



PANDEMIC PREPAREDNESS PLAN

Here is a flexible guide for responding to the problems associated with a pandemic influenza outbreak. 31 Pages 20-859

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Pandemic Preparedness Plan

1. SCOPE

This document defines pandemic preparedness plan template for staff at [ORG].

2. PURPOSE

To provide a fluid and flexible guide for dealing with the problems associated with a pandemic influenza outbreak. This is not written to provide a specific step by step process.

3. PROCEDURE/REQUIREMENTS

3.1 Influenza is a highly infectious viral illness that causes yearly seasonal epidemics, causing an average of up to 56,000 deaths in the US each year, primarily among the elderly. Influenza virus is transmitted in most cases by droplets through coughing and sneezing of infected persons, but can be transmitted by direct contact. Typical symptoms include:

- Abrupt onset of fever (101°F to 102°F)
- Headache
- Chills
- Fatigue
- Muscular pain or tenderness
- Sore throat and nonproductive cough
- Runny or stuffy nose

3.1.1 Annual influenza vaccination is the best method of protection against influenza. Frequent hand washing, staying home when sick, and institution of public health measures for universal respiratory hygiene and cough etiquette, will help stop the spread of influenza.

3.1.2 Influenza viruses are unique in their ability to cause sudden infection in all age groups on a global scale. A pandemic – or global epidemic – occurs when there is a major change in the influenza virus so that most or all of the world's population never exposed previously, is thus vulnerable to the virus. Three pandemics occurred during the 20th Century causing several million deaths worldwide.

3.1.3 The impact of the next pandemic could have a devastating effect on the health and wellbeing of the U.S. public. The Centers for Disease Control and Prevention estimates in the United States between 64 and 94 million people will be infected. In [location] it is estimated that between 5,000 and 72,000 will be hospitalized. Between 1,000 and 21,000 will be in the ICU. There estimated to be between 300 and 12,000 deaths. This is over an 8-week outbreak period. Using a serving population of 300,000 people locally, [ORG] can estimate to have between 60,000 and 90,000 infected locally. Admissions will be between 750 and 10,000. ICU admissions will range from 150 to 3,000. Deaths will range from 45 to 1,700.

3.1.4 Effective preventive and therapeutic measures, including vaccines and antiviral agents will likely be in short supply, as might some antibiotics to treat secondary infections. Health care workers and other first responders will likely be at even higher risk of exposure and illness than the general population, further impeding care of patients. Widespread illness in the community

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will also increase the likelihood of sudden and potentially significant shortages of personnel who provide other essential community services.

- 3.1.5 An influenza epidemic will impact multiple communities across [location] simultaneously. Therefore, contingency planning is required to moderate the impact through a coordinated effort between internal health care, and external state and local government, public health, and local partners. Advanced planning for a large scale and widespread public health emergency is required to optimize health care delivery through a pandemic.
- 3.1.6 A Pandemic Influenza Plan was designed to ensure [ORG] is prepared to implement an effective pandemic response. The plan consists of components consistent with international, federal and state guidelines, as well as general principles of emergency response. It utilizes the National Incident Command Management System (NIMS) and Hospital Incident Command System (HICS).
- 3.1.7 The [ORG] Pandemic Influenza Plan will adjust interventions based on trigger points from guidelines provided by:
- 3.1.7.1 The CDC Pandemic Influenza Plan.
- 3.1.8 **LEVEL I:** Investigation and Recognition
- 3.1.9 **LEVEL II:** Initiation of a pandemic wave
- 3.1.10 **LEVEL III:** Acceleration of a pandemic wave
- 3.1.11 **LEVEL IV:** Deceleration of a pandemic wave
- 3.1.12 **LEVEL V:** Preparation for future pandemic waves
- 3.1.13 The [ORG] Pandemic Influenza Plan was developed with the following components:
- Surveillance Plan
 - Communications Plan
 - Facility Access, Triage and Admission Plan
 - Surge Capacity Plan
 - Occupational Health Plan
 - Clinical Guidelines
 - Education and Training Plan
 - Medicines Plan
 - Psychosocial Plan
 - Mortuary Plan
- 3.1.14 This plan outlines roles, responsibilities, and key activities before, during and following a pandemic influenza. It will be modified as situations dictate.

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3.2 Surveillance Plan

3.2.1 LEVEL I: Investigation and Recognition

- 3.2.1.1 Periodically review and revise Infection Control Surveillance Plan as appropriate.
- 3.2.1.2 Test for influenza per normal lab protocol.
- 3.2.1.3 Maintain contact with [location] Health Department for direction of increased surveillance, testing parameters, screening parameters, and reports of local cases.

Monitoring of seasonal influenza is conducted by Infection Prevention and may include:

3.2.1.4

- 3.2.1.4.1 Number of individuals treated for influenza
- 3.2.1.4.2 Number of employees treated for influenza
- 3.2.1.4.3 Number of all hospitalized admissions for influenza, or tested for influenza
- 3.2.1.4.4 Number of mortality cases from influenza and/or complications of influenza

- 3.2.2 Review and educate on [Health Alert Network Notification System](#) (HAN). This is a communications tool that will allow for real time dissemination of information during a pandemic flu or other public health event.

3.2.3 LEVEL II: Initiation of a Pandemic Wave

- 3.2.3.1 Infection Prevention to assemble and brief the Infection Control Prevention Team, the Emergency Management Team, and applicable persons within 48 hours of notification of pandemic flu outside the United States.
- 3.2.3.2 Implement hospital surveillance for pandemic influenza in incoming and already admitted patients.
- 3.2.3.3 Any suspected cases are reported to the [location] Health Department at [#]. If unreachable the [name] Health Department is contacted at [#].
- 3.2.3.4 Areas within the organization are contacted to insure they are aware of heightened surveillance level, and screening criteria being used. HAN alerts are shared

3.2.4 LEVEL III: Acceleration of a Pandemic Wave

- 3.2.4.1 Continue with steps outlined above.
- 3.2.4.2 Infection Prevention convenes and briefs Infection Prevention Team of pandemic flu in the United States.
- 3.2.4.3 Infection Prevention contacts administration, safety, or other applicable persons.
- 3.2.4.4 Notify employees to report their flu-like symptoms immediately to Employee Health or other designated notification system.
- 3.2.4.5 Infection Prevention Team and Emergency Management Team meet as determined by pandemic activity.

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3.2.5 **LEVEL IV: Deceleration of a Pandemic Wave**

- 3.2.5.1 Activate plan.
- 3.2.5.2 Contact the Administrative Supervisor.
- 3.2.5.3 Establish incident command; open the Emergency Operations Center/ Incident Command Center.
- 3.2.5.4 Activate the Medical Alert Plan of [ORG].
- 3.2.5.5 Contact the [location] Department of Health and [location] emergency management agency.
- 3.2.5.6 Prior to reporting to their work area, all staff members will be screened by taking their temperature and will be questioned about having any flu-like symptoms with information recorded.
- 3.2.5.7 Measure vaccine availability.
- 3.2.5.8 Monitor staffing and other resources that are needed.
- 3.2.5.9 Check reports on [Health Alert Network](#) and the news for hospitals with pandemic influenza cases to determine potential local impact.

3.2.6 **LEVEL V: Preparation for Future Pandemic Waves**

- 3.2.6.1 Continue surveillance activity as with all alert levels in anticipation of second-wave of influenza.
- 3.2.6.2 Gather data to report how many individuals were treated for influenza.
- 3.2.6.3 Gather data to report how many employees were treated for influenza.
- 3.2.6.4 Gather data of all mortality cases from influenza and/or complications of influenza.
- 3.2.6.5 Gather data for total hospital admissions for influenza.
- 3.2.6.6 Conduct debriefing of how the Surveillance Plan and Pandemic Flu Plan worked.
- 3.2.6.7 Assess the effectiveness of vaccine and antiviral distribution.

3.3 **Communication Plan**

3.3.1 **LEVEL I: Investigation and Recognition**

- 3.3.1.1 Periodically review and revise Communication Procedure as appropriate.
- 3.3.1.2 Place [ORG] Pandemic Influenza Plan on Hello page. Notify employees of availability of the plan and state's declaration of current pandemic level.
- 3.3.1.3 Assess need for media training for chief executive officer, chief operating officer, medical director, chief nursing officer, public relations, infection prevention, Medical director of ED, Medical Director of Hospitalists, and Chief of Staff, utilizing Addendum A, "Communications Issues".

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3.3.1.4 Collaborate with Health dept for criteria to set up Flu on Call, and investigate use of ezVisit.

3.3.1.5 Monitor the national and [state] news media, [location] health department, as well as international news media. Include notices from Health Alert Network.

3.3.2 **LEVEL II: Initiation of a Pandemic Wave**

3.3.2.1 Notify employees of the state's declaration of the current pandemic level via home page.

3.3.2.2 Post Signs and supplies for respiratory hygiene and cough etiquette in public areas and waiting rooms.

3.3.2.3 Emphasize the need for employees to develop homecare kits. Kits will include instructions on home-based self-care, information on transmission and prevention methods, and possibly include minimal supplies, such as a thermometer, Tylenol, Gatorade, masks, gloves and hand sanitizer.

3.3.2.4 Infection Prevention assembles periodic Communications Team meeting. This team should include a vice president, infection control nurse, public relations staff, one physician and one nurse manager. All public messages to staff, board, or public must go through this team or designated Public Information Officer.

3.3.2.5 Address the following agenda at the Infection Control team meeting:

3.3.2.5.1 Review key messages from [state], federal CDC and colleague agencies.

3.3.2.5.2 Review and evaluate messages delivered in the prior week by [ORG].

3.3.2.5.3 Review issues and concerns from callers to the Health ezVisit and others in the public; include discussion about rumors and potential for quelling them.

3.3.2.5.4 Seek agreement on key messages for the week. Create a list of volunteers to cover phones as needed.

3.3.2.5.5 Seek agreement on modes of delivering key messages (public statements, flyers, advertisements, phone, internet, media, radio and other).

Put out an update at the end of each meeting that:

3.3.2.5.6

- Identifies Administrative Supervisor as clinical spokesperson, and Director of Public Relations as media spokesperson
- Releases an internal statement that all public statements must be routed through the PIO
- Continues recruitment of volunteers to staff the hotline

3.3.2.6 Put out a statement from [ORG] COO or President for the local community within 48 hours of a declaration of Level II or III. The statement should give:

3.3.2.6.1 Expression of empathy with people's worries and fears

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- 3.3.2.6.2 Confirmation of known facts and action steps from [ORG]
- 3.3.2.6.3 Steps taken to address the unknowns and the constant contact with state and federal officials
- 3.3.2.6.4 Statement of commitment to be here for the long-term and do all that is possible
- 3.3.2.6.5 A list of where people can get information and what they can do to be personally ready
- 3.3.2.6.6 Role of pandemic flu hotline workers
- 3.3.2.6.7 Resources in [County] or in callers' own county
- 3.3.2.7 Report to Incident Command where resources are needed and where they are unavailable.
- 3.3.2.8 Monitor call volume and the topic of questions.
- 3.3.2.9 Screen people with medical complaints.
- 3.3.2.10 Provide web site and Hello information that features information on flu issues and what people can do to prepare.
- 3.3.3 **LEVEL III: Acceleration of a Pandemic Wave**
 - 3.3.3.1 Follow Level II steps as outlined above
 - 3.3.3.2 Notify employees of the state's declaration of the current pandemic level.
 - 3.3.3.3 Hold communications team meeting more frequently as needed.
 - 3.3.3.4 Consider setting up a pandemic flu hotline.
 - 3.3.3.5 Issue a public statement by [ORG] COO or President following same format as above.
 - 3.3.3.6 Convene Infection control team and Incident command team to go over key messages, strategies and the pandemic flu plan for [ORG] and the entire community.
- 3.3.4 **LEVEL IV: Evidence of [state] Pandemic Flu, and Increased and Sustained Transmission in the General Population**
 - 3.3.4.1 Notify employees of the [state]'s declaration of the current pandemic level via the web site.
 - 3.3.4.2 Set up daily Incident Command meetings
 - 3.3.4.3 Post door signs as per direction of Incident Commander and/or Infection Prevention.
 - 3.3.4.4 Consider staffing flu hotline 24 hours per day.
 - 3.3.4.5 Issue public statement by [ORG] COO or President following same format as above.

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3.3.4.6 Develop daily briefings with message that includes empathy, current situation and numbers, what is not known, what we are doing to address unknowns, what people should do. All staff should monitor:

3.3.4.6.1 Public via radio

3.3.4.6.2 Print media releases with updates

3.3.4.6.3 Web sites

3.3.4.6.4 Overhead pages

3.3.4.7 Notify physicians and others as needed about the hotline.

3.3.5 **LEVEL V: Preparation for Future Pandemic Waves**

3.3.5.1 Notify employees of [state]'s declaration of the current pandemic level via website .
Notify medical center employees when it is safe to return to work.

3.3.5.2 Notify general community through the above communication methods of:

3.3.5.3

3.3.5.3.1 [state]'s declaration of the current pandemic level

3.3.5.3.2 [ORG]'s return to pre-pandemic operations Risk of second

3.3.5.3.3 wave

3.3.5.4 Consider producing a narrative of the events of the pandemic period.

3.4 **Facility Access, Triage and Admission Plan**

3.4.1 **LEVEL I: Investigation and Recognition**

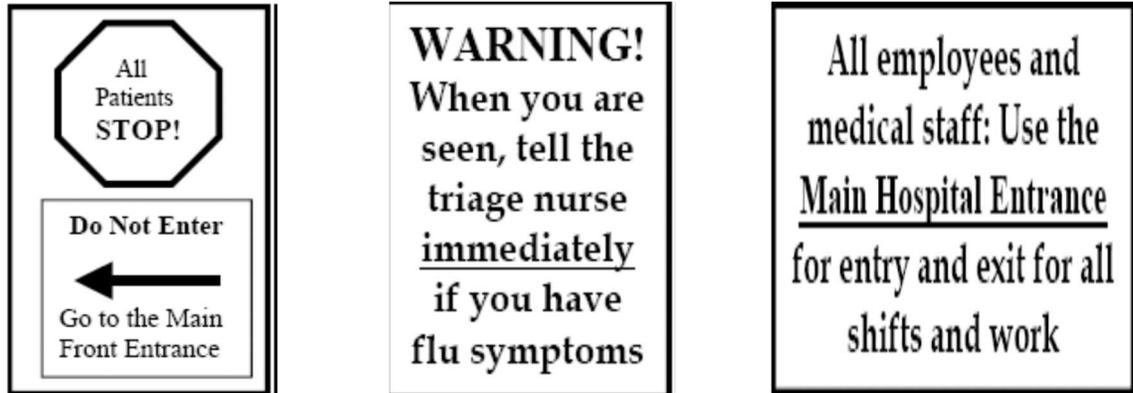
3.4.1.1 Develop training program for affected personnel (nursing, security, etc.).

3.4.1.2 Develop and produce signs to direct everyone, including patients and employees, to the triage location and post the signs in two locations. The Emergency Department is the only point of entry for patients during actual pandemic influenza.

3.4.1.3 Develop signs instructing all patients to let the triage nurse know if they have influenza-like symptoms.

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Figure 1 Example Signage



3.4.1.4 Develop Pandemic Security Plan.

3.4.1.5 Establish number of available on-hand beds, stretchers, pillows, blankets, linens, intravenous poles, etc.

3.4.1.6 Provide screening criteria to CDC as needed.

3.4.2 **LEVEL II: Initiation of a Pandemic Wave**

3.4.2.1 Alert network health care workers of [state]'s declaration of the current pandemic level via web site.

3.4.2.2 Assemble the Infection Control team within 48 hours.

3.4.2.3 Designate director of security or applicable person to identify, notify and train extra security personnel as needed. Implement Security Plan as needed.

3.4.2.4 Implement hospital surveillance for pandemic influenza on incoming and already admitted patients. (See Infection Control Surveillance Plan)

3.4.2.5 Implement a system for early detection and treatment of health care personnel as per Surveillance and Employee Health plans.

3.4.2.6 Make available a quantity of quarantine and home care information for staff and public.

3.4.2.7 Post signs for respiratory hygiene and cough etiquette in all facility public areas, restrooms and other key settings.

3.4.2.8 Review mutual aid agreements with other hospitals, local home health agencies and other health care groups to obtain adequate staffing during pandemic period.

3.4.2.9 Place extra supplies of tissues and no-touch waste receptacles in waiting areas.

3.4.2.10 Maintain high suspicion of patients presenting with influenza-like symptoms.

3.4.2.11 Evaluate daily census and discharge plans.

3.4.2.12 Review and confirm room availability throughout [ORG].

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3.4.3 **LEVEL III and IV: Acceleration of Pandemic wave and Deceleration of a pandemic wave**

- 3.4.3.1 Activate Pandemic Influenza Plan, and the Emergency/Disaster Preparedness Plan.
- 3.4.3.2 Establish the incident Command and open the Incident command Center.
- 3.4.3.3 Ask Human Resources to provide an accurate list of Medical Center employees and phone numbers.
- 3.4.3.4 Contact [location] Health Department and [location] emergency management office.
- 3.4.3.5 Based on input from [state] Health Department, ask senior leadership to consider canceling or closing non-critical departments. Criteria for closure include staffing and patient exposure to infection.
- 3.4.3.6 Deliver extra stretchers, supplies to Triage area.

3.4.3.6.1 Access Control

- 3.4.3.6.1.1 Consider lock-down all entrances except the ED entrance East and West, the Main Entrance East and West and the Plaza Entrance East and post security at the entrance to the emergency department.
- 3.4.3.6.1.2 Put up signs directing all patients how to enter the Medical Center.
- 3.4.3.6.1.3 Assign security to assist in limiting access as needed.
- 3.4.3.6.1.4 Post signs at each entrance with instructions for patients to immediately tell the triage nurse if they have flu symptoms.
- 3.4.3.6.1.5 Employees should use entrance designated for them.
- 3.4.3.6.1.6 Have security and triage personnel screen and record employees with influenza symptoms and send them home if present, unless they need further medical attention. Place daily sticker on name tag if employee is cleared to work.
- 3.4.3.6.1.7 Consider closing [locations].

3.4.3.6.2 Triage Guidelines

- 3.4.3.6.2.1 Assign a nurse to triage each entrance.
- 3.4.3.6.2.2 Allow one patient at a time to enter and undergo rapid triage by a nurse.
- 3.4.3.6.2.3 Segregate patients with an influenza-like illness.
- 3.4.3.6.2.4 Evaluate these patients in the triage area, admitting them or sending them home with self-care and home care instructions.
- 3.4.3.6.2.5 Patients without flu-like symptoms will be directed to the appropriate service.
- 3.4.3.6.2.6 Other patients will be triaged, evaluated and treated in the ER as usual.

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- 3.4.3.6.2.7 Screen all visitors and volunteers through designated entrance for influenza. Send home any with positive findings unless they need further medical evaluation.
- 3.4.3.6.2.8 Establish a backup plan. If entrances are overwhelmed with influenza patients, The College of Health Sciences and conference centers on East and West could be converted to another flu outpatient area where triage and initial treatment can be done. Notify [location] Emergency Management Office if we need a trailer for mass clinic or triage.
- 3.4.3.6.2.9 In this backup plan, non-influenza patients seeking care will be treated per usual in the ER. All employees and staff are to report to designated entrance. All will be evaluated; temperatures and symptoms will be recorded.
- 3.4.3.6.2.10 If the front entrance becomes too busy, consider having employees enter through an alternate entrance.

3.4.3.6.3 Hospital Admissions

- 3.4.3.6.3.1 Defer elective admissions and procedures until local epidemic wanes (schools back in session).
- 3.4.3.6.3.2 Discharge appropriate in-house patients as soon as possible.
- 3.4.3.6.3.3 Locate patients admitted with influenza to a single wing or area. Remove all non- influenza patients from identified influenza area.
- 3.4.3.6.3.4 Isolate all patients admitted with droplet precautions per isolation precaution standards. (See Addendum C.)
- 3.4.3.6.3.5 Limit visitors to only those who are essential for patient support and who have been cleared of influenza symptoms.
- 3.4.3.6.3.6 Consider temporarily closing the hospital to new admissions after considering surge capability, staffing ratios, isolation capacity and risks to non-influenza patients.

3.4.4 Level V: Preparation for Future Pandemic Waves

- 3.4.4.1 Close triage area; return triage to emergency department.
- 3.4.4.2 Lift restrictions on visitors.
- 3.4.4.3 Close the employee screening process.
- 3.4.4.4 Close temporary patient surge areas and return to regular services.
- 3.4.4.5 Open clinics and departments as soon as reasonable.
- 3.4.4.6 Reassess all staffing levels.
- 3.4.4.7 Contact the [location] Health Department to coordinate post-pandemic activities, such as surveillance, data collection and reporting; and need for supplies, support personnel and other support.

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- 3.4.4.8 Gather members of the Incident Command Team to debrief, review and update plan.
- 3.4.4.9 Maintain surveillance of all patients seen in ED, outpatient clinics and outside offices.
- 3.4.4.10 Anticipate a secondary resurgence of pandemic influenza even weeks or months after first wave.

3.5 Surge Capacity Plan

3.5.1 Staffing

3.5.2 **LEVEL I: Investigation and Recognition**

- 3.5.2.1 Estimate the number of local community patients expected to be infected, and those seeking outpatient care, hospitalized and dying during an eight-week period:
 - Population infected: 15,880
 - Total admissions: 1,158
 - Hospital capacity: 559
 - Total death: 225
 - ICU capacity: 132
 - Ventilator capacity: 144(*Data can be obtained from the [CDC Web site](#).)
- 3.5.2.2 Build a list of essential support personnel needed to maintain hospital operations, including but not limited to personnel in environmental, maintenance, EMS, nutrition, information services, administrative, clerical, medical records, laboratory, radiology, pharmacy, cardiopulmonary and security.
- 3.5.2.3 Create a list of non-essential positions that can be reassigned to support critical hospital services, including but not limited to personnel in physical therapy, oncology, mammography, surgery, outpatient clinics, Heart Institute, education, billing, and development.
- 3.5.2.4 Have departments use High Census Procedure to determine contingency staffing plans for a minimum duration of eight weeks.
- 3.5.2.5 Review procedure on High Census Plan.
- 3.5.2.6 Communicate to laboratory, radiology and pharmacy they should expect no decrease in their typical baseline demand for services.
- 3.5.2.7 Maintain current staffing levels unless altered level of care or staffing is instituted by the Incident Command.
- 3.5.2.8 Review state and national guidelines related to altered standards of care and staffing during a disaster.
- 3.5.2.9 Institute procedure for credentialing volunteer medical personnel. Contact Medical Reserve Corp for volunteer health care workers as needed.

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- 3.5.2.10 Develop method for rapid badging for non-facility volunteers with photo identification and title.
- 3.5.2.11 Determine pay scale and have established generic contracts available to non-facility staff.

3.5.3 **LEVEL II-IV: Initiation, Acceleration, and Deceleration waves**

- 3.5.3.1 Follow above steps.
- 3.5.3.2 Establish staging area for staffing
- 3.5.3.3 Utilize the incident command system, with the incident commander to coordinate with HR the oversight of the pool of volunteers, staff, retirees, etc. to ensure staffing needs are met.
- 3.5.3.4 Activate plan for rapidly credentialing health care professionals.
- 3.5.3.5 Increase cross training of personnel to provide support for essential patient-care areas at times of severe staffing shortages (e.g., in ED, ICU, medical-surgical, etc.)
- 3.5.3.6 Have departments review and update their list of essential support personnel who are needed to maintain hospital operations.
- 3.5.3.7 Create a list of nonessential positions that can be reassigned to support critical hospital services.
- 3.5.3.8 Create a list of nonessential positions that can be placed on administrative leave as needed to limit the number of people in the hospital
- 3.5.3.9 Determine needs of outlying medical offices and facilities, per incident command system.

3.6 **Bed Capacity**

3.6.1 **LEVEL I: Investigation and Recognition**

- 3.6.1.1 Identify rooms in the hospital that could be utilized for expanded bed capacity if needed.
- 3.6.1.2 Identify areas that could accept overflow capacity if needed. This plan is based on the use of Out Patient Surgery on East and West as an overflow unit and closed hospital units as a secondary space.
- 3.6.1.3 Obtain approval from hospital licensing agencies to expand bed capacity beyond current capacity as needed.
- 3.6.1.4 Identify beds and supplies needed to accommodate extra patients.
- 3.6.1.5 Determine the total patient bed capacity at each facility.

3.6.2 **Level II: Initiation of a Pandemic Wave**

- 3.6.2.1 1. Once schools consider closing, consider need to cancel elective surgeries.

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- 3.6.2.2 2. Prepare for the possibility of early rapid discharge. Coordinate with medical director and social services where possible. Refer to high census procedure.
- 3.6.2.3 3. Work with Home Health agencies where possible, to arrange for at-home follow-up care of early discharged or deferred admission patients.
- 3.6.2.4 4. Work with communications to arrange follow-up calls for early discharged patients.
- 3.6.2.5 5. Determine areas that could be used for aggregating influenza patients.
- 3.6.2.6 6. If there is a need, coordinate with community resources to determine if outside facilities could be used to house patients beyond what the hospital can accommodate, and what personnel and supplies would be needed.

3.6.3 **LEVEL III-IV: Acceleration of a pandemic wave and Deceleration of a pandemic wave**

- 3.6.3.1 Determine if other hospitals have capacity to take non-influenza, non-critical patients in transfer. Review on a daily basis.
- 3.6.3.2 Admitted influenza patients will be located in units as determined by Incident Command:
 -
 - Overflow will then be located where incident command team determines.
 - Contact [name] Emergency Management to determine alternate care sites in community.
- 3.6.3.3 Ventilated influenza patients will be located in appropriate areas:
 - Initially they will be located East 6 North, East 4 South, West 2 South.
 - Overflow will be located on Progressive care areas.
 - Patients should be evaluated to determine whether they could be moved to Progressive Care to free up ICU beds.

3.7 **CONSUMABLE AND DURABLE SUPPLIES**

3.7.1 **LEVEL I: Investigation and Recognition**

- 3.7.1.1 Evaluate the existing system for tracking medical supplies to determine if it can detect rapid consumption, trigger point to order additional supplies, and to respond to growing needs.
- 3.7.1.2 Assure access to enough consumable goods for duration of pandemic (8 weeks to 12 weeks).
- 3.7.1.3 Anticipate the need for additional antibiotics to treat bacterial complications of influenza.
- 3.7.1.4 Contact the [location] Emergency Management regarding access the National Strategic Stockpile during an emergency.
- 3.7.1.5 Determine food supplies in the hospital; refer to inventory list (available from Safety Officer).

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3.7.1.6 Maximize the storage capacity of fuel oil and propane gasses.

3.7.2 **LEVEL II: Initiation of a pandemic phase-** Follow same as above.

3.7.2.1 Alert Nutrition to stockpile certain non-perishable food goods

3.7.3 **LEVEL III-IV: Acceleration of a pandemic phase and Deceleration of a pandemic phase**

3.7.3.1 Order additional antibiotics to treat bacterial complications of influenza as needed.

3.7.3.2 Determine and address how essential services will be maintained for people with chronic medical problems served by the hospital (e.g., hemodialysis E7E, oncology E5N, wound clinic Specialty clinic, etc.)

3.7.4 **Level V: Preparation for future pandemic wave**

Reassess for upcoming waves and re-stock as needed

3.8 Continuation of Essential Medical Services

3.8.1 Consider moving out patient services to offsite facilities to limit exposure to influenza infection.

3.8.2 Consider reestablishing these services in-house if the pandemic influenza rate appears to be slowing, as per direction of incident command.

3.9 Occupational Health Plan

3.9.1 **LEVEL I: Investigation and Recognition**

3.9.1.1 Periodically review and revise Employee Health Procedures as appropriate.

3.9.1.2 Plan education/training according to education plan.

3.9.1.3 Encourage employee seasonal influenza vaccination and immunize as appropriate.

3.9.1.4 Consider administrative mandate that all health care workers will receive their annual flu shot.

3.9.1.5 Monitor for signs and symptoms of influenza. (See Section 3.2 Surveillance Plan).

3.9.2 **LEVEL II: Initiation of a Pandemic Wave**

3.9.2.1 Assemble Incident Command Team and Infection Control Team to review the Pandemic Influenza Plan.

3.9.2.2 Instruct employees to call supervisor when exhibiting influenza-like symptoms before duty. Do not report to work if ill.

3.9.2.3 Conduct staff training on protocol for early detection and treatment of health care workers.

3.9.2.4 Communicate to all staff procedures for screening, and any new guidelines to include procedures for calling in sick and absenteeism.

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- 3.9.2.5 Implement a system for early detection and treatment of health care workers who might be infected with the pandemic strain of influenza.
- 3.9.2.6 Have employees research alternative daycare arrangement in anticipation of schools and/or daycares closing.
- 3.9.2.7 Check for influenza-like symptoms that include:
 - 3.9.2.7.1 Temperature greater than 100.4° F
 - 3.9.2.7.2 Cough, sore throat or difficulty breathing
 - 3.9.2.7.3 Other symptoms as recommended by the CDC or [state] Health and Human Services Department.
- 3.9.2.8 Immediately isolate the employees with the above symptoms using droplet precautions:
 - 3.9.2.8.1 Employee health staff use appropriate PPE per Droplet precautions when caring for employee.
 - 3.9.2.8.2 Collect nasal swab and discussion treatment plan and follow up. Send employee home with mask as appropriate.
- 3.9.2.9 Arrange testing for employees who meet above criteria and have recently traveled to a place where Pandemic flu has been identified.
- 3.9.2.10 If they meet the case definition of Pandemic Flu, call the [location] Health Department immediately.
- 3.9.3 **LEVEL III and IV: Acceleration of a pandemic wave and Deceleration of a pandemic wave**
 - 3.9.3.1 Have incident command establish employee screening area in front entrance East and West under the direction of employee Health.
 - 3.9.3.2 Assign adequate appropriate personnel to employee health to screen all employees, including personnel, to document and alert managers of ill employees.
 - 3.9.3.3 Give employee and medical staff access to enter front entrance where health care worker screening area is located before reporting to their workstation.
 - 3.9.3.4 Screen all staff by the taking their temperature and questioning staff about having any flu-like symptoms. This will be recorded on a log. (See Addendum B)
 - 3.9.3.5 Ask any employees who develop flu-like symptoms during their workday to return to the health care worker screening area for evaluation and disposition.
 - 3.9.3.6 Have employees call the Pandemic Flu Hotline (if established) or their manager to screen for symptoms if they have any concerns they are ill before they come to work.
 - 3.9.3.7 Have screening staff don a PAPR. Apply gloves, gowns as appropriate using droplet precautions.

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- 3.9.3.8 When an employee is identified with influenza-like symptoms, have screening personnel record the date, employee's name, date of birth, department and supervisor's name. Screening personnel will alert supervisors to ill employees. See description of "ability for work" below.
- 3.9.3.9 Test employees with flu symptoms for influenza per [state] Department of Health and Human Services guidelines.
- 3.9.3.10 Send ill employees who cannot go to work either home with instructions (see quarantine/self-care brochure) or if needed send patient where they will be medically evaluated.
- 3.9.3.11 Have all non-ill employees report to their workstation after screening. If pandemic vaccination/antivirals are available, give to these employees (as per pandemic influenza Medications Plan).
- 3.9.3.12 If there is a high risk of complications consider reassigning personnel at high risk of complications to low-risk duties (e.g., non-influenza patient care, administrative duties that do not involve patient care) or send home.

3.9.4 **Level II, III and IV: Ability to Work**

- 3.9.4.1 Ideally, health care workers are fit to work when one of the following conditions apply:
 - 3.9.4.1.1 They have recovered from pandemic flu during earlier phases of the pandemic.
 - 3.9.4.1.2 They have been immunized against the pandemic strain of influenza as outlined in Pandemic Influenza Medication Plan.
 - 3.9.4.1.3 They are on appropriate antivirals as outlined in the medication plan.
- 3.9.4.2 Health care workers fit for work may work with all patients and may be selected to work in units where there are patients infected with influenza.
- 3.9.4.3 Remind staff to notify employee health of any change in condition.
- 3.9.4.4 Whenever possible, well, unexposed health care workers should work in non-influenza areas.
- 3.9.4.5 Asymptomatic health care workers may work even if influenza vaccine and antivirals are unavailable.
- 3.9.4.6 Meticulous attention should be paid to hand hygiene, and health care workers should avoid touching mucous membranes of the eye and mouth to prevent exposure to the influenza virus and other infective organisms.
- 3.9.4.7 Ideally, staff with influenza-like illness should be considered "unfit for work" and should not work. However, in cases of extremely limited resources, employees may be asked to work if they are well enough to do so and must follow these guidelines:
 - 3.9.4.7.1 Such health care workers must work with non-exposed patients (non-influenza areas) and should be required to wear a mask. Try to assign to non-patient care duties if possible.

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3.9.4.7.2 They must pay meticulous attention to hand hygiene.

3.9.4.7.3 They should not be redeployed to intensive care areas, nursery or an area with severely immuno-compromised patients, (i.e., transplant recipients, hematology/oncology patients, patients with chronic heart or lung disease, or patients with HIV/AIDS, and dialysis patients).

3.9.4.8 Employee health can make referrals to Directions for employees who need counseling to maximize professional performance and personal resilience by addressing management of grief, exhaustion, anger, fear, self and family physical needs, and ethical dilemmas.

3.9.4.9 The chaplain should be contacted for the above support for those employees who prefer faith-based counseling, or the individual employee's own faith-based support can be contacted.

3.9.5 **Level V: Preparation for Future Pandemic Waves**

3.9.5.1 Reinforce continuous precautionary procedures, such as hand hygiene, respiratory etiquette, etc. in anticipation of second wave.

3.9.5.2 Maintain list of all employees and volunteers who recovered from cases of pandemic flu.

3.9.5.3 Gather data to report how many employees tested for influenza, and the results of those tests.

3.9.5.4 Gather data of all employee mortality cases from influenza and/or complications of influenza.

3.9.5.5 Gather data for all employees hospitalized for influenza.

3.9.5.6 Conduct debriefings and evaluations of how the Occupational Health Plan worked.

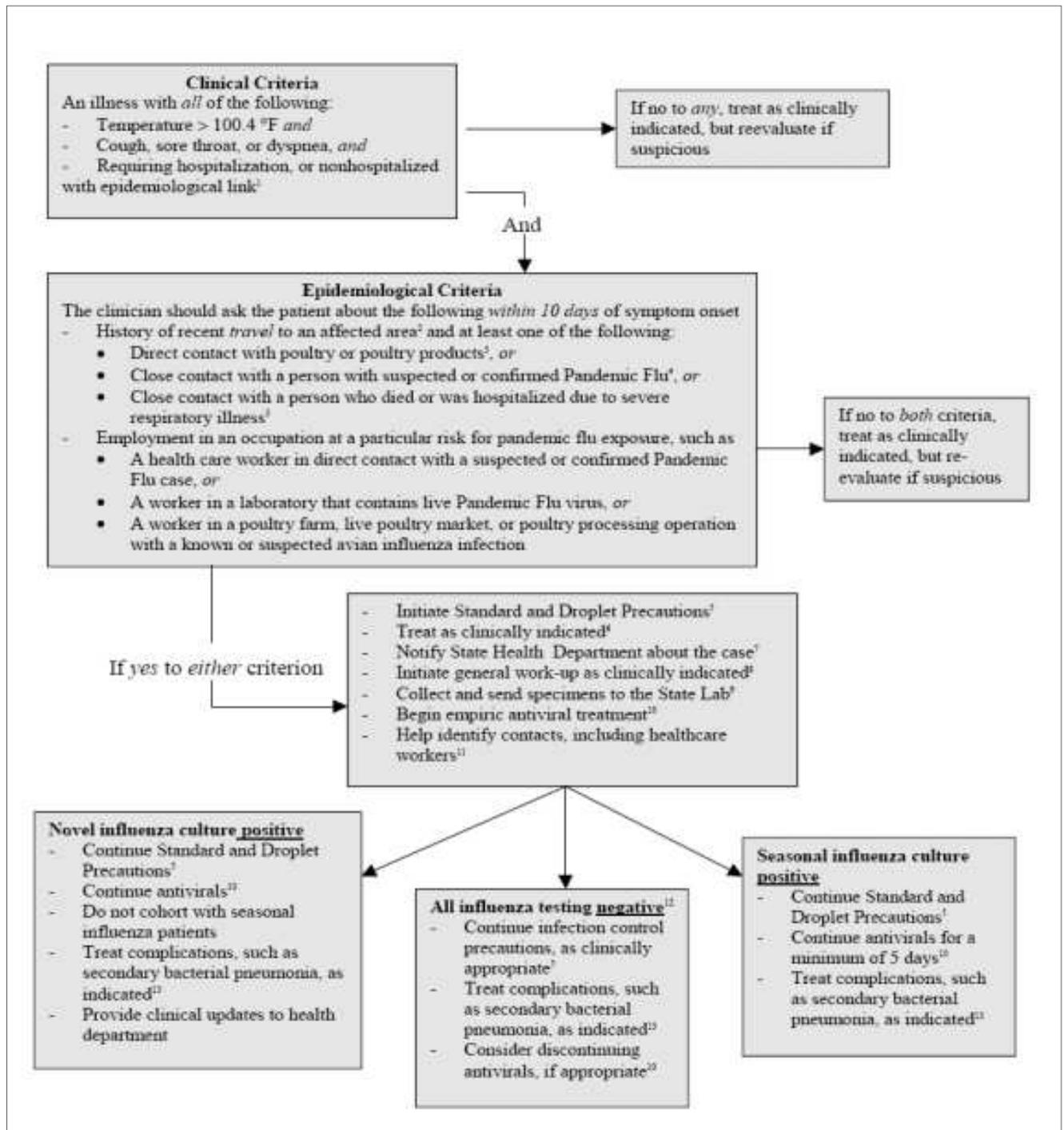
3.9.5.7 Assess the effectiveness of vaccine and antiviral distribution for employees.

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3.10 Clinical Guidelines

3.10.1 LEVEL I: Investigation and Recognition

Figure 2 Case Detection and Clinical Management



3.10.1.1 Further evaluation and diagnostic testing should also be considered for outpatients with strong epidemiological risk factors and mild or moderate illness.

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- 3.10.1.2 For persons who live in or visit affected areas, close contact includes touching live poultry (well appearing, sick or dead) or touching or consuming uncooked poultry products, including blood. For animal or market workers, it includes touching surfaces contaminated with bird feces. In recent years, most instances of human infection with a novel influenza A virus having pandemic potential, including influenza A (H5N1), are thought to have occurred through direct transmission from domestic poultry. A small number of cases are also thought to have occurred through limited person-to-person transmission or consumption of uncooked poultry products. Transmission of novel influenza viruses from other infected animal populations or by contact with fecal contaminated surfaces remains a possibility. These guidelines will be updated as needed if alternate sources of novel influenza viruses are suspected or confirmed.
- 3.10.1.3 Close contact includes direct physical contact, or approach within three feet of a person with suspected or confirmed novel influenza.
- 3.10.1.4 Standard and droplet precautions should be used. (See Addendum C.)
- 3.10.1.5 Hospitalization should be based on all clinical factors, including the potential for infectiousness and the ability to practice adequate infection control. If hospitalization is not clinically warranted, and treatment and infection control are feasible in the home, the patient may be managed as an outpatient. The patient and his or her household should be provided with home quarantine and self-help information. The local health department staff should monitor patient and close contacts for illness.
- 3.10.1.6 Guidance on how to report suspected cases of novel influenza to the [state] Department of Health and Human Services is provided in the Surveillance Plan.
- 3.10.1.7 The general workup should be guided by clinical indications. Depending on the clinical presentation and the patient's underlying health status, initial diagnostic testing might include:
 - 3.10.1.7.1 Pulse oximetry
 - 3.10.1.7.2 Chest radiograph
 - 3.10.1.7.3 Complete blood count with differential
 - 3.10.1.7.4 Blood cultures
 - 3.10.1.7.5 Sputum (in adults), tracheal aspirate, pleural effusion aspirate (if pleural effusion is present), gram stain and culture
 - 3.10.1.7.6 Antibiotic susceptibility testing (encouraged for all bacterial isolates)
 - 3.10.1.7.7 Multivalent immunofluorescent antibody testing or PCR of nasopharyngeal aspirates or swabs for common viral respiratory pathogens, such as influenza A and B, adenovirus, parainfluenza viruses, and respiratory syncytial virus, particularly in children
 - 3.10.1.7.8 In adults with radiographic evidence of pneumonia, Legionella, and pneumococcal infections, use urinary antigen testing

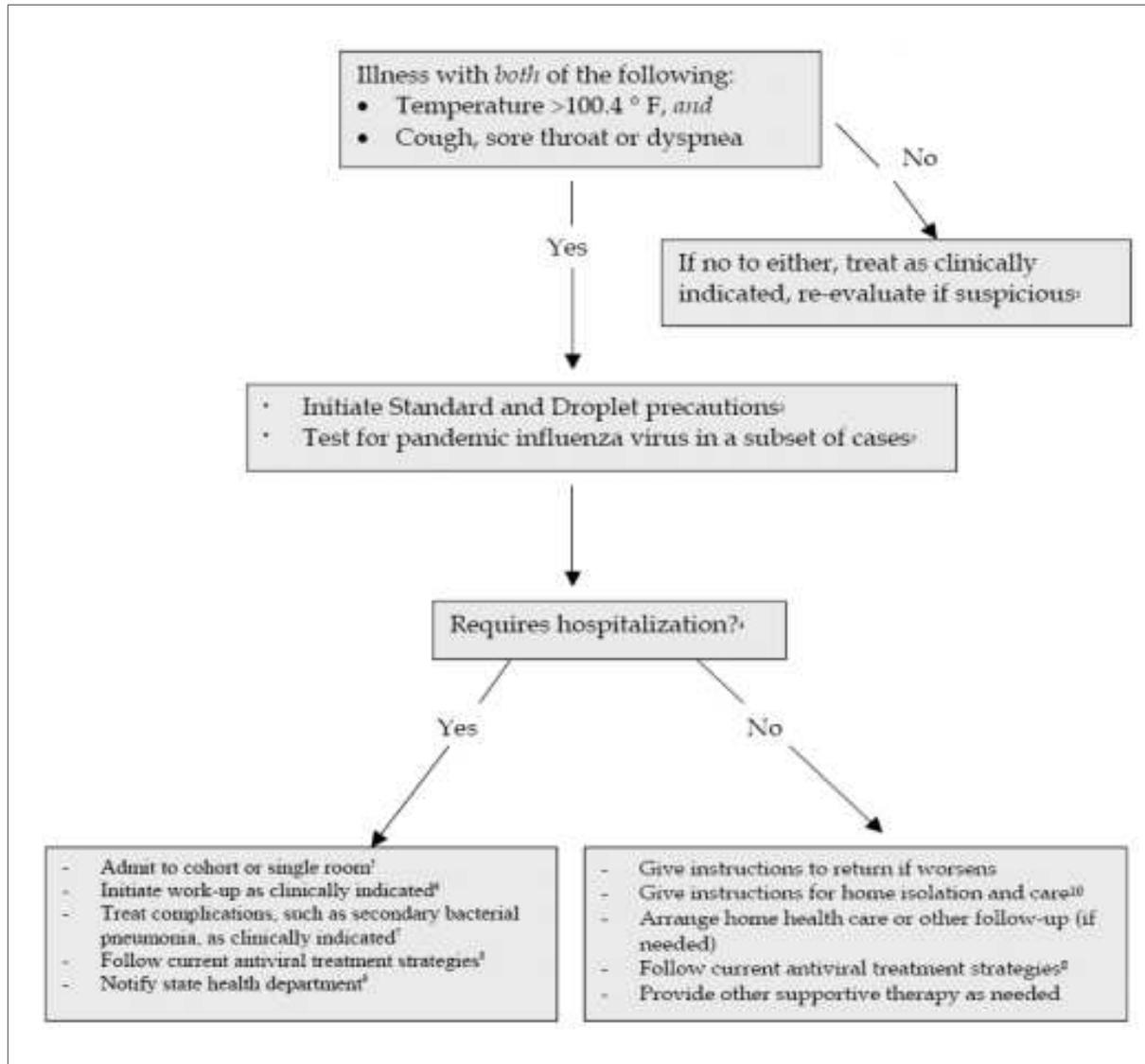
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- 3.10.1.7.9 Radiographic pneumonia testing for adults and children younger than 5 if clinicians have access to rapid and reliable testing (e.g., PCR) for *M. pneumoniae* and *C. pneumoniae*
- 3.10.1.7.10 Comprehensive serum chemistry panel if metabolic derangement or other end organ involvement, such as liver or renal failure, is suspected.
- 3.10.1.8 Guidelines for novel influenza virus testing as per [state] Department of Health and Human Services guidelines include collect specimens. All of the following respiratory specimens should be collected for Novel Influenza A virus testing: nasopharyngeal swab; nasal swab, wash, or aspirate; throat swab; and tracheal aspirate (for intubated patients), stored at 4° C (39° F) in viral transport media; and acute and convalescent serum samples.
- 3.10.1.9 Strategies for the use of antiviral drugs are provided in pandemic influenza Medication Plan.
- 3.10.1.10 Guidelines for the management of contacts in a health care setting are provided in Occupational Health Plan.
- 3.10.1.11 Given the unknown sensitivity of tests for novel influenza viruses, interpretation of negative results should be tailored to the individual patient in consultation with the state health department. Novel influenza directed management might need to be continued, depending on the strength of clinical and epidemiological suspicion. Antiviral therapy and isolation precautions for novel influenza may be discontinued on the basis of an alternative diagnosis. The following criteria may be considered for this evaluation:
 - 3.10.1.11.1 Absence of strong epidemiological link to known cases of novel influenza
 - 3.10.1.11.2 Alternative diagnosis confirmed using a test with a high positive-predictive value
 - 3.10.1.11.3 Clinical manifestations explained by the alternative diagnosis.

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3.10.2 LEVEL II-IV: Initiation, Acceleration and Deceleration of a pandemic wave

Figure 3 Case Detection and Clinical Management



3.10.2.1 Antiviral therapy and isolation precautions for pandemic influenza should be discontinued on the basis of an alternative diagnosis only when both of the following criteria are met:

3.10.2.1.1 Alternative diagnosis confirmed using a test with a high positive-predictive value

3.10.2.1.2 Clinical manifestations entirely explained by the alternative diagnosis

3.10.2.2 Standard and droplet precautions are used. (See Addendum C.)

3.10.2.3 See guidance from the state on laboratory testing during the pandemic period. Generally, specimens should include respiratory samples (e.g., nasopharyngeal

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wash/aspirate; nasopharyngeal, nasal or oropharyngeal swabs; or tracheal aspirates) stored at 4° C in viral transport media.

- 3.10.2.4 Routine laboratory confirmation of clinical diagnoses will be unnecessary as pandemic activity becomes widespread in a community. CDC will continue to work with state health laboratories to conduct virologic surveillance to monitor antigenic changes and antiviral resistance in the pandemic virus strains throughout the pandemic period.
- 3.10.2.5 The decision to hospitalize should be based on a clinical assessment of the patient and the availability of hospital beds and personnel.
- 3.10.2.6 Guidelines on cohorting can be found in Facility Access, Triage and Admission Plan. Laboratory confirmation of influenza infection is recommended when possible before cohorting patients.
- 3.10.2.7 The general workup should be guided by clinical indications. Depending on the clinical presentation and the patient's underlying health status, initial diagnostic testing might include:
 - 3.10.2.7.1 Pulse oximetry
 - 3.10.2.7.2 Chest radiograph
 - 3.10.2.7.3 Complete blood count with differential
 - 3.10.2.7.4 Blood cultures
 - 3.10.2.7.5 Sputum (in adults) or tracheal aspirate, Gram stain and culture
 - 3.10.2.7.6 Antibiotic susceptibility testing (encouraged for all bacterial isolates)
 - 3.10.2.7.7 Multivalent immuno-fluorescent antibody testing of nasopharyngeal aspirates or swabs for common viral respiratory pathogens, such as Influenza A and B, adenovirus, Para influenza viruses, and respiratory syncytial virus, particularly in children
 - 3.10.2.7.8 In adults with radiographic evidence of pneumonia, Legionella and pneumococcal infections, use urinary antigen testing
 - 3.10.2.7.9 Radiographic pneumonia testing for adults and children younger than 5 if clinicians have access to rapid and reliable testing (e.g., PCR) for M. pneumoniae and C. pneumoniae
 - 3.10.2.7.10 Comprehensive serum chemistry panel if metabolic derangement or other end-organ involvement, such as liver or renal failure, is suspected
- 3.10.2.8 Strategies for the use of antiviral drugs are provided in the pandemic influenza Medication Plan.
- 3.10.2.9 Guidance on the reporting of pandemic influenza cases is provided in the Surveillance Plan.

- 3.10.2.10 Patients with mild disease should be provided with home-care kits, including standardized instructions on home management of fever and dehydration, pain relief and recognition of deterioration in status. Patients should also receive information on infection control measures to follow at home. Patients cared for at home should be separated from other household members as much as possible. All household members should carefully follow recommendations for hand hygiene, and tissues used by the ill patient should be placed in a bag and disposed of with other household waste. Infection within the household may be minimized if a primary caregiver is designated; ideally, this should be someone who does not have an underlying condition that places them at increased risk of severe influenza disease. Although no studies have assessed the use of masks at home to decrease the spread of infection, the patient or caregiver use of a surgical or procedure mask during interactions may be beneficial. Separation of eating utensils for use by a patient with influenza is not necessary, as long as they are washed with warm water and soap.

3.11 Education and Training Plan

3.11.1 LEVEL I: Investigation and Recognition

- 3.11.1.1 Periodically review and revise Education and Training Plan as appropriate.
- 3.11.1.2 Identify educational resources (consistent with [location] Health Department) to address needs of staff, patients, family members and visitors.
- 3.11.1.3 Educate employees, volunteers, students, and other providers on:
- 3.11.1.3.1 Explanation of seasonal vs. pandemic influenza and implications of pandemic influenza
 - 3.11.1.3.2 Difference between upper respiratory infection and influenza
 - 3.11.1.3.3 Prevention and control of influenza
 - 3.11.1.3.4 Benefits of annual influenza vaccination
 - 3.11.1.3.5 Review of infection control strategies, including respiratory hygiene/cough etiquette, hand hygiene, standard precautions, droplet precautions and airborne precautions
 - 3.11.1.3.6 Information regarding quarantine/home care and self-care
 - 3.11.1.3.7 Procedures for restricting visitors and mechanisms for enforcing those procedures
 - 3.11.1.3.8 Staffing contingency plans, including how the facility will deal with illness in personnel
 - 3.11.1.3.9 The risk of infection and subsequent complications in high-risk groups
 - 3.11.1.3.10 Information to encourage those who are symptomatic with influenza-like illness but do not require formal health care to remain at home until their symptoms have

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been resolved and information to encourage them to avoid visiting/contact with those who are at high risk for complications of influenza

3.11.1.3.11 Surveillance activities in all patient intake areas, including triage (ED)

3.11.2 **LEVEL II: Initiation of a Pandemic Wave**

3.11.2.1 Ask education department scrutinize to plan, prioritize, an emphasize training toward pandemic preparedness.

3.11.2.2 Establish methods and plan for general education/training of all staff (and a mechanism for documenting participation) regarding the Pandemic Influenza Plan.

3.11.2.3 Train appropriate staff and volunteers on responses to:

3.11.2.3.1 Telephone Hotline

3.11.2.3.2 Answers to frequently asked questions

3.11.2.3.3 Referral resources

3.11.2.3.4 Documentation of calls (See Communication Plan.)

3.11.2.4 Review CDC guidelines for the care of pandemic influenza patients, including how and where these patients will be assigned. (See Addendum C – Isolation Precaution Standards.)

3.11.2.5 Develop content and a schedule for the education/cross-training for clinical personnel, who can provide support for essential patient-care areas (i.e. emergency department, ICU, medical unit).

3.11.2.6 Establish content for an educational/training “quick” course for non-clinical staff who may be asked to assist clinical personnel with certain patient care needs (i.e. distribution of food trays, transportation of patients and other duties).

3.11.2.7 Train intake and triage staff to implement immediate containment measures to prevent transmission of influenza.

3.11.3 **LEVEL III and IV: Acceleration of a pandemic wave and Deceleration of a pandemic wave**

3.11.3.1 Under direction of incident command, cancel all previous community room bookings/functions. Consider canceling non-essential hospital meetings.

3.11.3.2 Review with all personnel the Pandemic Influenza Plan.

3.11.3.3 Continually educate and cross-train employees as needed.

3.11.3.4 Provide information on influenza precautions to visitors while in the medical center (visiting hours, visitor access)

3.11.4 **LEVEL V: Preparation for Future Pandemic Waves**

3.11.4.1 Review with all staff the possibility of a second wave.

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- 3.11.4.2 Ensure brochures and other educational materials regarding pandemic influenza are still available to general public.
- 3.11.4.3 Debrief and evaluate effectiveness of education programs and refine as needed.
- 3.11.4.4 Review Pandemic Influenza Plan modules to assess need for revisions/updates.

3.12 Medications Plan

3.12.1 Note: This plan does not follow the same format as other components of the plan. It is organized by types of influenza medication, rather than by pandemic levels.

3.12.2 Pandemic Influenza Vaccine

3.12.2.1 Pre-Pandemic Period

- 3.12.2.1.1 Periodically review and revise influenza Medications Plan as appropriate.
- 3.12.2.1.2 Monitor [location] Health Department recommendations on development, distribution and use of vaccine.
- 3.12.2.1.3 Coordinate with state and local health departments for plans for distribution and priority use of vaccine.
- 3.12.2.1.4 Review priority list of vaccine distribution. (See Addendum D – Prioritization of Those Receiving Pandemic influenza Vaccination.)
- 3.12.2.1.5 Estimate of the numbers of vaccine needed for all employees who may be exposed or effected by the virus.
- 3.12.2.1.6 Develop a plan to prioritize vaccination use in the organization due to limited supplies. Include plan for re-vaccination one month later to ensure effectiveness. Plan to allocate half of available doses for the first round of vaccinations and the second half for the second round of vaccinations to the same individuals.
- 3.12.2.1.7 Plan a secure storage area for vaccine vials (Pharmacy controlled substance room). Develop plan for security at all sites and establish accountability for supplies.
- 3.12.2.1.8 Develop an educational plan on vaccination training and adverse effects, monitoring, and treatment as needed (following guidelines from CDC).
- 3.12.2.1.9 Procure and stock vaccination areas with supplies, including handouts (quarantine/self-care information), adverse reactions, syringes, needles, alcohol swabs, needle boxes, epinephrine, Benadryl, gloves, gowns, masks, and hand sanitizer.
- 3.12.2.1.10 Monitor distribution and use of vaccine.
- 3.12.2.1.11 Monitor and investigate adverse events. Report to state per its guidelines.

3.12.2.2 Throughout Pandemic Period (Before vaccine becomes available)

- 3.12.2.2.1 Meet with Incident Command, Infection Control, Pharmacy, Security, Employee Health, and Nursing Leadership..

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- 3.12.2.2.2 Review and update vaccine plan using HHS and CDC recommendations.
- 3.12.2.2.3 Notify the medical community about status of plan and expected availability of vaccines.
- 3.12.2.2.4 Conduct training for personnel involved in distributing and administering vaccines.

3.12.2.3 Throughout Pandemic Period (After vaccine becomes available)

- 3.12.2.3.1 Working with CDC and utilizing vaccination plan:
- 3.12.2.3.2 Increase security of vaccine, including transportation, storage, distribution, etc. similar to narcotic control.
- 3.12.2.3.3 Vaccinate persons in priority groups based on availability. (See Addendum D.)
- 3.12.2.3.4 Provide second dose, if required, at recommended interval.
- 3.12.2.3.5 Monitor vaccine supply, distribution and use.
- 3.12.2.3.6 Monitor and investigate adverse effects. Relay to FDA.

3.12.2.4 Post-Pandemic Period

- 3.12.2.4.1 Assemble Incident Command Team to debrief, review and critique vaccination process.
- 3.12.2.4.2 Evaluate all response activities, including vaccine tracking and delivery, adverse effects and effectiveness of communications.
- 3.12.2.4.3 Continue to provide vaccine if available and appropriate.

3.12.3 Anti-Viral Medication

3.12.3.1 Pre-Pandemic Period

- 3.12.3.1.1 Establish list of priority groups who receive antiviral medication based on therapeutic need or prophylaxis.
- 3.12.3.1.2 Determine the number of doses available for addressing predetermined priority groups.
- 3.12.3.1.3 Identify sources of antiviral drugs. (Health Department stockpile, Drug Company)
- 3.12.3.1.4 Procure antiviral medication from local stockpile in accordance with the state plan.

3.12.3.2 Seasonal Influenza Vaccine

- 3.12.3.2.1 Increase the use of seasonal influenza vaccine to vulnerable persons.
- 3.12.3.2.2 See current recommendations from CDC.
- 3.12.3.2.3 See screening questionnaire <http://www.immunize.org/catg.d/p4o66.pdf>.

3.12.4 Pneumonia Vaccine

- 3.12.4.1 Increase the use of pneumococcal polysaccharide vaccine to persons vulnerable to a secondary bacterial infection.

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3.12.4.2 Continue to Screen all patients for pneumonia vaccine.

3.12.4.3 Consider vaccinating employees in high risk groups

3.12.5 Antibiotics

3.12.5.1 Pre-Pandemic Phase

3.12.5.1.1 Inventory stock of antibiotics (Levaquin, Erythromycin, and Zithromax) for pneumonia complications. (Three-month supply is recommended).

3.12.5.2 Pandemic Period

3.12.5.2.1 Closely monitor use and availability of antibiotics and increase stock as needed.

3.13 Psychosocial Plan

3.13.1 Level I Investigation and Recognition

3.13.1.1 Inform staff of intent to use Hello and website as the vehicle to communicate pandemic flu news with employees.

3.13.1.2 Identify vulnerable populations subject to psychosocial issues, and develop a preliminary plan to address their needs. These special populations include:

3.13.1.2.1 Children

3.13.1.2.2 Those grieving loss of a loved one

3.13.1.2.3 People with mental health, addiction, or mental challenges

3.13.1.2.4 Elderly/Vulnerable adults

3.13.1.3 Review Region V Behavioral Health Disaster Plan regarding support to community based resources and emergency and medical service providers (ED staff, police, fire, EMS, physicians, nursing and other direct care staff).

3.13.1.4 Create a list of local behavior health resources, agencies, and organizations. (Contact Counseling Center, Independence Center, and Director of Mental Health)

3.13.1.5 Identify availability of mental health counselors and social workers who may be available to contribute assistance or support to the medical center.

3.13.1.6 Notify Mental Health leaders regarding roles during pandemic. These roles include:

3.13.1.6.1 Director of Mental Health Services

- Serves as point of contact for and coordinates psychiatric consultation service response
- Provides consultation and supervision for employee behavioral health
- Collaborates with pharmacy to determine need for psychotropic medication stockpiling

3.13.1.6.2 Mental Health Managers

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- Serves as point of contact for Incident Command leadership
- Provides leadership regarding an employee behavioral health agency-wide response
- Develops protocol for and directs redeployment of non-crisis program staff to assist in response to pandemic

3.13.1.6.3 Mental Health Program Manager

- Provides communication link with the DHHS behavioral health disaster coordinator
- Manages and supervises day-to-day operations and activities of behavioral health during crisis
- Coordinates response program with local/regional emergency response activities
- Ensures that all staff has appropriate training to respond to event, as well as debriefing techniques when necessary

3.13.2 Level I Investigation and Recognition

3.13.2.1 Alert Period

- 3.13.2.1.1 Encourage staff to plan for alternate childcare arrangements in the event of school and daycare center closures. (See Addendum E, Planning Guide for disasters)
- 3.13.2.1.2 Assign mental health staff at triage areas to screen persons needing emergency mental health services and debriefing.
- 3.13.2.1.3 Identify areas that, safety permitting, could accept overflow of mental health patients if needed. (Include closed unit on Mental Health or independence Center)
- 3.13.2.1.4 Notify pharmacy of any increased use of psychotropic medications stocks and estimate needed dosing. In particular, consider stocking antipsychotics, anxiolytics and mood stabilizers.

3.13.3 LEVEL II Initiation of a pandemic wave

3.13.3.1 Triage/Intake

- 3.13.3.1.1 Screen routine requests for mental health services, and direct to appropriate resource or service.
- 3.13.3.1.2 Monitor call volume and the focus of requests.
- 3.13.3.1.3 Maintain awareness of agency non-emergency resources/capacity.
- 3.13.3.1.4 Determine threshold for canceling routine scheduling of therapy and medication management clients, and move toward emergency response scheduling.
- 3.13.3.1.5 Acquire/create an informational packet on psychosocial and/or medical self-care, and contact numbers for those individuals who will be returning home, away from the hospital.

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- 3.13.3.1.6 Develop plan for providing rest and recuperation sites/support for service staff.
- 3.13.3.1.7 Have Incident Command meet and discuss:
 - 3.13.3.1.7.1 Key messages from DHHS and the medical center
 - 3.13.3.1.7.2 Issues and concerns from clients and callers
 - 3.13.3.1.7.3 Volume of emergency mental health contacts
 - 3.13.3.1.7.4 Staffing issues, training needs and agency response
- 3.13.3.1.8 Review plan for staff reassignments.
- 3.13.3.1.9 Determine need to activate contingency staffing plan when appropriate.
- 3.13.3.1.10 Have Incident Commander activate Medical Alert.
- 3.13.3.1.11 Have behavioral health director/manager ensure that rest and recuperation sites/supports are available to staff. (Employee Health Wellbeing Support Branch Director)

3.13.4 **Level III-IV: Acceleration of a pandemic wave and Deceleration of a pandemic wave**

- 3.13.4.1 Deploy immunocompromised employees to telephone hotline/support activities.
- 3.13.4.2 Determine availability and capacity for accepting clients.
- 3.13.4.3 Review on a daily basis.
- 3.13.4.4 Determine if psychiatric facilities have the capacity to accept patients who meet criteria for admission. Review on a daily basis.
- 3.13.4.5 Establish communication with the state-operated mental health facilities to determine their ability to address the needs of special at-risk clients.
- 3.13.4.6 Provide crisis intervention and brief supportive counseling to victims and family members, as well as to medical center employees and first responders.
- 3.13.4.7 Provide outreach and advocacy to survivors, family members and the community at large.
- 3.13.4.8 Conduct daily check-in with direct service staff to monitor for stress, exhaustion and need for rest/recuperation during emergency.
- 3.13.4.9 Track crisis-related activities performed and report to DHHS behavioral health disaster coordinator.
- 3.13.4.10 If necessary, contact the DHHS behavioral health disaster coordinator to request facilitation of reassigning staff from other local DHHS programs to assist and supplement

3.13.5 **Level V: Preparation for Future Pandemic Waves**

- 3.13.5.1 Provide continued outreach, triage and stabilization services.
- 3.13.5.2 Assist in coordinating/providing debriefing services as requested.

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3.14 Mortuary Plan

3.14.1 Level I: Investigation and Recognition

- 3.14.1.1 Review Community Mortuary Plan and Medical Alert Plan.
- 3.14.1.2 Determine temporary morgue facilities and refrigeration if needed:
 - 3.14.1.2.1 Establish contact with trucking companies and consider contracts.
 - 3.14.1.2.2 Plan on where to place truck and consider power/diesel fuel requirements.
 - 3.14.1.2.3 Address security concerns.
 - 3.14.1.2.4 Explore potential local storage facilities.
- 3.14.1.3 Plan for rapid removal and disposition of bodies.
- 3.14.1.4 Plan for transportation of bodies.
 - 3.14.1.4.1 Licensed vs. non-licensed transportation.
 - 3.14.1.4.2 Designation of who can transport in an emergency
- 3.14.1.5 Continue Isolation Precautions until body placed in bag or wrapped in plastic.
- 3.14.1.6 Have a predetermined memorandum of understanding with local morticians and the county emergency management agency.
- 3.14.1.7 Establish list of local funeral homes and crematories.

3.14.2 Level II Initiation of a pandemic wave

- 3.14.2.1 Establish contracts for storage of bodies. Same actions as above.
- 3.14.2.2 Establish Incident Command system

3.14.3 Level III and IV Acceleration of a pandemic wave and deceleration of a pandemic wave

- 3.14.3.1 Confirm areas for body storage. Same actions as above.
- 3.14.3.2 Cooperate with local funeral homes in the ultimate disposition of all bodies.
- 3.14.3.3 Using incident command system, assign responsibility for removal and transport of bodies.
- 3.14.3.4 Cancel contracts as appropriate, keeping in mind the potential for a second-wave of pandemic influenza.
- 3.14.3.5 Explore reimbursement from local, state and federal sources for cost associated with emergency mortuary services.
- 3.14.3.6 Review plan and adjust per recommendations.
- 3.14.3.7 Keep a record of associated costs involved in on site storage of bodies.

4. RESOURCES

Pandemic Preparedness Plan

Screening Questionnaire <http://www.immunize.org/catg.d/p4066.pdf>

Addendum A: Communication Issues during a Pandemic

Addendum B: Daily Log of Employee Symptoms

Addendum C: Isolation Precautions Standards <http://www.hhs.gov/pandemicflu/plan>

Addendum D: Prioritization of Those Receiving Pandemic Influenza Vaccination

Addendum E: Personal Planning Guide for Disasters

Addendum F: Flu Hotline

Addendum G: Skills and Skill Sets for Providers

Addendum H: Adaptations of Standards (Medical procedure pending)

5. REFERENCES

Pandemic Influenza Plan 2017 Update, US Dept of Health and Human Services
<https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>

Pandemic Influenza. Centers for Disease Control.
<https://www.cdc.gov/flu/pandemic-resources/index.htm>

6. APPENDIX

7. OWNER

Infection Prevention Coordinator

8. APPROVER

Infection Prevention Coordinator