an Influenza Pandemic on Your Practice

Fill in the best estimate you have of the number of active patients in your panel. The rest of the calculations will be done for you. You can test assumptions that differ from CDC's by changing the numbers in the green boxes.

	Active Patients	Total number of your patients who will get sick assuming an illness rate of	Pandemic Severity		Case Fatality Rate	Projected Admissions Rate	Projected Ratio OP Visits:Sick	
			1	2	3	4	5	
	1,000	30%	300		(up to) 0.1%	0.5%	0.4	
					0.1 - < 0.5%	1.0%	0.76	
					0.5 - < 1.0%	3.0%	1.8	
					1.0 - < 2.0%	5.0%	2.5	
					+ 2%	7.0%	3.8	
Distribution over an 8 week wave (CDC projection) for a pandemic								
Week	1	2	3	4	5	6	7	8
Percent of the total	6%	10%	15%	19%	19%	15%	10%	6%
Number who will get sick								
	Assuming the illness rate in the blue box above							
	18	30	45	57	57	45	30	18
Number of outpatient visits								
	Assuming 3.8 ratio of visits : number sick (Not all of the sick will seek health care, but those that do may have more than one visit.)							
	68	114	171	217	217	171	114	68
Number of hospitalizations								
	Assuming 7% of those who get sick will require hospitalization							
	1	2	3	4	4	3	2	1
Number who will die								
	Assuming 2% of those who get sick will die							
	0	1	1	1	1	1	1	0

CDC assumes a 30% illness rate for all pandemic severities. The case fatality rate varies by Pandemic Severity Index (PSI) as shown in the box above. The projected admissions rate and the projected ratio of outpatient visits to the number sick were derived from the default data in CDC's FluAid 2.0.

General avian/pandemic influenza information

www.health.state.ga.us/pandemicflu

www.health.state.ga.us/epi/flu/whatyouknow.asp

www.health.state.ga.us/epi/flu/recommendations.asp

www.health.state.ga.us/epi/flu/flu-diabetes.asp

www.pandemicflu.gov

www.hhs.gov/flu/

www.dhhs.gov/nvpo/pandemics/

www.cdc.gov/flu/

www.cdc.gov/flu/avian/

www.cdc.gov/flu/avian/gen-info/pandemics.htm

www.who.int/topics/influenza/en/

www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_2005_5

Plans and Planning

World Health Organization (WHO), Responding to the Avian Influenza Pandemic Threat: Recommended Strategic Actions, 2005.

www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_05_8-EN.pdf

www.cdc.gov/flu/pandemic/healthprofessional.htm

www.pandemicflu.gov/plan/medical.html.

Public Health Guidance Supplements to the HHS Pandemic Influenza Plan:

Surveillance: www.hhs.gov/pandemicflu/plan/pdf/S01.pdf

Laboratory: www.hhs.gov/pandemicflu/plan/pdf/S02.pdf

Healthcare Planning: www.hhs.gov/pandemicflu/plan/pdf/S03.pdf.

Infection Control: www.hhs.gov/pandemicflu/plan/pdf/S04.pdf

Clinical Guidelines: www.hhs.gov/pandemicflu/plan/pdf/S05.pdf

Vaccine Distribution and Use: www.hhs.gov/pandemicflu/plan/pdf/S06.pdf

Antiviral Drug Distribution and Use: www.hhs.gov/pandemicflu/plan/pdf/S07.pdf

Community Disease Control and Prevention: www.hhs.gov/pandemicflu/plan/pdf/S08.pdf

Managing Travel-Related Risk of Transmission: www.hhs.gov/pandemicflu/plan/pdf/S09.pdf

Public Health Communications: www.hhs.gov/pandemicflu/plan/pdf/S10.pdf

Workforce Support: www.hhs.gov/pandemicflu/plan/pdf/S11.pdf

Clinical Management

www.who.int/csr/disease/avian_influenza/guidelines/pharmamanagement/en/index.html WHO Rapid Advice Guidelines on pharmacological management of humans infected with avian influenza A (H5N1) virus

Vaccines and Antivirals

www.who.int/csr/disease/avian_influenza/guidelinetopics/en/index5.html

www.pandemicflu.gov/vaccine/index.html

Joint working group of the Advisory Committee on Immunization Practices (ACIP) and the National Vaccine Advisory Committee (NVAC) regarding priorities for vaccine and anti-viral distribution during a pandemic when these resources are in short supply can be found at [NVAC/ACIP Recommendations on Use of Vaccines and NVAC Recommendations on Pandemic Antiviral Drug Use](#).

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Infection Control

www.hhs.gov/pandemicflu/plan/#part2 *Interim Guidance on Planning for the Use of Surgical Masks and Respirators in Health Care Settings during an Influenza Pandemic*, augments and supersedes recommendations provided in Part 2 of the *HHS Pandemic Influenza Plan*

www.cdc.gov/flu/professionals/infectioncontrol/ Infection control recommendations related to seasonal influenza

www.cdc.gov/flu/avian/professional/infect-control.htm Infection control recommendations related to avian influenza A (H5N1)

www.cdc.gov/flu/professionals/infectioncontrol/maskguidance.htm The use of surgical masks by hospitalized patients and other symptomatic persons

http://www.who.int/csr/disease/avian_influenza/guidelines/EPR_AM_final.pdf World Health Organization (WHO), Infection Control Recommendations for avian influenza in health-care facilities, 2006

Appendices

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If the State of Georgia is ever confronted with a mass casualty incident, a bioterrorism event or disease pandemic, the demand for medical care could greatly outstrip the normal operating capacity of the health care system. This may occur in a single community; a region of the state, or the entire state. In the case of an influenza pandemic, it could be occurring throughout the country at the same time.

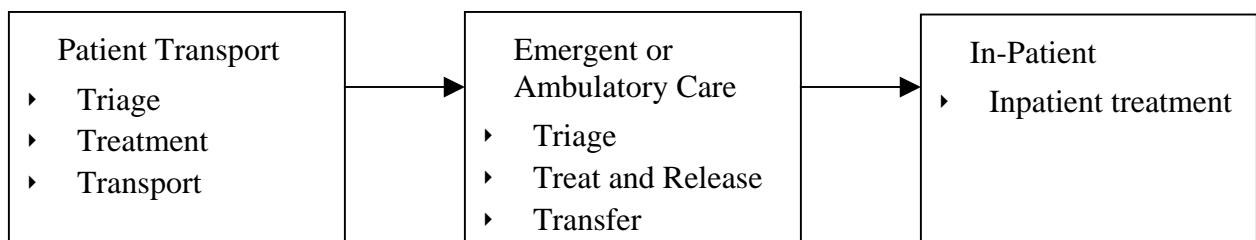
This document provides an overview of the State of Georgia's **Statewide Plan for Scalable Surge Capacity** to respond to just such a major health emergency. It outlines how we can increase our ability to provide patient care no matter which scenario confronts us. Because we need to be prepared for any scenario, of any size, we must be flexible in our planning and agile in our response.

To make this plan work, each provider of health care services must take steps to identify how much they can expand their capacity in a health emergency, and what they would need in order to make it happen. Systems must also be in place to allow communication and coordination of all of the components of the health care system. Management of the response to hurricanes Katrina and Rita also demonstrated the need for the medical care system to coordinate effectively with the Mental Health system and with emergency human services. The Office of Preparedness is providing planning kits to assist individual organizations in this planning. It is also developing the systems to coordinate all of the components in a health emergency.

This effort began as a means to ensure that the State of Georgia would be prepared for a bioterrorism event. It then broadened to include preparedness for "all hazards", including other forms of terrorism, natural disasters, and industrial accidents. Most recently, the focus has narrowed to ensure that the systems being developed will be adequate to address the most immediate threat we are facing: an influenza pandemic. This focus on pandemic influenza has resulted in a shift in the locus of some of the planning from the public health district level to the county level, and a broadening of the planning effort to include all segments of the community. The result has been the creation of County Pandemic Influenza Planning Committees across the state. These county committees are charged with enlisting the broadest possible participation in pandemic preparedness planning, and with ensuring that resources are coordinated community-wide. Health care system surge capacity and emergency response will continue to be coordinated at the district level.

Integrated Surge Capacity Planning

Health care system surge capacity can be viewed as having three components:



Overview

For each one of these components to have effective surge capacity, the following resources are required:

- ▶ Physical facilities and equipment - Physical facilities and equipment includes patient care equipment and supplies, pharmaceuticals, personal protective equipment (PPE) for healthcare workers, and equipment to ensure that health care facilities remain available and can coordinate care in an emergency (e.g., emergency generators and communications equipment).
- ▶ Personnel - Personnel resources are finite, and in many cases in short supply. Providing sufficient personnel in an emergency requires effective and efficient systems for moving these finite resources to the areas most in need. It also requires that services be in place to address the physical and psychosocial needs of health care workers and their families. During a pandemic, however, each community will need to be prepared to manage with its own health care workers and be able to provide support for their needs from within its own community.
- ▶ Training - Training ensures that all of the personnel within the health care system are familiar with the systems in place to respond to an emergency, and practiced in the changes to patient care protocols that may be necessary, depending on the extent of the event.

Integrated planning for scalable surge capacity must address all of these resources for each component of surge capacity, and must knit them together into an integrated response system, flexible enough to address an event of any size: affecting only a single facility, an entire community, a region of the state, the entire state, or even a multi-state area.

We divided Surge Capacity into the following types, each of which requires a somewhat different approach to planning:

- ▶ ***Internal Surge Capacity*** Patient care capacity that can be created by existing health care providers by re-purposing resources or using non-patient care areas for patient care in an emergency.
- ▶ ***Temporary capacity*** set-up in response to a health care emergency following the Modular Emergency Medical System (MEMS) model created by the Department of Defense. (See Box on MEMS)

For internal surge capacity, planning involves identifying how existing facilities and resources can be stretched through advance planning, deployment of caches, development of emergency staffing mechanisms, and training of staff. In a healthcare emergency, these facilities must be able to communicate and coordinate with each in a way not normally required, and with the emergency response framework of the community.

Temporary facilities require that plans be in place to create, within hours, a health care facility that is equipped and staffed, with predetermined procedures and a management team that communicates and coordinates with the health care system and the emergency response framework of the community.

The sections that follow describe how the planning model described above is being applied to each of the three components of health care system surge capacity

Inpatient Care

Internal Surge Capacity

The first step in hospital surge capacity planning was to determine how much hospitals in the state could expand their capacity in an emergency. While most hospital disaster plans provide for canceling elective procedures, putting beds in hallways, and setting up temporary patient care areas in classrooms and auditoriums, the extent to which the system could expand through these activities had never been quantified. We developed a Hospital Surge Capacity Planning Kit to assist in quantifying and documenting this capacity.

We subdivided hospital Internal Surge Capacity into the following Planning Areas, based on the resources required for activation:

Internal Surge Capacity Planning Area 1 (ISC1) is those inpatient beds that are equipped, but ARE NOT routinely staffed. These beds are the quickest and easiest to activate in an emergency, utilizing existing hospital personnel and family members to provide care. In most cases, each individual facility should be able to staff these beds within 3 hours in an emergency. Staffing assistance may be required if they will be needed for an extended period of time. Caches of supplies and pharmaceutical are being placed in hospitals for quick access.

Internal Surge Capacity Planning Area 2 (ISC2) includes day treatment beds and beds in special service units such as Post Anesthesia Care Units (PACU), Admit/Recovery Units (ARUs), Cardiac Cath Labs, Endoscopy labs, temporary holding units for ED overflow, etc. These beds are also relatively easy to activate in an emergency (within 3 hours). They are already equipped, and staffing ratios on these units generally exceed that of med/surg units. Mutual aid personnel would augment internal staffing in certain circumstances. Caches of supplies and pharmaceutical are being placed in hospitals for quick access. While ISC2 beds are immediately available surge capacity, they cannot be used for surge capacity for a long period of time. The elective procedures for which these beds are normally used, can only be cancelled for a few days at most. Other alternatives need to be available for events of longer duration, such as a disease pandemic.

Internal Surge Capacity Planning Area 3 (ISC3) required each hospital to identify space within its buildings where additional beds could be placed. Use of this space involves placing beds, stretchers, or cots in hallways, classrooms, or other non-patient care areas, and/or in existing patient rooms. Implementing this surge capacity will require district-based caches of equipment, as well as supplies and pharmaceuticals. Staffing for these beds may require supplementation of existing staff with mutual aid staff, medical volunteers, and the assistance of family members. ISC3 beds are planned for activation within 24 hours of notification. Caches to convert ISC3 areas into patient care are being deployed as district-based caches that can be transported where needed in an event. In most cases, ISC3 spaces can be used as surge capacity for an extended period of time.

We distributed worksheets to all of the hospitals in the state to assist in documenting the Internal Surge Capacity in the above ISC planning areas within hospital facilities. All of the state's 150 acute care hospitals responded, reporting a total of:

- ▶ 2,276 ISC1 beds,
- ▶ 4,365 ISC2 beds, and
- ▶ 6,993 ISC3 beds.

There are normally approximately 17,642 normally equipped and staffed beds in Georgia's acute care hospitals.

Caches of supplies and pharmaceuticals have been placed in individual hospitals to support the ISC1 and ISC2 capacity they reported. District caches to support ISC3 beds include 7,000 disaster hospital beds, as well as other equipment, supplies, and pharmaceuticals.

Temporary Inpatient Facilities - Acute Care Centers (ACCs)

In addition to the Internal Surge Capacity of the state's hospitals, we felt it prudent to plan for some temporary facilities to provide mobile, flexible surge capacity. Furthermore, we noted that very little of the Internal Surge Capacity documented by the hospitals can be used as isolation surge capacity (except for cohorting of patients). Therefore, we are purchasing a 50-bed "pop-up" hospital for each of our 18 health districts. While these units can be used however needed in an event and need not be used for isolation, they provide the additional advantage of being easily, and relatively affordably, destroyed if contaminated by a highly infectious agent.

Each health district has been asked to identify one or more Supporting Hospitals to manage the 50-bed temporary hospital for the district. An *Acute Care Center Planning Kit* is being developed to assist these teams in planning for these facilities.

Emergent and Ambulatory Care

Internal Surge Capacity

To provide for the most effective use of Hospital Surge Capacity, it will be necessary to ensure that triage functions and care of the "walking wounded" take place in the most effective venue: Hospital emergency departments with augmented capacity, and in non-hospital facilities. In "big bang" events (e.g., terrorist attacks involving explosives or chemical agents, or large scale industrial accidents) only the ambulatory care facilities in the immediate vicinity of the event will likely be involved, and then only to the extent that patients self-transport to these facilities. An *Emergent Care Planning Kit* has been developed to assist Hospital Emergency Departments with their surge capacity planning.

In a biological terrorism event or a widespread natural outbreak such as pandemic influenza, the effect on ambulatory care facilities will be much more widespread. A *Pandemic Influenza Planning Kit for Outpatient Providers* has been developed for physicians' offices, outpatient clinics and urgent care facilities to determine how well these providers will be able to meet the needs of their patients in a pandemic, and to suggest ways that they might expand their capacity through effective advance planning. It will ask that they convey any deficit or excess capacity to their County Pandemic Influenza Planning Committee for use in community-wide outpatient surge capacity planning.

Temporary Outpatient Facilities - Neighborhood Emergency Help Center (NEHC)

The Neighborhood Emergency Help Center (NEHC) is the component of the MEMS system designed to be used in a bioterrorism event or disease outbreak as Points of Dispensing (PODs) under the Strategic National Stockpile (SNS) system for distribution of pharmaceuticals for prophylaxis or treatment. The MEMS NEHC concept includes somewhat more capability than a simple POD for treatment prior to transfer to an appropriate facility. These NEHCs may be used in an influenza pandemic to address the demand for outpatient treatment that exceeds the surge capacity of ambulatory care facilities.

Patient Transport

Internal Surge Capacity- Emergency Medical Services (EMS)

In a defined event, initial treatment and transport of victims to health care facilities is the first component of surge capacity activated. In order to provide these services effectively, Emergency Medical Services (EMS) must have the resources noted above: equipment, personnel, and training.

We are asking both Ambulance Zone providers and non-zone ambulance providers to fill out the *EMS Surge Capacity Planning Kit*, documenting their current resources (equipment, personnel, and training). Planning Areas parallel to the Internal Surge Capacity Planning Areas used by hospitals have been developed for the EMS Surge Capacity Planning Kit:

EMS-SC1 – Internal EMS Inventory EMS-SC1 Surge Capacity is all of the vehicles owned and operated by Ambulance Zone providers, both active and reserve units.

EMS-SC2 – Licensed Vehicles Available through MOUs EMS-SC2 Surge Capacity are licensed units available through MOUs with non-zone providers within your region, and Ambulance Zone providers from outside of your region. These units are immediately available surge capacity, as these units will respond as soon as requested.

EMS-SC3 – Non-licensed Vehicles Available through MOUs In a very large mass casualty event, it may be necessary to use non-licensed multi-passenger vehicles under the direction of the EMS system. These vehicles will also be the core of the Patient Transportation System (described below) that will be developed to support the longer term transportation needs of a bioterrorism event or pandemic disease outbreak.

The EMS Surge Capacity Planning Kit also covers planning for personnel surge capacity and other response capabilities such as communications, personal protective equipment (PPE), decontamination, behavioral health, training and exercises.

Temporary Capacity - Patient Transportation System

Planning for the transportation component of MEMS, the Patient Transportation System (PTS) will be lead by County Pandemic Flu Planning Committees using a *Patient Transportation System Planning Kit*. The PTS is designed to support the longer term transportation needs of a bioterrorism event or pandemic disease outbreak. The core of the PTS will be the community transportation systems (e.g., buses, senior transport services, etc.) documented in Planning Area EMS-SC3. These community transportation assets can be used as part of either the EMS System or the PTS, depending on the nature of the event.

The PTS will also be a key resource when Home Patient Care Management (see below) is activated. The PTS will be used to transport patients between home and outpatient treatment facilities or hospitals, and from outpatient treatment facilities to hospitals.

Home Patient Care Management

In a widespread or highly contagious event, the best way to extend surge capacity may be to use various kinds of technology to supervise the care of patients who remain at home with family members as primary care givers. Home Patient Care Management is a surge capacity concept we developed for a bioterrorism event or disease outbreak. Lower acuity patients would be managed at home by family members under the guidance of healthcare professionals, supported by information technology such as the internet and cable and satellite systems. This will allow hospitals to concentrate on, and provide better care to, the sickest patients. It should also help to reduce the exposure of patients in waiting rooms or emergency rooms to others with infectious diseases. Community-based support will be needed to assist these patients.

Implementation of this type of surge capacity will require the same resources required for the other types of surge capacity: equipment, personnel, and training. However, it will require a significantly different approach to planning. Local systems must be developed to deliver equipment, pharmaceuticals, caregiver support, and training to individual homes. These local systems must be supported and augmented by technology-based systems that will allow for significant extension of the reach of trained health care personnel.

A Home Patient Care Management (HPCM) System is planned that will allow public health nurses and nurses employed by participating private physicians, to manage the care of patients over the phone. Non-clinical volunteers supported by “expert systems”, will help the nurses to prioritize patients, and increase the volume of patients that they can manage effectively. The HPCM System will work with organizations in the community to provide support to affected households. A *Home Health Care Surge Capacity Planning Kit* will help organizations providing home health care to document how much surge capacity they will have in a health emergency.

In an influenza pandemic, however, more support services will be needed. County Pandemic Influenza Planning Committees (PIPCs) are being asked to organize these support systems at a community level. The kinds of support services we anticipate the county PIPCs coordinating include picking up prescriptions or over-the-counter medications, grocery shopping, and meal delivery. [See the Appendix on Pandemic Influenza for more details.](#)

Mental Health System Surge Capacity

The need for surge capacity in the mental health system is somewhat different than in the medical care system. If the victims of the event access traditional mental health services, it will not be until after their physical needs have been addressed, often several weeks after the event. More often, mental health services, in the form of crisis counseling, must be provided in non-traditional settings in the community where the victims of the event are accessing other services. No temporary mental health facilities comparable to MEMS facilities are created in response to an event, but temporary mental health capacity is provided at MEMS facilities, as well as at existing facilities and other locations within the community. Another unique feature of mental health response is the need to provide services to the individuals providing services to the

victims: first responders, health care workers, emergency human service workers, and volunteers.

A surge may be experienced by mental health providers among their regular clients as these individuals assimilate their experience of the event, whether or not they were directly impacted. They may need additional services for a short time, or they may require a more intensive intervention to help them to process the event and its impact on their lives. Some chronic patients may experience a disruption in their normal support systems, triggering a need for professional intervention.

Command and Control Systems

The planning of individual organizations will be of limited effectiveness if the flow of patients and the resources needed to care for them is not coordinated. Experience has shown that in a healthcare or other emergency, effective communications are critical to an effective response. To address this need, our Integrated Surge Capacity Plan also includes command and control systems modeled on the National Incident Management System.

Hospital Operations Center (HOC)

As each hospital activates its disaster plan, it will also activate its Hospital Operations Center (HOC). The HOC should have an individual or individuals designated to serve as liaison to the District Operations Center, the Regional Coordinating Hospital Operations Center and to the Community Emergency Operations Center.

District Operations Center (DOC)

The Public Health District Operations Center (DOC) has overall responsibility for health and medical care in its district. The public health aspects of this responsibility (e.g., epidemiology) are coordinated out of the District Operations Center. However, public health has limited experience in providing direct patient care, and virtually no experience in providing inpatient care. Therefore, we are asking each of the Regional Coordinating Hospitals created through the Georgia Hospital Association's Mutual Aid Group to assume responsibility for Medical Care Command for their region through their Regional Coordinating Hospital Operations Center (RCHOC)..

Regional Coordinating Hospital Operations Center (RCHOC)

The Regional Coordinating Hospitals created through the Georgia Hospital Association's Mutual Aid Group activate a Regional Coordinating Hospital Operations Center (RCHOC) for their region when the surge capacity plan is activated. They coordinate resource movements and patient flow among inpatient facilities, outpatient facilities, and the Home Patient Care Management System. **The Patient Transportation System should have a representative at the RCHOC to coordinate patient transportation.**

Unified Medical Branch

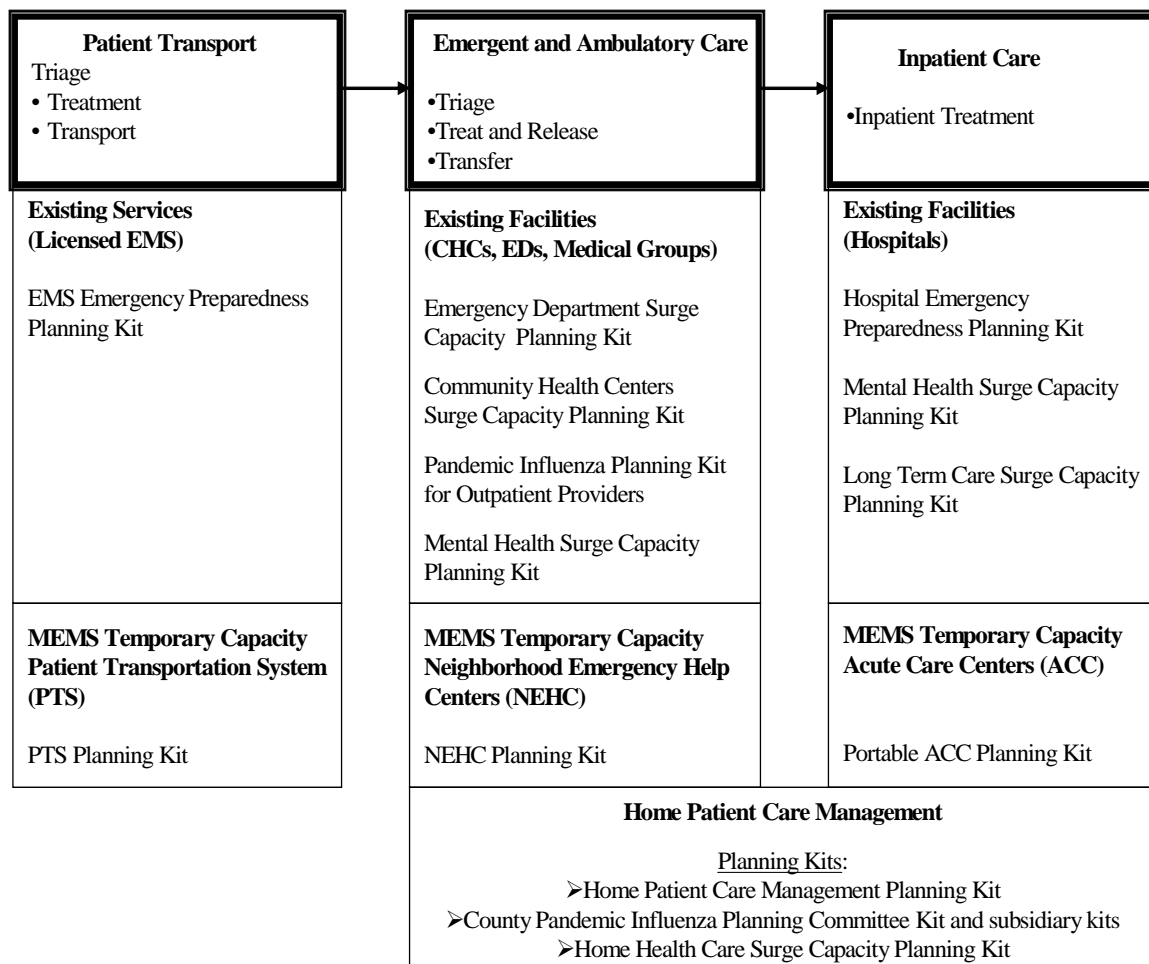
When more than one region is involved, coordination between and among regions will occur out of the Department of Human Resources Emergency Operations Center (DHR EOC). **The Georgia Hospital Association should have a representative at the DHR EOC to assist in coordinating activities among the RCHs and the EMS Regions.**

Summary

From its inception, the emphasis of the Georgia Hospital Community Emergency Preparedness Program has been on district-based planning aimed at improving response by strengthening the relationships between the hospital community and public health. We have been able to encourage and support these relationships by providing tools to guide the local planning efforts of our HCOs and District Staffs. As we move into broader-based planning including community organizations, we are extending these relationships into the community as a whole. With each district following a planning process parallel to those of all the other districts, we are ensuring consistency across communities throughout the state, allowing us to respond to larger events more effectively.

The diagram below summarizes our planning for developing scalable integrated surge capacity for the State of Georgia. It also lists the planning kits being developed to support this effort.

Integrated Healthcare Surge Capacity Planning



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.

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> <hr/> <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> <hr/> <p>State health department contact: (Insert name, title and contact information)</p> <hr/> <p><input type="checkbox"/> The office or clinic'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 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> <hr/> <hr/>

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

Completed	In Progress	Not Started	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)
<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) <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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A plan for triage and management of patients during a pandemic has been developed.</p> <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"/>	<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> <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)

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"/>	<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"/> 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"/>	<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.