

Pandemic Influenza Plan Template

MPCA

Pandemic Influenza Planning Template

The purpose of the <CHC> Pandemic Influenza Preparedness and Response Plan (PIPRP) is to supplement the overall Emergency Operation Plan (EOP) with information to respond specifically to an influenza pandemic. The intent of this template is to provide a tool to health centers whether just starting the process of developing a comprehensive Pandemic Influenza Plan or for use in updating and existing Pandemic Influenza Plan.

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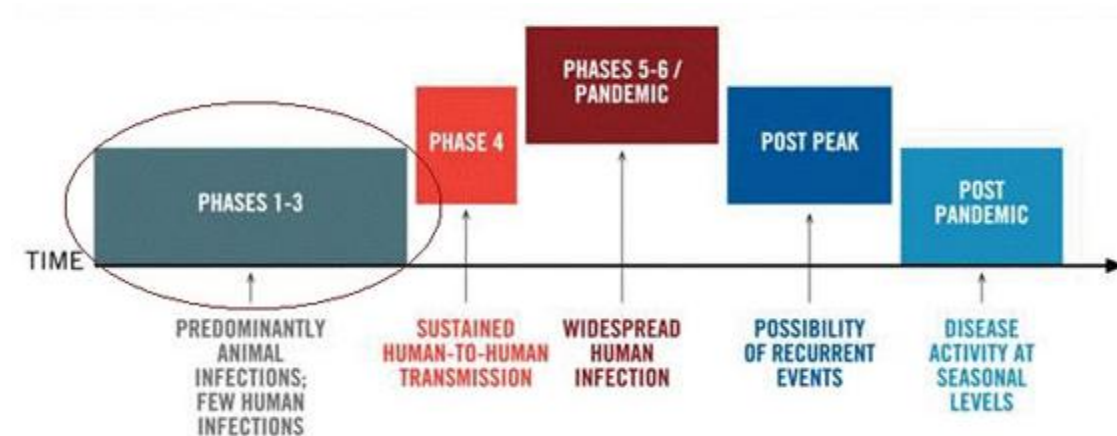
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1 INTRODUCTION

1.1 Purpose

The purpose of the <CHC> Pandemic Influenza Preparedness and Response Plan (PIPRP) is to supplement the overall Emergency Operation Plan (EOP) with information to respond specifically to an influenza pandemic.

This plan is organized according to the World Health Organization (WHO) phases associated with pandemic influenza (1 through 6). This model was designed to assist with public health, medical and emergency preparedness to respond to an occurrence, or threat of an occurrence, of pandemic influenza.



1.2 Goals

The goals of the Pandemic Influenza Preparedness and Response Plan include:

- To define key planning assumptions
- To outline the role and responsibilities of <CHC>
- To define concept of operations during a pandemic influenza outbreak
- To list the actions undertaken by <CHC> to prepare
- To meet recommendations set forth by the Department of Health and Human Services around pandemic planning for medical offices and clinics. Portions of this plan that relate to the checklist provided by DHHS are indicated by red text. This planning checklist can be found at <http://www.flu.gov/professional/pdf/medofficesclinics.pdf>.

1.3 Objectives

The objectives of the overall emergency management program include:

- To provide maximum safety and protection from injury for patients, visitors, and staff.

- To attend promptly and efficiently to all individuals requiring medical attention in an emergency situation.
- To provide a logical and flexible chain of command to enable maximum use of resources.
- To maintain and restore essential services as quickly as possible following an emergency incident or disaster.
- To protect health center property, facilities, and equipment.
- To satisfy all applicable regulatory and accreditation requirements.
- To support the community in a way to ensure that there are no secondary injuries, illnesses, or deaths that result from the failure of clinical services after an incident.

1.4 Policy

- <CHC> will be prepared to respond to a pandemic influenza outbreak in a manner that protects the health and wellbeing of its patients and staff, and that is coordinated with a county-wide response to minimize infection and maximize survivability and ensure continuity of operations.
- All employees will know and be prepared to fulfill their duties and responsibilities as part of a team effort to provide the best possible health care services. Each supervisor at each level of the organization will ensure that employees are aware of their responsibilities.
 - All employees will receive additional training on the proper use of personal protective equipment to minimize their exposure and risk from a pandemic.
 - All employees will receive training on personal emergency preparedness to ensure that their families are prepared and have plans in place so the employee is able to perform work functions to support their community.
- The <CHC> will work in close coordination with their county health department and other local emergency officials, agencies, and health care providers to ensure a community-wide coordinated response to disasters.

1.5 Scope

- This plan draws upon existing structures in place as part of the <CHC> overall emergency preparedness activities and EOP.
- This plan serves as an appendix to the <CHC> all-hazards EOP and describes the part of the <CHC> emergency management program designed to guide actions in the event of a Pandemic Influenza threat or confirmed outbreak, as well as providing guidance to any other large scale infectious disease outbreak.
- This plan describes the actions <CHC> will follow to prepare and respond to a Pandemic Influenza Outbreak in each of the phases of pandemic, as outlined by the World Health Organization (WHO).

1.6 Implementation

This template provides an outline to develop or revise a plan. **A multi-disciplinary committee is needed to modify this plan and develop policies to support implementation in your center.** Collaboration with your local health department and hospital is critical to establish protocols for communication,

management of patients and access to vaccine, antivirals, supplies and equipment. Phases 1-3 lay the foundation of the response and additional activities are added as situation progress through Phases 4-6.

One person should be assigned responsibility for coordinating preparedness planning for the practice organization (hereafter referred to as the pandemic influenza response coordinator). Responsibilities will include incorporating Department of Health and Human Services Pandemic Influenza Plans as well as pandemic plans from the Michigan Department of Community Health.

[Appendix A](#) is a checklist for Administrative Planning. [Appendix B](#) is a checklist for planning at the department level.

2 WHO Phased Planning

2.1 Phase 1-3 – Predominantly Animal Infections – Few Human Infections

2.1.1 Introduction

The focus in the inter-pandemic period is monitoring the global threat of a novel virus, building the infrastructure in <CHC> to support Pandemic Influenza planning, implementation of policies and procedures to support the plan, patient and staff education on the importance of annual influenza vaccination as one means of reducing the spread of a Pandemic Influenza and reinforcement of Universal Respiratory Etiquette.

2.1.1.1 WHO Phases

Phase 1: No viruses circulating among animals have been reported to cause infections in humans.

Phase 2: An animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans, and is therefore considered a potential pandemic threat.

Phase 3: An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.

2.1.1.2 Planning

The Infection Control Officer has been appointed the Pandemic Influenza Response Coordinator and oversees the internal planning and external coordination with County agencies and organizations.

To guide monitoring and planning activities, <CHC> will create a Pandemic Influenza and Infectious Disease Outbreak Committee. Members of this committee include the **Infection Control Officer** as Chair, **Medical Director, Health Clinical Director (or Nurse Manager)**, Behavioral Health Director, **Reception Supervisor**, Human Resources Manager, Safety Officer, Dental Director and **Chief Operating Officer**,

Environmental Services representative, and Laboratory Manager (if applicable). Other staff will be brought in as needed.

Meetings will be held quarterly during Phases 1-3, monthly in Phase 4 and weekly in Phases 5-6. Post Peak meetings will occur monthly until influenza incidence has returned to the appropriate baseline for the season. Minutes will be produced from each meeting and summary reports will be given to the Board of Directors.

A representative from the Pandemic Influenza and Infectious Disease Outbreak Committee will sit on the <CHC> Emergency Management Committee and will provide updates on activities as available. In most cases, the Safety Officer will fill this role.

<CHC> will work with the local, county and state departments of public health to ensure that all clinicians and key staff are linked into the HAN.

2.1.1.3 Monitoring

<CHC> will assign two staff members to monitor seasonal influenza and note any new influenza virus subtypes that have been identified by health experts as potential threats to humans.

Influenza-Like Illness (ILI) can be tracked internally using the methodology used by the CDC at sentinel sites. Unusual cases should be reported to the local public health authorities.

The case definition for ILI is fever (> 100 F)* AND cough and/or sore throat (in the absence of a known cause other than influenza) *Temperature can be measured in the office or at home. See [Appendix C](#).

Rates should be calculated by dividing the number of cases in each age strata by the total number of visits in that age strata per week. This data can be collected over a number of years to provide baseline ILI rates within a particular community each week and will allow for the early identification of both peaks in seasonal influenza and the emergence of pandemic related illness within the community. The age strata are:

- 0-4 years
- 5-24 years
- 25-49 years
- 50-64 years
- >64 years

During seasonal influenza outbreaks, the two staff members will review weekly local/county/state and national reports provided by the county or state health departments the CDC Flu Activity reports at <http://www.cdc.gov/flu/weekly/fluactivity.htm>. These reports will be shared with the Medical Director, Health clinical Director, Infection Control Officer (who will bring it to the Pandemic Influenza and Infectious Disease Outbreak Committee and Emergency Management Committee) and others as appropriate.

Year-round, the **Infection Control Officer or designee will be a point of contact for questions and/or consultation on infection control measures to prevent transmission of pandemic influenza has been identified.** In addition, they will be responsible to monitor novel influenza virus strains noted on the federal website at <http://www.pandemicflu.gov/>. This will be done on a monthly basis and increased activity or news of concern will be reported to the Medical Director, Health clinical Director, Emergency Management Team and others as appropriate. An additional resource to monitor emerging disease threats is through an email notification system at the Center for Infectious Disease Research and Policy at the University of Minnesota. <http://www.cidrap.umn.edu/services/email>

As part of our ongoing vigilance to protect the health and well being of staff and patients, health clinicians and phone triage staff will complete [Nurse/Clinical Telephone Triage \(Appendix D\)](#). The Infection Control Officer or his/her designee will review the data on a weekly basis. A log will be kept that tracks compliance with daily monitoring and the number of patients presenting with influenza like illness. Unusual trends will be reported to the Medical Director immediately and need to alert the X County Health Department will be determined. **The <CHC> CEO will also be alerted of unusual ILI activity and of any notification to the X County Health Department.**

Data should be submitted for the previous week by the second business day of the following week.<Insert process/procedure for reporting concerning trends to X County Health Department here>

Completed Nurse/Clinical Telephone Triage forms will be filed in the patient chart after review by the Infection Control Officer.

Health clinicians providing after hours coverage will not be required to complete the Flu Triage and Symptoms Form in Phases 1-3 due to the added data collection and reporting burden.

2.1.1.4 Vaccination and Universal Respiratory Etiquette (URE)

<CHC> will undertake an aggressive campaign to increase the influenza vaccination rate among both patients and staff and reinforce the importance of Universal Respiratory Etiquette (cover cough appropriately, hand hygiene, stay home if ill, mask use).

Staff vaccinations: Each year, reminders will go out in paycheck stubs in September and October reminding staff of the importance of receiving an annual influenza vaccination. Information included in the reminder will describe the risk of healthcare workers acquiring influenza, the symptoms and treatment of influenza and the risk/benefit of getting an annual vaccination.

Patient education material will be placed in common areas to provide additional information. <CHC> will sponsor a 'flu health center' for the staff on two afternoons shortly after the vaccine has arrived from the manufacturers. The Infection Control Officer will report percentage of staff vaccinated monthly at appropriate meetings. Blinded, aggregated data will be provided to the Performance Improvement Committee (PIC) to be incorporated as an ongoing PI project around influenza vaccination rates. Thresholds will be established by the PIC to implement more aggressive influenza vaccination campaigns for employees the following years if targets are not met. If vaccination rate goals are not achieved, mandatory influenza vaccination programs will be reviewed by administration.

Patient vaccinations: Patient education material will be placed in patient areas of <CHC> in the dominant languages of the region starting in August and September. Reminders will be sent to patients who identified by the Advisory Committee on Immunization Practices (ACIP) as high risk for developing complications due to Influenza. The Infection Control Officer will be responsible to check for annual updates to recommendations. These recommendations are routinely found in the Morbidity and Mortality Weekly Report: Recommendations and Reports and can be found at http://www.cdc.gov/mmwr/mmwr_rr/rr_cvol.html.

Health clinical staff will also be reminded to offer influenza vaccine to high risk patients and supply dependent, <CHC> will sponsor two 'flu health centers' for patients during October and November. Vaccination rates will be monitored by the Infection Control Officer or Health clinical Director through electronic data reports in the presence of an electronic medical record (EMR) or two chart audits of 100 charts of patients in the target population at a frequency to be determined by the PIC. Data from the audits will be presented to the PIC to be incorporated as an ongoing PI project around influenza vaccination levels among at-risk patients.

Universal Respiratory Etiquette: Patients and staff will be educated on URE through brochures and posters hung in common areas throughout the health center. The CDC has posters for this purpose in a number of languages available at <http://www.cdc.gov/flu/protect/covercough.htm>. Another resource for ESL resources is through Emergency Communication and Health Outreach of Minnesota. <http://www.echominnesota.org/>.

Staff will also be reminded of the <CHC> policy regarding illness. This policy states that staff may be asked to go home and use a sick day (or day of PTO) in the event that they show up to work ill and their Supervisor or the Infection Control Officer determine that they pose an infection risk to patients and/or staff with whom they have contact. In certain circumstances, they may be allowed to work while wearing a surgical mask, but this will be determined on a case by case basis. This will be the exception more than the rule though and will only occur in times of a severe staffing shortage.

2.1.1.5 PIPRP Review and Maintenance

The Pandemic Influenza and Infectious Disease Outbreak and Emergency Management Committees will review the <CHC> Pandemic Influenza Preparedness and Response Plan annually to ensure it remains reflective of organizational change.

A tabletop exercise focusing on pandemic influenza or other large scale infectious disease outbreak will be scheduled as determined by an annual risk assessment as part of the Emergency Management Program. After Action Reports (AAR) will be drafted and shared with the Board of Directors. Revisions to the PIPRP based on AAR recommendations will be implemented by the Infection Control Officer no later than 90 days following the release of the AAR.

2.2 Phase 4 – Sustained Human to Human Transmission

2.2.1 Introduction

Phase 4: Characterized by verified human-to-human transmission of an animal or human-animal influenza reassortant virus able to cause “community-level outbreaks.” The ability to cause sustained disease outbreaks in a community marks a significant upwards shift in the risk for a pandemic. Any country that suspects or has verified such an event should urgently consult with WHO so that the situation can be jointly assessed and a decision made by the affected country if implementation of a rapid pandemic containment operation is warranted. Phase 4 indicates a significant increase in risk of a pandemic but does not necessarily mean that a pandemic is a forgone conclusion.

To ensure the needs of our patients and staff are recognized and included in the County plans, <CHC> is committed to participating in regional Pandemic Influenza Planning activities. Effective delivery of outpatient care will require effective coordination of efforts between <CHC>, the county health department, local hospitals, and the state health department.

2.2.2 Surveillance

In addition to systematic monitoring of the influenza activity in the community and state, <CHC> will increase the tracking of influenza among the patients seen by our health clinicians as well as our staff when the WHO identifies that we are in Phase 4.

It is important to standardize methodology across the state to characterize ILI incidence. This will be particularly important in WHO pandemic phases 4-6. Use the methodology in [Appendix C](#) to help with improving the ease of aggregate community monitoring.

<CHC> will implement a screening form for all patients who call ([Appendix E](#)) or present with influenza like illness ([Appendix D](#)). The same procedure as described in [Appendix C](#) will be followed but the frequency of monitoring may increase to daily. Daily monitoring should be implemented if there is a statistically significant (over two standard deviations increase) over the mean rate for that week based on previous data or if the sustained human-to-human transmission is occurring within the state.

If daily reporting is deemed necessary at this point, departments must enter data into the system by noon of the following business day.

To monitor illness among our staff members, we will provide them with a copy of our human resources policy regarding reporting of ILI symptoms. This policy lists the common symptoms of influenza and asks staff members to voluntarily report if they are suffering from an ILI when they notify <CHC> of their absence. Only the date(s) of absence and department will be recorded in the tracking database for inclusion in the Infection Control review. This information will be kept in the strictest of confidence and will not be shared with other staff members nor kept as part of the personnel record - it is strictly for the purpose of ILI tracking.

As staff becomes comfortable with the use of this syndromic surveillance data and is clear that it is not for administrative or punitive purposes, the clinic administration will assess the benefit of collecting syndromic data on staff for other infectious processes, primarily gastrointestinal and upper respiratory system infections.

2.2.3 Communication

<CHC> has compiled a list of key public health, healthcare and <CHC> site manager points of contact to support rapid and ongoing information sharing during a pandemic. See Attachment X for these lists. It is updated annually as part of the review of this plan by the Pandemic Influenza and Infectious Disease Outbreak Committee.

<CHC> will participate in the state HAN network, but will also develop an internal HAN process.

<CHC>' <Insert title of PIO> has been appointed the Public Information Officer (PIO) for this organization. This person has the responsibility to coordinate the release of health center information internally and externally to media and community. The PIO will develop a Disaster Public Information Plan to guide health center information dissemination and response to media and community inquiries following the disaster. Staff are instructed that all media inquiries are to be directed to the PIO.

This plan will include provisions for coordination with the county health department PIO during an emergency to ensure availability of up-to-date information and consistency of released information. It will address the information needs of the health center's community, patients, staff, volunteers and other interested parties. This type of planning will be coordinated through the Joint Information Center (JIC).

The plan will define how the following information is gathered, verified, coordinated with the Health Department PIO, and communicated to communities served by the health center and other stakeholders:

- The nature and status of the emergency.
- Appropriate actions for protection, seeking health care services, and obtaining needed information.
- The status of the center and its ability to deliver services.

It will also include provisions for employee meetings, internal informational publications, press releases and other programs intended to disseminate accurate information regarding the event and its impact as well as deal with misinformation.

A roster of patients with regular visits will be created that includes contact information to facilitate rapid rescheduling and cancellation of appointments if needed.

<CHC> will incorporate disaster preparedness information into its normal communications and education programs for staff and patients including:

- Home and family preparedness. Useful resources include

- <http://www.ready.gov/>
- <http://do1thing.com/>
- Information on health center emergency preparedness activities.

2.2.4 Staff Education and Training

<CHC> will provide ongoing opportunities for staff education and training to better prepare them for response roles. These may be local or distance. The CDC maintains some training at <http://www.cdc.gov/flu/professionals/training/>. The health clinical director has responsibility for coordinating trainings on topics related to Pandemic Influenza with the Infection Control Officer and for maintaining attendance rosters. Trainings will include an overview of emergency management in general with emphasis on a number of topics identified as higher risk according to the Hazard Vulnerability Assessment conducted by <CHC>. Among these topics is Seasonal and Pandemic Influenza. A one-hour training session will be presented during an all-staff meeting in August or September. A pre and post test will be administered and results will be compiled and tracked by Human Resources.

<CHC> requires that all staff take a basic infection prevention course ([Appendix F](#)). Universal respiratory etiquette, isolation precautions ([Appendix G](#) and [Appendix H](#)) basic personal protective equipment (PPE), and a respiratory protection program ([Appendix I](#)) will be included as part of this training. If a respiratory protection program has not been established, a planning checklist is available in [Appendix J](#).

In addition to the above training, staff members who have been assigned roles in the Incident Command Structure (as laid out in the EOP), supervisors, department managers and senior staff will complete NIMS training, depending on their level of response. Online courses are available free of charge (and include CEUs) through the FEMA Emergency Management Institute. Recommend courses (determined by response roles) include:

- IS-100.HCb Introduction to the Incident Command System (ICS 100) for Healthcare/Hospitals
<http://training.fema.gov/EMIWeb/IS/is100HCb.asp>
- IS-200.HCa Applying ICS to Healthcare Organizations
<http://training.fema.gov/EMIWeb/IS/is200HCa.asp>
- IS-700.a National Incident Management System (NIMS) An Introduction
<http://training.fema.gov/EMIWeb/IS/is700a.asp>
- IS-800.b National Response Framework, An Introduction
<http://training.fema.gov/EMIWeb/IS/IS800b.asp>

Language and reading level appropriate materials related to emergency preparedness and Pandemic Influenza will be produced or identified and placed in common areas around the health center.

<CHC> may initiate Psychological First Aid (PFA) courses for staff. A pandemic on the scale of 1918 would likely trigger psychological trauma and PFA awareness would help coworkers identify early signs of stress. PFA courses can be found through many venues such as the American Red Cross or online at <http://learn.nctsn.org/course/category.php?id=11>. Ideally, leaders should have some awareness on this topic to help their staff deal with the stress that would result from a major pandemic.

2.2.5 Patient Education

<CHC> will incorporate additional patient education during October through March to provide a basic level of awareness among our patients. This will be done in appointments and other patient interactions (such as outreach) when possible as well as providing printed materials to be taken home. Language and reading level appropriate materials related to emergency preparedness and Pandemic Influenza will be produced or identified and placed in common areas around the health center. See <http://www.echominnesota.org/> for some ESL resources.

Topics will include basic information about seasonal and pandemic influenza, personal preparedness measures that patients can take to help protect themselves and general infection control concepts.

2.2.6 Triage

<CHC> will implement a phone triage system during flu season or during WHO Phase 4 in an effort to reduce the number of non-essential appointments and minimize the number of infectious patients entering the health center. Implementation of this system during the WHO Phase 4 will also provide opportunities to test and refine this system that will be essential during a pandemic influenza outbreak in the region. A template for a recording for the clinic during a pandemic is attached in Appendix K.

The Performance Improvement Committee (PIC) will develop criteria to evaluate the effectiveness of <CHC>' phone triage system. This will be incorporated into an ongoing project and monitored annually to ensure that organizational adjustments (staff turnover, changes in appointment scheduling, etc.) have not impacted the functionality.

2.2.7 Surge Capacity

<CHC> will utilize the Staffing Level Algorithm to help us determine at what point we should consider cancelling non-essential appointment, requesting additional staff, diverting patients and closing the center. This tool will also help us determine how many additional patients we could treat based on the staffing levels on any given day. See Attachment X for a copy of this tool.

Emergency staffing may be required during a Pandemic outbreak. <CHC> will meet with X County and the Michigan Primary Care Association to determine available options through ESAR-VHP, MRC or other state based programs designed to pre-credential providers who are available to augment staff in an emergency. The <insert title of HR manager> in coordination with the Health clinical Director will assess staffing level using the Staffing Level Algorithm tool. If additional staff is needed for continued operations, the <insert title of HR manager> will pursue through pre-established arrangements.

<CHC> will pursue Memoranda of Agreement (MOA) with nearby healthcare facilities to provide healthcare workers from each other's organization in an emergency situation. MOA's may not be a viable option during a Pandemic or large event and our planning will reflect this possibility.

As part of our ongoing preparedness process, the <insert title of HR manager> will work with each department manager to determine which functions are essential and how employees are currently cross trained to perform them. Any essential function which less than three employees can perform will be noted and staff for cross training will be identified and trained as part of the implementation activities of

the <CHC> PIPRP. A log of cross trained staff will be maintained by the Human Resources Department. [Appendix L](#) is an altered duty planning worksheet.

It may become necessary to alter the mix of services provided. <CHC> will assess services to have advanced plans for demobilizing some services in order to augment a pandemic response. A template for identifying a staged process for service suspension is in [Appendix M](#).

<CHC> will pursue Memoranda of Agreement (MOA) with nearby healthcare facilities to accept patients from each other's organization in an emergency situation. MOA's may not be a viable option during a Pandemic or large event and our planning will reflect this possibility.

<CHC> will develop policies to arrange providing non-influenza related care at smaller sites and/or during specified times during the day or week during a Pandemic outbreak.

<CHC> will coordinate with the X County Health Department, local hospitals and other key agencies to develop a plan to protect hospitals so they are able to care for the sickest patients. In addition, this group will develop criteria for patients with pandemic influenza who may need a higher level of care than is available in a primary care setting but not meet the criteria for admission to a hospital for acute care. (this is part of the process for developing alternative care facilities – which may be a role for some of <CHC>' sites).

<CHC> will develop plans to increase operating hours to provide ambulatory services to an increased number of patients seeking care. Human Resources will be included in the development of these plans to determine the need for revised or new staff policies.

<insert title of person responsible for monitoring consumable and durable supplies> will evaluate the existing systems for tracking supplies on hand at <CHC>. In addition, <position of above person> will identify the supplies which are consumed at the fastest rate.

Working with X County Health Department and the Michigan Primary Care Association, the Infection Control Officer will identify the supplies which may be scarce in a Pandemic Influenza outbreak. A plan will be developed for stockpiling in <CHC> or accessing stockpiled goods from nearby storage facilities.

<CHC> will explore the feasibility of stockpiling antibiotics to treat bacterial complications of influenza. The needs of both adult and pediatric patients will be considered in this process. As an alternate, <CHC> will also determine the possibility of accessing antibiotics stockpiled as part of local, state, or federal preparedness (i.e. SNS).

2.2.8 Infection Control

<CHC> will determine the area in our center to triage and house the symptomatic patients away from other patients in the waiting room.

Signage in English and Spanish will be placed on the front entrance (only one that is accessible to patients) that requests all patients with influenza symptoms are go to the designated area and notify the reception personnel.

Procedure masks (both adult and pediatric) will be available to all symptomatic patients and those who accompany them. In addition, we will place boxes of tissues in all waiting areas and exam rooms and provide hand sanitizer in accordance with regulations and JCAHO standards. Signs in English and Spanish reminding patients of URE will be hung in all waiting areas and in the entrance way.

<CHC> will provide appropriate personal protection equipment as recommended by national authorities to all reception and triage personnel to further reduce the risk of spread.

A policy will be developed that requires Standard and Droplet Precautions be adopted when staff are in contact with symptomatic patients. As previously mentioned, <CHC> will also stockpile or make arrangements to provide needed supplies to support adoption of Standard and Droplet Precautions.

2.2.9 Vaccine and Anti-Viral Distribution

<CHC> will follow federal and/or state health department recommendations for the use and distribution of vaccine and anti-viral distribution to staff and patients during a pandemic event. The Infection Control Officer will monitor recommendations on Pandemicflu.gov and the X State Department of Public Health websites once published. These recommendations will be summarized and provided to all staff and posted for patient information.

Based on HHS guidance, <CHC> will estimate the number of staff and patients who would be targeted as first and second priority for receipt of vaccine or antiviral prophylaxis. To estimate the number of staff, <CHC> will determine which functions are essential and what positions support these functions, including infrastructure support staff (security, registration, facilities and so on) to arrive at an estimated figure.

2.2.10 Occupational Health

<CHC> will develop a comprehensive, non-punitive personnel policy for managing staff with symptoms of or documented illness. The policy will include provisions to address staff who become ill at work; when staff may return to work after recovering from pandemic influenza; when staff who are symptomatic but well enough to work may return; staff who need to care for ill family members; psycho-social support for staff and their families.

<CHC> will designate appropriate staff to monitor the health status of staff before starting work and periodically throughout the day in a confidential and sensitive manner.

<CHC> will work with department managers to determine the process for delivering 'just in time' training and education regarding <CHC> PIPRP and other topics vital to safety and wellness during a pandemic influenza outbreak.

<CHC> will continue to promote annual influenza vaccination among staff and their families and will develop a system for documenting staff vaccination.

As mentioned in the Communication section, <CHC> will promote staff personal and family preparedness through provision of education and materials to assist in the development of a plan, creation of a go-bag and stockpiling food, water, supplies and life sustaining medications.

2.3 Phase 5 – Pandemic Alert Period

2.3.1 Introduction

Characterized by human-to-human spread of the virus into at least two countries in one WHO region. While most countries will not be affected at this stage, the declaration of Phase 5 is a strong signal that a pandemic is imminent and that the time to finalize the organization, communication, and implementation of the planned mitigation measures is short.

2.3.2 Healthcare Planning

<CHC> will fully implement the <CHC> Pandemic Influenza Preparedness and Response Plan using the Incident Command System.

<CHC> will stand up the Emergency Operations Center (EOC), as detailed in the Emergency Operations Plan.

<CHC> will notify staff of EOC and Plan activation at a weekly staff meeting. In addition, staff will be reminded of the importance of personal and family plans.

<CHC> will provide increased staff access to behavioral health professionals to help manage stress and fear.

2.3.3 Surveillance

<CHC> will maintain heightened surveillance among patients and staff and provide surveillance data to X County Health Department as requested

<CHC> will work with the County or State Health Department to review or clarify testing protocol for suspected Pandemic Influenza. Information will be reviewed with health clinical and laboratory staff.

Staff members assigned to monthly reviews of novel strains will increase frequency of website visits to daily and monitor all public health advisories. All information of importance will be reported to the Infection Control Officer as soon as it is identified.

Front desk and triage staff will be encouraged to continue and increase the use of screening forms, provision of procedure masks for symptomatic patients and alternate waiting room areas to reduce exposure to other patients.

Provider and frontline staff will receive refresher training on Infection Control and an update of the current situation.

The Infection Control Officer will remind all key staff to stay current with Health Alert Network notices on daily basis.

<CHC> will increase monitoring of staff absenteeism for unusual increases they may indicate early cases of pandemic influenza.

<CHC> will comply with all requests from state and local health departments regarding ILI encounters.

Maintain a high index of pandemic influenza suspicion for any patients who present with ILI.

As determined jointly with state and local health departments, <CHC> will report any clusters of ILI among patients and staff.

2.3.4 Vaccine

<CHC> will work with X County Health Department to determine the number of doses of vaccine and/or anti-viral needed for high priority populations, as recommended by DHHS.

2.3.5 Communication

Updates will be provided by PIO to local, county and state departments of health as requested.

The Health clinical Director will review all Health Alert Network messages and distribute to staff, as appropriate.

The <CHC> PIO will contact local and county level health department and hospital PIOs to review communications plan for consistent messaging.

<CHC> will maintain close contact with health departments, the Michigan Primary Care Association and other community partners.

<CHC> will designate staff to participate in key meetings about pandemic influenza. Information from these meetings will be shared with the Infection Control Officer to ensure distribution to all key staff.

Staff will be briefed in weekly staff meetings. Talking points will be distributed to provide an update on the current pandemic influenza status and frequently asked questions to enable them to respond to patient questions.

<CHC> will set up a hotline (or participate in a community wide one) that provides information to patients about influenza activity worldwide, in the US and in the local area. Signs and symptoms of influenza will be listed as well as home care methods and indications that signal the need for medical treatment. This message will be recorded in both English and Spanish.

<CHC> will develop or adopt an existing communications plan that will facilitate information sharing and response between local and regional health care facilities. This plan will include communication plan with the MPCA and other health centers in Michigan.

2.3.6 Surge Capacity

<CHC> will evaluate the amount of supplies on hand and determine gaps to manage a surge of patients.

<CHC> will review county wide plan for managing patients presenting with pandemic influenza in ambulatory setting.

<CHC> will set up health clinical evaluation area for patients and staff that is separate from the general waiting area.

<CHC> may cancel some appointments and create blocks of time in which to see influenza and non-influenza patients as a means to limit transmission or respond to staff illnesses.

2.3.7 Education and Training

The Human Resources Manager will review the staff cross trained log to ensure that all essential patient care services are supported by at least three staff that can perform duties in the event of severe staff shortages.

The Medical Director will hold training sessions to review the criteria for distinguishing pandemic influenza from other respiratory diseases as defined by the CDC.

<CHC> will review the PIPRP with staff in department meetings and provide any 'just in time' training needed to fully implement the plan.

2.3.8 Infection Control

Provide refresher information at all staff meetings on control measures needed to minimize the spread of influenza.

Post signs for hand hygiene and respiratory etiquette in all common areas for staff and patients.

- <http://www.cdc.gov/flu/protect/covercough.htm>
- http://www.cdc.gov/handhygiene/Patient_materials.html

Post signs and symptoms of pandemic influenza in and around all entrances.

- <http://www.cdc.gov/flu/freeresources/print.htm>

Request that patients identify themselves to greeter / front desk reception staff if they are experiencing pandemic influenza symptoms.

Provide procedural masks to patients and those accompanying them who report ILI.

Direct all patients with pandemic influenza symptoms to the health clinical evaluation area.

2.3.9 Occupational Health

Instruct all staff to notify supervisor if feeling ill. If symptoms of pandemic influenza are present, staff must report to the health clinical evaluation area.

If onset of illness occurs at home, employees are to call their supervisors to notify them. Staff will be asked to stay home until symptoms resolve and/or at least 7 days (based on current data about virus shed. This will change if recommendations are revised).

The Human Resources Department track illness by department to detect possible clusters within <CHC>.

<CHC> staff at high risk for complications of influenza will be reassigned to lower risk jobs that do not directly expose them to influenza patients or be placed on administrative leave.

2.4 Phase 6 – Pandemic

2.4.1 Introduction

Characterized by community level outbreaks in at least one other country in a different WHO region in addition to the criteria defined in Phase 5. Designation of this phase will indicate that a global pandemic is under way.

2.4.2 Surveillance

<CHC> will remain on heightened alert for ILI in patients and staff.

<CHC> will track the number of patients presenting with influenza like illness and provide data to public health authorities as requested

- Any clusters of ILI among staff or patients will be reported to the X County Health Department.
- Human Resources will track the number of staff who call in or leave work due to ILI.

2.4.3 Communication

<CHC> will continue to provide patient education about pandemic influenza during encounters, through posters in common areas and brochures in waiting rooms.

<CHC> will coordinate key messages for the community with county and state health departments. Themes will include signs and symptoms of influenza, when to seek healthcare when ill with influenza, and infection control basics.

<CHC> and health departments will determine triggers for releasing messages, frequency of repeat and mechanisms of release, i.e. newspaper, website, radio, and television.

<CHC> will implement the emergency communication plan developed in section 6 of this plan.

2.4.4 Surge Capacity

In anticipation of an influx of ill and worried and concerned patients, <CHC> will determine the need to clear time for behavioral health staff to be available to support patients in walk-in or call-in visits.

<CHC> will cancel any planned leave (other than medical) of key employees to maximize staffing levels.

Implement the phone triage system and provide patients with guidance on providing supportive care at home, when to seek medical attention, and where to go as determined by the community response plan.

<CHC> will cancel all non-acute appointments to increase capacity to provide care to those who need prompt medical attention. Registration staff will call patients to inform them of their cancelled appointment and contact them when the demand for healthcare services decreases.

<CHC> will increase the hours of operations if staff capacity can cover it.

The Chief Operating Officer, or designee, will review staffing levels with Human Resources every morning to determine if they are adequate to remain open at full capacity using the staffing algorithm spreadsheet. If the staffing level is found to be inadequate for full operations, the COO, or designee, will determine if <CHC> will close, scale back services if one department is affected more than another, or bring in volunteer providers, if any are available.

2.4.5 Occupational Health

Behavioral health staff will be positioned in the lunch/break room throughout the day as well as making themselves available for private discussions with staff, as needed.

Supervisors will be briefed on signs of stress among the employees in their departments. If someone is having trouble managing the stress of the situation, they will be referred to Behavioral Health for additional support.

3 Post Peak

3.1 Introduction

Pandemic activity appears to be decreasing; however, it is uncertain if additional waves will occur and During the post-peak period, pandemic disease levels in most countries with adequate surveillance will have dropped below peak observed levels. The post-peak period signifies that pandemic activity appears to be decreasing; however, it is uncertain if additional waves will occur and countries will need to be prepared for a second wave.

3.2 Surveillance

<CHC> will remain on heightened alert for ILI in patients and staff since additional waves of illness may still occur.

3.3 Surge Capacity

<CHC> will begin assessing the ability to reestablish services that may have been dropped to handle influenza patient volumes. These should be started in the reverse order in which they were cancelled.

<CHC> will assess supply inventories and begin rebuilding par levels back to levels prior to the pandemic as supply chains begin to restore capacity. This will likely be a slow process due to the nature of just-in-time manufacturing processes so this should be a priority in order to maintain services.

3.4 Psychological First Aid

<CHC> leaders will monitor their staff for psychological stress. As the worst of a serious pandemic passes the stress of the situation will manifest itself more and more as staff reflect on what has happened in the world around them. This also may be provided by collaboration with faith-based, mental health, or social service organizations.

4 Post Pandemic Period

4.1 Introduction

Influenza disease activity will have returned to levels normally seen for seasonal influenza. It is expected that the pandemic virus will behave as a seasonal influenza A virus. At this stage, it is important to maintain surveillance and update pandemic preparedness and response plans accordingly.

4.2 Surveillance

<CHC> will assess whether to conduct surveillance for influenza like illness. The Michigan Department of Community Health may recommend this practice and request reporting on an ongoing basis. This data can be used both internally and in aggregate to assess influenza activity on an ongoing basis and to identify when seasonal rates exceed two standard deviations from seasonal means which can trigger specific response activities in the future.

4.3 Psychological First Aid

<CHC> staff will continue to monitor for signs of psychological stress. Post traumatic stress disorder can occur depending on the severity of the pandemic and early referrals to behavioral health providers will help staff with the recovery process in a timely manner.

4.4 After Action Reports

<CHC> staff will meet to discuss what went smoothly and areas for improvement in order to more adequately deal with a future pandemic or other similar situation. These discussions will be used to further update and refine this plan.

5 Preparedness Timeline

A rapid overview of some preparedness activities based on geographical location of a pandemic is found in Appendix N.

6 Appendices

6.1 Appendix A. Administration Planning Checklist

CLINIC ADMINISTRATION		
PRE-PANDEMIC INFECTION PREVENTION PLANNING		
	Delegation Date/ Responsible Party	Completion Date
Assure staff receive infection control training and education (See General Infection Prevention Recommendations)		
Develop facility communication plan <ul style="list-style-type: none"> • Maintain current knowledge of CDC clinical recommendations • Assure staff are aware of pandemic plans and protocol • Develop/maintain Emergency Contact information 		
Collaborate with neighboring hospitals and ambulatory care facilities to designate “well” and “ill” locations to reduce disease transmission among facilities.		
Establish memorandums of understanding or other legal documents as needed.		
Identify a Respiratory Protection Program Administrator		
Assure implementation of annual influenza vaccination program for all staff and patients. <ul style="list-style-type: none"> • Establish protocols to assess influenza vaccination status of all patients at every visit during influenza season • Consider implementing program to increase influenza vaccination rates among staff 		
Assure hand hygiene stations are readily accessible to staff and patients throughout the facility, including waiting areas and exam rooms.		
Determine staff responsibilities during normal operations and during pandemic setting		
List and prioritize services provided by the facility. <ul style="list-style-type: none"> • Identify services that may not be available during a pandemic • Identify services that may be performed from home 		
Assess surge capacity for increased numbers of appointments and special needs. <ul style="list-style-type: none"> • Consider alternate appointment scheduling (e.g. postponing well visits) • Route to alternate facilities in order to reduce risk of exposure to symptomatic patients and disease transmission. 		
Complete an inventory assessment on equipment and supplies. <ul style="list-style-type: none"> • Increase supplies of appropriate Personal Protective Equipment (PPE), (e.g. N-95 respirators, goggles, face shields, gowns, gloves, disposable PPE kits) • Research PPE product options or alternate vendors • Identify funding sources for additional PPE and clinic supplies. 		

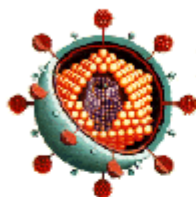
6.2 Appendix B. Department Planning Checklist

CLINIC DEPARTMENT LEADER		
PRE-PANDEMIC INFECTION PREVENTION PLANNING		
	Delegation Date/ Responsible Party	Completion Date
Assure that staff receive appropriate Infection Control training and staff education		
Assure that adequate infection control supplies are available and accessible. <ul style="list-style-type: none"> Secure information from administration on which vendor contracts are to be used Implement process for restocking supplies and identify responsible person (surgical masks, tissues, alcohol-based hand sanitizer) 		
Post visual alerts in waiting areas and other appropriate places. (See www.cdc.gov/flu/protect/covercough.htm)		
Promote social distancing <ul style="list-style-type: none"> Designate an area of the waiting room for “ill” and “well” patients Space chairs at least 3-6 feet apart, if possible 		
Instruct staff to request that patients wear a surgical mask if they are coughing or sneezing frequently <ul style="list-style-type: none"> Ask staff to alert triage personnel of symptomatic respiratory patients <ul style="list-style-type: none"> Refer to Telephone Triage Guidelines Direct symptomatic respiratory patients to designated area of waiting room Assess patient to determine if immediate rooming is warranted. 		
Review clinic flow practices and designs that could be altered to reduce pandemic influenza transmission. 2006. Olesen MA. Prevent the transmission of respiratory disease. <i>Healthcare Building Ideas</i> . 2(3): 74-79.		

6.3 Appendix C. CDC ILI Case Definition



INFLUENZA-LIKE ILLNESS **CASE DEFINITION**



Influenza-like Illness (ILI) =
fever ($\geq 100^{\circ}$ F)*
AND
cough and/or sore throat
(in the absence of a known cause
other than influenza)

**Temperature can be measured in the office or at home*

Please report all patients that meet the ILI case definition above unless diagnostic tests confirm a cause other than influenza. For example, a patient with fever, cough, and vomiting or a patient with fever and sore throat should be reported as having ILI unless a laboratory result confirms another diagnosis (e.g., a positive strep test).

Please report only those patients that meet the ILI case definition. For example, a patient with fever, chills, body aches, and nasal congestion but no cough or sore throat is not considered a case of ILI.

Although this clinical definition by itself is very general, when combined with information on circulating viruses, the information on ILI activity provides an excellent picture of influenza activity in the United States.

6.4 Appendix D. Nurse/Clinical Telephone Triage

Nurse / Clinical Telephone Triage

Name: _____ Date: _____

DOB: _____ Gender: M F

These questions will be used by medical personnel for triaging potential patients.

This sheet should be placed in the patient's chart for medical records after review by the Infection Control Officer.

	Yes/No	Severity	Onset
Fever			
Cough			
Shortness of Breath			
Difficulty Breathing			

Has the patient

Traveled out of the country in the past two weeks*? Yes No

Location _____

Dates _____

If the patient answered "Yes" to any of the above questions, schedule for a clinic appointment

Instruct the patient when and where to enter the facility. Make efforts to schedule ill patients at the end of the day and ask them to use an entrance that will result in the least number of encounters with others. Inform symptomatic patients that they will be asked to wear a surgical mask at the entrance of the facility.

*Note: Check for current epidemiological / clinical criteria.

6.5 Appendix E. Appointment Desk Telephone Triage

Appointment Desk Telephone Triage

These questions will be used for triage purposes by non-clinical staff.

NOTE: Specific triage symptoms may need to be adapted, depending on the presenting clinical signs/symptoms of the circulating influenza strain.

Name: _____

DOB: _____ Gender: M F

Does the patient have:

Fever? Y N

Cough? Y N

Shortness of breath? Y N

Difficulty breathing? Y N

If the patient answers “yes” to any of the above questions, transfer the call for clinical triage.

6.6 Appendix F. General Infection Prevention Recommendations

KEY POINTS: GENERAL INFECTION PREVENTION RECOMMENDATIONS	
1. Basic infection control recommendations for all health care facilities	Standard precautions for all patients, plus droplet precautions for patients with acute febrile respiratory illness.
2. Respiratory hygiene/cough etiquette	Patients/family members cover cough with mask or tissue and perform hand hygiene.
3. Early recognition and reporting of pandemic influenza cases	Consider pandemic influenza in patients with acute febrile respiratory illness who have been in AI or PI affected regions within the prior 2 weeks and who had bird exposure or exposure to human cases while in the region.
4. Isolation precautions for suspected and confirmed pandemic influenza cases	Full barrier precautions (standard, droplet contact, and airborne) and patient placement in negative pressure room.
5. Additional measures to reduce the possibility of transmission	Limit numbers of health care workers/family members/visitors exposed pandemic influenza patient.
6. Specimen collection/transport within health care facilities	Full barrier precautions for health care workers collecting specimens, careful transport of specimens to laboratory.
7. Family member recommendations	Family members should be limited to those essential for patient support and should use full barrier precautions.
8. Waste disposal	Treat waste possibly contaminated with AI or PI virus as clinical waste.
9. Environmental cleaning and disinfection	Use routine health care disinfectants, clean and disinfect frequently touched surfaces twice daily, other surfaces once a day.
10. Patient care equipment	Dedicate to pandemic influenza patients. Clean and disinfect before reuse.
11. Occupational health recommendations	Monitor health of exposed health care workers, use antiviral prophylaxis if available. Provide seasonal vaccine.
12. Health care facility administrative controls	Health care worker pandemic influenza education, training, and risk communication. Adequate staffing and PPE.
13. Prioritization of PPE when supplies are limited	Hand hygiene and facial protection of health care workers (eyes, nose, and mouth) are priorities if PPE is limited.
14. Health care facility engineering controls	Spatial separation, barriers between patients. Ventilation, negative pressure.

6.7 Appendix G. Infection Control Precautions

Infection control precautions are a set of standard recommendations designed to reduce the risk of transmission of infectious agents from body fluids or environmental surfaces.

These precautions include the use of personal protective equipment, hand hygiene, cleaning and disinfection.

6.7.1 Standard Precautions

Standard precautions are the basic level of infection control to reduce the risk of transmission of microorganisms from both known and unknown sources.

- Use Standard Precautions in the care of all patients all of the time.
- Standard Precautions applies to blood, all body fluids, secretions and excretions (except sweat) whether or not they contain visible blood; non-intact skin; and mucous membranes.

6.7.1.1 Standard Precautions include:

- Hand hygiene
 - Always - following any patient contact. Wash hands for 15 seconds with soap and warm water especially if visibly soiled. Clean hands with alcohol-based hand rub if not visibly soiled
- Gloves
 - Wear clean, non-sterile gloves when touching or coming into contact with blood, body fluids, secretions or excretions
 - Apply gloves just before touching mucous membranes or contacting blood, body fluids, secretions, or excretions
 - Remove gloves promptly after use and discard before touching non-contaminated items or environmental surfaces, and before providing care to another patient
 - Clean hands immediately after removing gloves
- Gowns
 - Fluid resistant, non-sterile
 - Protect soiling of clothing during activities that may generate splashes or sprays of blood, body fluids, secretions and excretions
 - Apply gown prior to performing such activities
- Mask, face shield, eye protection
 - Protect eyes, nose, mouth and mucous membranes from exposure to sprays or splashes of blood, body fluids, secretions and excretions
 - Apply appropriate protection prior to performing such activities
- Patient Care Equipment
 - Avoid contamination of clothing and the transfer of microorganisms to other patients, surfaces and environments

- Clean, disinfect or reprocess non-disposable equipment before reuse with another patient
- Discard single-use items properly

6.7.2 Contact Precautions

Contact precautions should be used when direct or indirect contact with contaminated body fluids, equipment or the environment is anticipated. Use Contact Precautions:

- In the care of patients known or suspected to have a serious illness easily transmitted by direct patient contact or by indirect contact with items in the patient’s environment
- In addition to Standard Precautions (see above)

Illnesses requiring contact precautions may include, but are not limited to: Gastrointestinal, respiratory, skin or wound infections or colonization

6.7.2.1 How contact transmission occurs:

- Direct Contact
 - Body-surface to body-surface contact and physical transfer of microorganisms between a susceptible person (host) and an infected or colonized person
 - More often occurs between a healthcare worker and a patient than between patients
- Indirect Contact
 - Involves contact of susceptible person (host) with a contaminated intermediate object such as needles, dressings, gloves or contaminated (unwashed) hands
- Disease is more likely to develop as a result of contact transmission when
 - The pathogen is highly virulent
 - Only a small dose is required to cause infection
 - The patient/HCW is immunocompromised.
- Poor hand hygiene is most often cited as a cause of contact transmission
- Contact precautions are indicated for persons with gastrointestinal (diarrheal) illness, and incontinent persons including those who use incontinent products

6.7.2.2 Contact Precautions include standard precautions with the addition of

- Gloves for possible contact with an infected or colonized patient and their environment
- Gown if substantial contact with the patient or their environment is anticipated

6.7.3 Droplet Precautions

Droplet precautions should be used when in the presence (within 3 feet) of a person with an infection transmitted via the droplet route. Droplets can be generated from the source person during coughing, sneezing, talking and during the performance of certain procedures such as suctioning or bronchoscopy

Droplets may contain microorganisms and generally travel no more than 3 feet from the patient. These droplets can be deposited on the host’s nasal mucosa, conjunctivae or mouth.

6.7.3.1 Droplet Precautions include standard precautions with the addition of a surgical mask when working within 3-6 feet of the patient

6.7.4 Airborne Precautions

Airborne precautions are required to protect against transmission of infectious agents spread via the airborne route.

Preventing airborne transmission requires personal respiratory protection and special ventilation and air handling.

6.7.4.1 How airborne transmission occurs:

- Airborne droplet nuclei (small-particles [5 micrograms or smaller] of evaporated droplets containing microorganisms that remain suspended in the air for long periods of time)
- Dust particles that contain an infectious agent
- Microorganisms spread by the airborne route can be widely dispersed by air currents and may be inhaled by a susceptible host in the same room or at a long distance from the source patient depending on environmental factors such as temperature and ventilation

Airborne precautions apply to patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei.

6.7.4.2 Airborne Precautions include standard precautions with the addition of

- Personal respiratory protection
 - N95 respirator (Prior fit-testing must be repeated annually and fit-check / seal-check prior to each use) **OR**
 - Powered Air-Purifying Respirator (PAPR)
- **AND** an Airborne Infection Isolation Room (AIIR) that at a minimum must:
 - Provide negative pressure room with a minimum of 6 air exchanges per hour
 - Exhaust directly to the outside or through High Efficiency Particulate Air (HEPA) filtration

6.7.5 Full Barrier Precautions

Full Barrier Precautions are the use of the combination of airborne and contact precautions, plus eye protection, in addition to standard precautions. The precautions would be used in the case of the emergence of a highly pathogenic influenza pandemic. Particular care must be used when donning and doffing PPE to ensure the protection of the user. This is a very resource intensive process and should be used with guidance from the state health department or the CDC.

6.8 Appendix H. Primary Infection Prevention Points

KEY POINTS: STANDARD PRECAUTIONS		KEY POINTS: RESPIRATORY HYGIENE/COUGH ETIQUETTE	
1. Hand hygiene	<ul style="list-style-type: none"> • Clean hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. • Use soap and water or an alcohol-based hand rub immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. • It may be necessary to clean hands between tasks and procedures on the same patient to prevent cross contamination of different body sites. 	1. Visual alerts	<ul style="list-style-type: none"> • Post visual alerts (in appropriate languages) at the entrance instructing patients and persons who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection when they first register for care and to practice Respiratory Hygiene/Cough Etiquette.
2. Gloves	<ul style="list-style-type: none"> • Wear gloves (clean, nonsterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items. • Put on clean gloves just before touching mucous membranes and non-intact skin. • Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. • Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient, and clean hands immediately to avoid transfer of microorganisms to other patients or environments. 	2. Respiratory protection and cough hygiene	<p>Patients with acute febrile respiratory symptoms should:</p> <ul style="list-style-type: none"> • Cover the nose and mouth when coughing/sneezing • Use tissues to contain respiratory secretions and dispose of them in the nearest receptacle after use • Perform hand hygiene after having contact with respiratory secretions or contaminated objects <p>Ensure the availability of materials so that patients can adhere to these measures:</p> <ul style="list-style-type: none"> • Tissues and no-touch receptacles for used tissue disposal • Alcohol-based hand rub and/or handwashing supplies (soap and water, clean towels)
3. Mask, eye protection, face shield	<ul style="list-style-type: none"> • Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. 	3. Masking and separation of persons with respiratory symptoms	<ul style="list-style-type: none"> • Offer surgical or procedure masks to persons who are coughing. • When space and chair availability permit, encourage coughing persons to sit at least 3 feet away from others in common waiting areas.
4. Gown	<ul style="list-style-type: none"> • Wear a gown (a clean, nonsterile gown is adequate) to protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Remove a soiled gown as promptly as possible, and wash hands to avoid transfer of microorganisms to other patients or environments. 	4. Droplet precautions	<ul style="list-style-type: none"> • Advise healthcare personnel to wear a surgical or procedure mask for close contact, in addition to standard precautions, when examining a patient with symptoms of a respiratory infection, particularly if fever is present. • These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires droplet precautions.

6.9 Appendix I. Clinic Respiratory Protection Program Template

Clinic Respiratory Protection Program Template

Policy

The purpose of this program is to ensure that all employees required to wear respiratory protection as a condition of their employment are protected from respiratory hazards through the proper use of respirators.

Program Components

- Program Administration
- Program Scope/Application
- Identifying Work Hazards
- Respirator Selection
- Medical Evaluations
- Fit Testing
- Proper Respirator Use
- Cleaning and Disinfecting
- Inspecting, Maintenance and Repairs
- Respirator Training
- Evaluating/Updating Program
- Roles and Responsibilities
- Documentation and Record-keeping

Program Administration

- _____ (example: clinic supervisor, employer's name, human resources person) will be responsible for the administration of the respiratory protection program and thus is called the Respiratory Program Administrator (RPA).
- _____ (example: clinic supervisor, employer's name, human resources person) will be responsible for monitoring the ongoing and changing needs for respiratory protection.

These functions can be performed by an RN or other appropriate employee as determined by the facility.

Program Scope and Application

This program applies to all employees who could potentially be exposed to airborne respiratory illnesses during normal work operations, and during non-routine or emergency situations. Some of the types of work activities required to wear respirators are outlined in the table below:

Work Process	Location	Type of Respirator
Contact tracing/disease investigation (Airborne Precautions)	Community Settings	N95- disposable PAPR
Patient contact/care (Airborne Precautions)	Patient Care Areas	N95- disposable PAPR

01/1/2004

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6.10 Appendix J. Respiratory Protection Planning Checklist

RESPIRATORY PROTECTION PROGRAM		
PRE-PANDEMIC PLANNING		
	Delegation Date/ Responsible Party	Completion Date
Develop a Respiratory Protection Program for the clinic <ul style="list-style-type: none"> • Program must meet OSHA standards • Collaborate with other facility managers and supervisors to identify job titles/positions that may need to provide care to patients with respiratory symptoms during pandemic influenza • Assure that medical evaluation and fit-testing are completed prior to using an N95 respirator 		
Collaborate with Administration to assure availability of appropriate inventory of respiratory protection supplies and other PPE. <ul style="list-style-type: none"> • Consider assembling an isolation container/bucket to store a small supply of Full Barrier PPE; (e.g. N95 respirators, disposable PPE kits, etc.) to assure rapid access to needed supplies • Educate staff on contents, location, and restocking procedure 		
Conduct staff education and training regarding Infection Prevention and Full Barrier Precautions.		
Maintain knowledge of current MDH and CDC recommendations. <ul style="list-style-type: none"> • Revise and implement facility procedures/protocols to reflect current CDC recommendations for: <ul style="list-style-type: none"> ○ Infection Prevention ○ Cleaning and disinfection ○ Clinical assessments and patient management • Assure that key facility staff receive timely updates to ensure appropriate clinical management of patients and protection of staff 		

6.11 Appendix K. Telephone Voice Message Guidelines

During an influenza pandemic, clinic office telephone lines should be set for telephone triage in which the listener is provided updated information regarding the symptoms of the disease, what precautions to take, and directions on how to access additional information (i.e. hotline numbers, website information, etc.). The purpose of the automated triage is to provide the public with helpful information while alleviating some of the burden for clinic office triage personnel.

Only those who are experiencing symptoms or are caring for those experiencing symptoms will be held on the line to talk to triage personnel.

Example of automated triage recording:

“Thank you for contacting (clinic name). Please understand that during a severe pandemic, hospital and clinic resources will be stretched beyond capacity and attention must be focused to who are ill. As such, we ask for your cooperation and that you only remain on the line if you believe that you or someone you are caring for is in need of medical attention. Symptoms of influenza include fever, headache, muscle aches, weakness, and respiratory symptoms such as a cough, a sore throat, or difficulty breathing. The disease may be spread from person to person by means of inhaling infectious particles expelled when an infected individual talks, coughs, or sneezes or by touching an infected individual or a contaminated surface and subsequently touching your eyes, nose, or mouth. Those at highest risk of becoming infected include children, the elderly, and those with underlying immunodeficiency or other medical ailments. The best methods to prevent the spread the disease include social distancing, proper hand hygiene, and covering your cough. Please refer to (website) or call the pandemic influenza hotline at (number) for additional information regarding pandemic influenza. If you are experiencing any of the symptoms previously mentioned, please remain on the line to speak to a clinic employee.”

Phone triage tips:

- Pandemic influenza is a respiratory disease that is easily spread from person to person by coughing and sneezing or by touching mucous membranes (eyes, nose, and mouth) with hands that are contaminated with influenza virus.
- Pandemic influenza is caused by a virus. Antibiotics won't help. Don't demand antibiotics; your healthcare provider will decide whether or not you need them.
- Everyone can help prevent the spread of influenza!
 - Clean your hands often by using soap and water for 20 seconds or an alcohol-based hand rub if your hands are not visibly soiled.
 - Cover your cough / sneeze with your upper arm or a tissue (and dispose of the tissue immediately after use).
- Inform patients with symptoms that they will be asked to wear a mask upon arrival at the clinic.

6.12 Appendix L. Altered Duty Planning Worksheet

	Normal Duties	Pandemic Duties	Licensing/Certification Required	Additional Training Required	Immunizations Required
Physicians					
PAs					
NPs					
RNs					
LPNs					
Medical Assistants					
Receptionists					
Billing					
Office Managers					
Laboratory Personnel					

6.13 Appendix M. Service Continuity Prioritization

Clinic managers should agree upon which services their clinics normally provide for patients and write those services in the far-left column. Each service should then be prioritized in order to determine which services must remain at full capacity and which services can be delayed for a given amount of time during a pandemic event. Both patient need and financial impact should be considered in this prioritization.

Facility: _____

Department/Section: _____

	Priority 1	Priority 2	Priority 3	Priority 4	
Services Provided	Must continue / be provided regardless of situation	Could be deferred temporarily (e.g. 1-2 weeks)	Could be deferred for longer periods of time, must be re-established within 6-8 weeks	Could be suspended for more than 8 weeks	Key job functions that could potentially be performed from home

Facility: _____

Department/Section: _____

	Priority 1	Priority 2	Priority 3	Priority 4	
Services Provided	Must continue / be provided regardless of situation	Could be deferred temporarily (e.g. 1-2 weeks)	Could be deferred for longer periods of time, must be re-established within 6-8 weeks	Could be suspended for more than 8 weeks	Key job functions that could potentially be performed from home

6.14 Appendix N. Rapid Overview of Recommended Planning Activities

This timeline is a dynamic outline of activities that should occur during various phases of pandemic preparedness. Activities start prior to the event and progress sequentially through to recovery. Evaluation of potential strategies should begin while the threat of pandemic influenza is low. The timeline will evolve as external events, guidance, and internal planning dictate. The phases are based on the World Health Organization’s pandemic phases. Each phase is associated with an action list. This timeline should be modified for individual site planning purposes.

SECTION	Preplanning/ Cases Overseas	Cases in US or in High Volume Travel Area from DTW	Cases in Michigan	Cases in Local Municipality	Recovery
Administration	<ul style="list-style-type: none"> • Develop All Hazards Plan <ul style="list-style-type: none"> ○ Address behavioral, mental health, and security issues ○ Develop Volunteer competencies • Establish contact with key public health, healthcare, and community partners • Conduct education/training for staff • Establish Annual Influenza Immunization Program • Appoint Respiratory Protection Program Coordinator • Develop Business Continuity Plan • Budget for contingency plan 	<ul style="list-style-type: none"> • Clarify role within regional plan • Maintain close contact with state and local health departments and healthcare facilities • Network with other facilities 	<ul style="list-style-type: none"> • Implement phone triage protocols • Enforce Respiratory Etiquette • Use special segregation or separate waiting rooms 	<ul style="list-style-type: none"> • Implement the disaster plan • Implement plan for Service Continuation 	
Training and Education	<ul style="list-style-type: none"> • Train Respiratory Protection Program Administrator • Identify educational resources • Develop competencies for HH, PPE, triage • Educate staff on IC principles and issues 				
Communication	<ul style="list-style-type: none"> • Develop key contact list • Keep staff current on recommendations from CDC 				

SECTION	Preplanning/ Cases Overseas	Cases in US or in High Volume Travel Area from DTW	Cases in Michigan	Cases in Local Municipality	Recovery
Human Resource Management	<ul style="list-style-type: none"> • Require immunizations to be current • Encourage annual influenza vaccination and assess mandating as condition of employment • Complete assessment of staff responsibilities under normal and pandemic settings • Update Emergency Contact Information 	<ul style="list-style-type: none"> • Initiate symptom identification protocol 	<ul style="list-style-type: none"> • Determine which staff are able to perform duties at home • Actively screen those with symptoms 		
Resource Management	<ul style="list-style-type: none"> • Complete a resource assessment using template in All Hazard's Plan • Stockpile supplies and medications as appropriate • Investigate alternative sources for supplies 	<ul style="list-style-type: none"> • Review and update inventory control assessment • Review contents of stockpile to ensure adequate amounts of supplies 	<ul style="list-style-type: none"> • Increase inventory of supplies as appropriate • Contact alternative suppliers as appropriate 	<ul style="list-style-type: none"> • Monitor supply inventory daily 	
Patient Management	<ul style="list-style-type: none"> • Post signs for Respiratory Etiquette • Determine surge capacity • Complete Service Continuation assessment • Educate staff on symptom identification and triage guidelines 	<ul style="list-style-type: none"> • Implement Triage Guidelines • Promote social distancing 			
Laboratory	<ul style="list-style-type: none"> • Evaluate capacity of testing • Establish communication with reference laboratory 	<ul style="list-style-type: none"> • Develop internal protocols for collection and testing of specimens • Sentinel reporting of predetermined specimens 			
Vaccine/ Treatment	<ul style="list-style-type: none"> • Outline how to set up immunization clinic • Evaluate facility requirements for vaccination • Identify key groups • Evaluate ability to purchase required medications 	<ul style="list-style-type: none"> • Implement immunization strategy • Determine what is available and secure resources 	<ul style="list-style-type: none"> • Set up immunization center 	<ul style="list-style-type: none"> • Continue to provide vaccination and prophylaxis 	
Facilities	<ul style="list-style-type: none"> • Complete a Hazard Vulnerability Analysis 		<ul style="list-style-type: none"> • Erect temporary partitions as deemed in the 		

			facility pandemic plan		
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