Franklin Community Health Network

Pandemic Influenza Plan

February 6, 2006

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Acknowledgment

The following individuals comprised the Franklin Community Health Network Pandemic Influenza Core Planning Team and were instrumental in producing this document.

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Disclaimer

This plan was developed based on currently available information from the Maine State Center for Disease Control (CDC), the United States CDC, the United States Department of Health and Human Services, and the United Nations World Health Organization (WHO). Ongoing situational developments and research may, and probably will, change these recommendations frequently.

This plan is intended to be used as a fluid and flexible guideline for dealing with the problems associated with a Pandemic Influenza outbreak in our home area, and not as strict policy and procedure. Please keep this in mind when applying these recommendations.

Thank you.

Pandemic Influenza Core Planning Team

Executive Summary

Influenza is a highly infectious viral illness that causes yearly seasonal epidemics reported since at least the early 1500's. In the U.S., complications of influenza cause an average of 36,000 deaths each year, primarily among the elderly. Influenza virus is transmitted in most cases by droplets through the coughing and sneezing of infected persons, but it 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, and may include runny or stuffy nose. An annual influenza vaccination is the best method of protection against influenza. Other measures, such as frequent hand washing, staying home when sick, and the institution of public health measures for universal respiratory hygiene and cough etiquette, will help stop the spread of influenza.

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 has never been exposed previously and is thus vulnerable to the virus. Three pandemics occurred during the 20th century. The Spanish Flu, in 1918 caused over 500,000 U.S. deaths and more than 20 million deaths worldwide. The Asian Flu Pandemic of 1957-58 and the Hong Flu Pandemic in 1968-69 also had a significant impact causing widespread illness and death. Recent outbreaks of human disease caused by avian influenza strains in Asia and Europe have highlighted the potential for new influenza strains to be introduced into the population.

An influenza pandemic has a greater potential to cause rapid increases in illness and death than virtually any other natural health threat. The impact of the next pandemic could have a devastating effect on the health and well being of the American public. The Centers for Disease Control and Prevention (CDC) estimates that, in the United States alone, up to 200 million people will be infected, 50 million people will require outpatient care, two million people will be hospitalized, and between 100,000 and 500,000 persons will die. Using software provided by the Centers for Disease Control and Prevention (CDC), it was estimated that in Maine, there would be approximately 165,000 outpatient visits, 4,000 hospital admissions, and 900 deaths during an influenza pandemic. Locally in our service catchment area of approximately 36,000 people, we can estimate in a predicted 8-week pandemic period, to have 9,220 people infected with 4,500 outpatient visits resulting in 126 admissions and 30+ deaths. This will increase hospital capacity by 28% at peak time, ICU capacity by 105%, and ventilator capacity by 132%.

Effective preventive and therapeutic measures including vaccines and antiviral agents will likely be in short supply, as may 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 the care of victims. Widespread illness in the community will also increase the likelihood of sudden and potentially significant shortages of personnel who provide other essential community services.

Unlike many other public health emergencies, an influenza epidemic will impact multiple communities cross Maine simultaneously. Therefore, contingency planning is required to moderate the impact through a coordinated effort between healthcare and state government, and in collaboration with local partners. Advanced planning for a large scale and widespread public health emergency is required to optimize health care delivery through a pandemic.

A Pandemic Flu Planning Committee was established to produce this response plan. It has been designed to ensure that Franklin Memorial Hospital and Franklin Community Health Network are prepared to implement an effective response before a pandemic arrives, throughout a response if an outbreak occurs, and after the pandemic is over. The overall goal of pandemic preparedness and response is to minimize serious illness and overall deaths. The plan is intended to be dynamic and interactive; it consists of components that are consistent with international, federal, and state guidelines as well as general principles of emergency response. It utilizes the Hospital Emergency Incident Command System (HEICS).

The FCHN Pandemic Influenza Plan will activate at set stages, based on certain trigger points from guidelines provided by:

Draft Pandemic Influenza Preparedness and Response Plan. Washington, DC: U. S. Department of Health and Human Services; August 2004.

WHO global influenza preparedness plan: The role of WHO and recommendations for national measures before and during pandemics. Switzerland, World Health Organization, Department of Communicable Disease Surveillance and Response Global Influenza Programme: 2005.

State of Maine Pandemic Influenza Plan (Draft). State of Maine Department of Health and Human Services, Maine Bureau of Health. July 2005.

Pre-pandemic / Interpandemic period
No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals, or a circulating animal influenza poses a substantial risk of human disease.

Maine State LEVEL I
Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.

Maine State LEVEL II
Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.

Maine State LEVEL III
Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is

becoming increasingly better adapted to humans, but may not yet be fully transmissible.

Maine State LEVEL IV
Pandemic Phase: Increased and sustained transmission in the general population.

Maine State LEVEL V Post-Pandemic
Indices of influenza activity have returned to pre-pandemic levels.

The FCHN 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

This plan outlines roles, responsibilities and key activities before, during, and following a pandemic influenza. It is a work in progress that will be updated and added to as situations arise and dictate.

All affiliates and departments who have created their own specific pandemic response plans must review their plans with the Pandemic Response Team.

Surveillance Plan

Maine Pre-pandemic

- Periodically review and revise Surveillance Plan as appropriate.

Maine Level I
(Alert Period)

- Test for influenza per normal lab protocol.
- Increase surveillance at triage, physician offices, and outpatient services by checking for influenza-like illness **year round**. Ask any individuals who present with influenza-like symptoms whether they have recently traveled in a country where bird flu has been identified.
- Require testing for patients who present with influenza-like symptoms and have recently traveled to a country where bird flu has been identified.
- Establish electronic monitoring of the following areas:
  - Numbers of individuals treated for influenza.
  - Numbers of employees treated for influenza.
  - Numbers of all hospitalized admissions for influenza.
  - Numbers of mortality cases from influenza and/or complications of influenza.
- Add members of Pandemic Influenza Response Team to HAN.
- Review and educate on HAN notification system:
  - When a HAN fax arrives during regular hours, the ER Secretary immediately notifies the FMH COO's office and confirms that he or she has received it.
  - When a HAN fax arrives during off-hours, the ER Secretary immediately notifies the Clinical Coordinator and confirms that he or she has received it. The Clinical Coordinator contacts the Administrator On-Call to alert him or her when appropriate.

Maine Levels II & III
(Evidence of pandemic flu outside the United States)

- Assemble and brief the Pandemic Influenza Response Team within 48 hours of notification of pandemic flu outside the United States.
- Establish with all areas their surveillance capabilities and that they are aware of heightened surveillance level.
- Implement hospital surveillance for pandemic influenza in incoming and already admitted patients.
- Test patients and employees and report cases per the following criteria:

1. Testing for avian influenza A (H5N1) is indicated for **hospitalized** patients with

- Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, **AND**

- History of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans

2. Testing for avian influenza A (H5N1) should be considered on a case-by-case basis in consultation with Maine CDC for **hospitalized or ambulatory** patients with:

   - Documented temperature of >100.4°F with one or more of the following: cough, sore throat, shortness of breath, **AND**
   - History of contact with poultry (e.g., visited a poultry farm, a household raising poultry, or a bird market) or a known or suspected human case of influenza A (H5N1) in an H5N1-affected country within 10 days of symptom onset.

3. If the above criteria are met, we must call the Maine State CDC Disease Reporting and Consultation line at 1-800-851-5821 (24 hours a day) as quickly as possible (see *Infection Control Surveillance Plan*.)

- Implement a system for early detection and treatment of healthcare personnel who might be infected with the pandemic strain of influenza. (see *Occupational Health Plan*.)

Maine Levels II & III
(Evidence of pandemic flu in the United States)

- Continue with steps outlined above.
- Influenza Preparedness Coordinator convenes and briefs Pandemic Influenza Response Team within eight hours of notification of pandemic flu in the United States.
- Pandemic Influenza Response Team contacts Administrator On-Call.
- Test for influenza with split specimen being obtained on all individuals with influenza-like symptoms (patients and employees).
- Notify employees to report their flu-like symptoms immediately to Occupational Health or ER (during off-hours) for testing.
- Pandemic Influenza Response Team meets as determined by pandemic activity.

Maine Levels II & III
(Evidence of pandemic flu in local area)

- See steps outlined in Maine Level IV below.

Maine Level IV
(Increased and sustained transmission in the general population)

- Activate Plan
  - Contact the FMH COO (during the day) or the Administrator-on-Call or the Clinical Coordinator (during off-hours).
  - Establish Incident Command / Open the Emergency Operations Center
  - Activate the Emergency Preparedness Plan of FMH
- Contact the Maine State CDC and Franklin Emergency Management Agency.
- Prior to reporting to their workstations, all staff will be screened by the taking of their temperature and will be questioned about having any flu-like symptoms with information recorded (see *Occupational Health Plan*).
- Measure vaccine availability (see *Pandemic Influenza Medications Plan*).
- Monitor phone calls to Flu Hotline to determine where staffing and other resources are needed.
- View Maine CDC web page (www.mainepublichealth.gov) for influenza surveillance reports that summarizes current surveillance information.
- Check reports, HAN, news, for hospitals with pandemic influenza cases to determine potential local impact.

Post-Pandemic Period (Maine Level V)
(Evidence of influenza activity returned to pre-pandemic level)

- Continue surveillance activity as per *Alert level* in anticipation of second-wave influenza
- Gather electronic numbers to report how many individuals treated for influenza.
- Gather electronic numbers to report how many employees treated for influenza.
- Gather electronic numbers of all mortality cases from influenza and/or complications of influenza.
- Gather electronic numbers for all hospitalized admissions for influenza.
- Conduct evaluation of how surveillance plan worked.
- Assess the effectiveness of vaccine and antiviral distribution.

Communication Plan

Maine Pre-pandemic

- Periodically review and revise Communication Plan as appropriate.
- Place FCHN Pandemic Influenza Plan on intranet. Notify employees of availability of the plan.
- Media training for CEO, COOs, Medical Director, CNO, VP, Infection control nurse, Community Relations staff, 2 physicians, 2 nurses, Healthy Community Coalition/ Franklin Health Access managers.
- Review Appendix B, "Communications Issues During a Pandemic."
- Integrate HCC on FCHN phone system to ready for speedy adaptation of HCC to a flu phone bank.
- Establish a list serve and phone list of all local communications officers for health and social service agencies and government.
- Establish routine communication system between FCHN community relations leadership and colleague agencies, the State CDC, and federal CDC.
- Community Relations prepares signs to direct employees in the event of a pandemic flu.
- Establish NetNews as the vehicle through which to communicate pandemic flu news with FCHN employees.

Maine Level 1

(Alert Period)

- Notify employees of the State's declaration of the current pandemic level via Outlook and Meditech.
- Establish a provisional budget for Healthy Community Coalition (HCC) and Franklin Health Access (FHA).
    - Send letters to all funders requesting continued grant funding for staffing and release from contractual obligations in the event of Level II or III pandemic. This will allow staff to be redeployed from categorical programs.
    - Based on response, establish a two-phased budget based on what staffing will be paid from grants, what staffing will require additional non-grant resources to deploy for pandemic flu, and what additional resources will be available for communication outreach.
    - Redeploy HCC and FHA staff in first phase of a new budget. These staff will set up a phone bank to respond to inquiries on the flu hotline.
- Widely advertise the flu hotline (778-3147) and update its message to provide guidance on what people should do to be ready in case of a pandemic.
- Create list of volunteers to help staff flu hotline.
- Develop training for volunteers and FHA and HCC staff on hotline and triage (sees Education Plan).
- Update Health Leaders Forum. Alert them to FCHN flu hotline and website, and encourage them to develop their own plans. Alert them that at the following Health Leaders Forum meeting, the FCHN Pandemic Plan for Communications will be discussed.

- Post signs for respiratory hygiene / cough etiquette in public areas, i.e.: ER, PTMA Waiting Rooms.
- Monitor National and Maine CDC as well as international news media. Check the Health Alert Network (HAN).

Maine Levels II & III

(Evidence of pandemic flu outside the United States)

- Notify employees of the State's declaration of the current pandemic level via Outlook and Meditech.
- Recruit volunteers, retired doctors and nurses, etc. to staff flu hotline.
- Create home-care kits for those individuals who will be turned away from the hospital. Kits will include instructions on home-base self-care and possibly other minimal supplies, such as a thermometer, Tylenol, Gatorade, masks, gloves, and hand sanitizer.
- Pandemic Influenza Response Team assembles Communications Team, to include individuals who are not critical to day-to-day crisis management and thus can focus more time to communications: VP/FCHN, infection control nurse, Community Relations staff, 1 physician, 1 nurse manager at HCC. Also include or brief Administrator On-Call. VP/FCHN serves as the Public Information Officer (PIO). Set up weekly meetings. All public messages to staff, board, or public must go through this team or in a time-sensitive situation through the PIO. All members of the team have dedicated back-ups.
- When Communications Team meets, they address the following agenda:
    - Review of key messages from Maine, federal CDC, and colleague agencies.
    - Review and evaluation of messages delivered in the prior week by FCHN.
    - Issues and concerns from callers to the flu hotline and others in the public, including rumors and potential for quelling.
    - Agreement on key messages for the week, including recorded message on flu hotline.
    - Agreement on modes of delivering key messages (public statements, flyers, advertisements, phone/internet, FCHN media, radio, other).
    - Update recorded message on flu hotline.
    - Communications Team puts out an update at the end of each meeting.
- Communications Team identifies Medical Director as clinical spokesperson, and VP/FCHN or Marketing/Community Relations Director as media spokesperson.
- Release internal statement that all public statements must be routed through the Communications Team or the PIO.
- Continue recruiting volunteers to staff the hotline.
- Statement from FCHN president for the local community within 48 hours of a declaration of Level II or III. Statement should express:
    - Expression of empathy with people's worries and fears
    - Confirmation of known facts and action steps FCHN is taking
    - Description of what we do not know at this point
    - Steps we are taking to address the unknowns and our constant contact with state and federal officials.

  - Statement of our commitment to be here for the long term and do all we can
  - Where people can get information (the flu hotline) and what they can do to be ready
- Train FHA and HCC on messages for hotline response. Hotline will focus on repeating key messages and linking callers with services in the community using the Community Connector (www.thecommunityconnector.org). HCC nurse manager will provide feedback on community issues and discussion on the hotline.
- Role of pandemic flu hotline workers (also see Education Plan):
  - Refer callers to appropriate resources in Franklin County or in their own county.
  - Report to Franklin Emergency Management Agency (EMA) and others where resources are needed and where they are unavailable.
  - Monitor call volume and the topic of questions.
  - Screen people with medical complaints.
  - Do not provide direct services.
- Contact the Health Leaders Forum and remind them to create their own plans. Alert them to FCHN Pandemic Plan.
- HCC and community relations will use Maine CDC information on prevention of transmission and management of flu symptoms to produce public service announcements, newspaper articles, website notices, and other media.
- Weekly briefings for FCHN staff are provided via NetNews.
- FCHN Website features information on flu issues and what people can do to prepare.
- Webmaster constructs template/code for pandemic flu page on FCHN website.
- Build link on FCHN website to Maine CDC website.

Maine Levels II & III
(Evidence of pandemic flu in the United States)

- Notify employees of the State's declaration of the current pandemic level via Outlook and Meditech.
- Communications Team meets every other day.
- Reroute hotline to HCC and have partial staff and volunteer deployment from 8 a.m. to 5 p.m. to staff the hotline.
- Issue public statement by FCHN President, following same format as above, in Maine Levels II & III, pandemic flu outside the United States.
- Convene Health Leaders Forum and go over key messages, strategies, and the pandemic flu plan for FCHN and the entire community.
- Webmaster conducts web surveillance on rumors and Communications Team works to quell them.

Maine Levels II & III
(Evidence of pandemic flu in local area)

- See steps outlined in Maine Level IV.

Maine Level IV
(Increased and sustained transmission in the general population)

- Notify employees of the State's declaration of the current pandemic level via Outlook and Meditech.
- Distribute flu kits to ER, Occupational Health, and ambulance bases.
- Post door signs as per direction of Pandemic Influenza Response Team through Incident Command System.
- Communications Team meets daily.
- Full staff and volunteer deployment on hotline. Immuno-compromised employees also are deployed to help answer hotline calls 24/7. Nurse manager at HCC coordinates schedule for hotline workers.
- Issue public statement by FCHN President, following same format as in Maine Levels II & III (pandemic flu outside the United States) above.
- Daily check-ins with communications officer lists at colleague agencies.
- Daily briefings with message: empathy, current situation and numbers, what is not known, what we are doing to address unknowns, what people should do:
    - All FCHN staff and board (smaller version of Net News) via Meditech and Outlook.
    - Public via radio at noon and 5 p.m.
    - Print media releases with updates
    - Website
- Notify physicians and others of the hotline.
- All HCC and FHA staff and volunteers dedicated to flu hotline, linking people to community support, development of community education materials, and reporting to FCHN on community feedback, detection of "mixed messages" and rumors. Providers will refer to HCC staff for social service issues.

Post-Pandemic Period (Maine Level V)
(Evidence of influenza activity returned to pre-pandemic level)

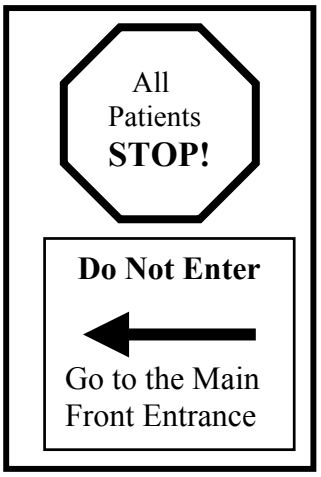
- Notify employees of the State's declaration of the current pandemic level via Outlook and Meditech.
- Notify FCHN employees when it is safe to return to work.
- Notify general community through the above communication methods of:
    - the State's declaration of the current pandemic level
    - FCHN's return to pre-pandemic operations, when appropriate
    - risk of second wave.
- Consider producing a narrative of the events of the pandemic period.

Facility Access, Triage and Admission Plan

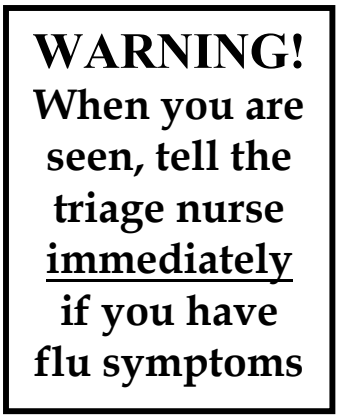
Maine Pre-pandemic Period

Develop this Facility Access, Triage and Admission Plan.

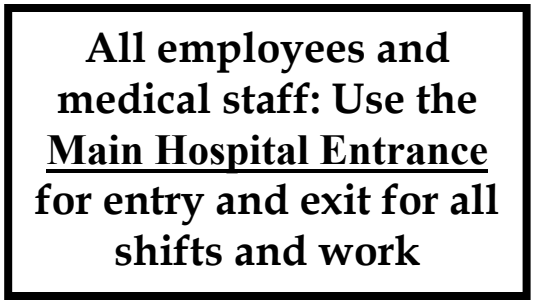
- Develop Training Program for involved Personnel (Nursing, Security, etc.).
- Develop and produce signs to direct everyone, including patients and employees, to the Main Front Entrance during Pandemic Influenza by Community Relations. Store signs in Security Office.



- Develop and produce sign instructing all patients to let the Triage Nurse know if they have Influenza-like Illness.



- Develop and produce signs directing all employees to use Main Hospital Entrance. Store in Security office.



- Develop a method of telephone triage for patients through the Flu Hotline to prioritize those who require medical intervention.
- Exercise plan as needed.
- Review and refine plan as needed.
- Establish availability of seventy beds, extra stretchers, pillows, blankets, linens, I/V poles, etc.

Maine Level I
(Alert Period)

- Increase surveillance at triage (see Surveillance Plan).
- Monitor National and Maine CDC as well as international news media. Check the Health Alert Network (HAN).

Maine Levels II and III
(Evidence of pandemic flu outside the United States)

- Alert network healthcare workers of status of plan (LEVEL II) via e-mail and bulletin board.
- Assemble the Pandemic Influenza Response Team within 48 hours.
- Review and update Facility Access, Triage, and Admission Plan.
- Director of HR to build accurate list of all FCHN employees and home phone numbers.
- Director of Security to identify, notify, and train extra security personnel.
- Implement hospital surveillance for pandemic influenza on incoming and already admitted patients (see Surveillance Plan).
- Implement a system for early detection and treatment of healthcare personnel as per Surveillance and Occupational Health Plans.
- Have available a quantity of "Quarantine / Home Care" information packets (see Communications Plan).
- Have available door signs that will re-direct patients to Main Hospital Entrance Triage area (see Communications Plan).
- Have available door signs for employees (see Communications Plan).
- Post signs for respiratory hygiene / cough etiquette in all facility public areas and rest rooms and key community settings per HCC.
- Evaluate potential room availability throughout FCHN.

Maine Levels II & III
(Evidence of pandemic flu in the United States)

- Director of HR to contact volunteers to ready them for service.

- Develop mutual aid agreements with other hospitals, local home health agencies, and other healthcare groups to obtain adequate staffing during pandemic period.
- Place extra supplies of tissues and no-touch waste receptacles in waiting areas.
- Maintain high suspicion of patients presenting with influenza-like symptoms.
- Evaluate daily census and discharge plans.
- Review/confirm room availability throughout FCHN.

Maine Levels II & III
(Evidence of pandemic flu in local area)

- See steps outlined in Maine Level IV.

Maine Level IV
(Increased and sustained transmission in the general population)

General
- Activate Pandemic Influenza Plan, part of the Emergency Preparedness Plan of FMH.
- Pandemic Influenza Response Team to establish Incident Command / Open Emergency Operations Center.
- Contact the Maine State CDC and Franklin Emergency Management Agency.
- Based on input from Department Head, consider canceling or closing non-critical departments (see Appendix C.). Criteria for closure:
    - Staffing
    - Patient exposure to infection
- Have Maintenance deliver extra stretchers, oxygen H-tanks to the Day Surgery waiting room on the second floor.

Access Control (as per incident command system)
- Lock-down and post security at the entrance to the emergency department.
- Put up sign directing all patients to the Main Hospital Entrance (front lobby).
- Open the front Outpatient Department and ready it to receive influenza patients.
- Assign a medical provider and adequate nursing personnel to Outpatient Department.
- Assign security to limit access to the Main Hospital Entrance.
- Put up sign at the Main Hospital Entrance with instructions for patients to immediately tell the triage nurse if they have flu symptoms. Get these signs from Security, where they have been stored.
- Put up signs at all for employees to use the Main Hospital Entrance.
- Coordinate with Communications Team to notify employees via email and intranet to use the Main Hospital Entrance to enter and leave building.
- Lock back employee entrance. Station Security to respond to questions and ensure that no one enters through this back entrance. Put up sign to redirect employees to the Main Hospital Entrance
- Have security and triage personnel screen and record employees with influenza symptoms and send home if present, unless they need further medical attention.
- Distribute dated wristbands for employees who are okay to work, after they have been triaged. Employees at outlying buildings within a ten-minute radius must come to

FMH for a wristband before reporting to their buildings (see Occupational Health Plan).

Triage Guidelines

- Assign a triage nurse to this front main entrance site.
- Allow one patient at a time to enter and undergo rapid triage by a nurse.
- Patients with an influenza-like illness will be segregated to the main lobby waiting area.
- These patients will be seen in the Outpatient Department and evaluated, admitted or sent home with "Self-Care / Home Care" instructions.
- Other patients will be directed to the ER waiting room.
- These patients will be triaged, evaluated, and treated in the ER as usual.
- BACK-UP PLAN - If Outpatient Services are overwhelmed with influenza patients, the Bass Room will be converted to Flu Outpatient area where triage and initial treatment can be done.
- Non-influenza patients will be treated per usual in the ER, with overflow going initially to the Outpatient Services Department, then to Oncology.
- All employees and staff to report to library. All will be evaluated; temperatures and symptoms will be recorded. (See Occupational Health Plan) (see Appendix D).
- If the front entrance becomes too busy, consider having employees enter through front side door fire exit.

Hospital Admissions

- Defer elective admissions and procedures until local epidemic wanes, as needed.
- Discharge appropriate in-house patients as soon as possible.
- Relocate existing patients to a common area, (see *Surge Capacity Plan*).
- Cohort patients admitted with influenza to a single wing or area, if possible (see *Surge Capacity Plan*).
- Isolate all patients admitted with Droplet Precautions per Isolation Precaution standards (see Appendix E).
- Utilize the second floor waiting room for surge capacity for an extra 6 patients when all regular rooms are full (see *Surge Capacity Plan*)
- Screen all visitors and volunteers through Main Front Entrance triage area for influenza, sending home any with positive findings unless they need further medical evaluation.
- Limit visitors to only 1 per patient and only those who are essential for patient support.
- Consider temporarily closing the hospital to new admissions after considering:
    - Surge capability
    - Staffing ratios
    - Isolation capacity
    - Risks to non-influenza patients

Maine Level V (Post-Pandemic)

(Evidence of influenza activity returned to pre-pandemic level)

- Close Main Hospital Entrance triage area – return Triage to Emergency Department.
- Lift restrictions on visitors.
- Close the employee screening process.
- Close temporary patient surge areas, clean and store stretchers.
- Open clinics and departments, as soon as reasonable.
- Reduce the number of extra and overtime positions of healthcare workers as soon as reasonable.
- Contact the Maine CDC to coordinate post-pandemic activities such as surveillance, data collection and reporting, need for supplies, support personnel and other support.
- Compile data on any adverse vaccine reactions.
- Gather members of the Pandemic Influenza Response Team to review and update plan.
- Maintain surveillance of all patients seen in ED, outpatient clinics, and outside offices.
- Anticipate a secondary resurgence of pandemic influenza even weeks or months after first wave.

Surge Capacity Plan

Staffing

Maine Prepandemic Period

- Estimate the number of local area patients expected to be infected, those seeking outpatient care, hospitalized and dying over an eight-week period. (Data obtained from CDC website. Projections current as of 2006.)

> *Population Infected 9,220*
> *Outpatient visits 4,500*
> *Total admissions 126 (52-169)*
> *Total Deaths 30+ (15-42)*
> *Hospital Capacity 28% (at peak)*
> *ICU capacity 105% (at peak)*
> *Ventilator Capacity 132% (at peak)*

- Build a list of essential support personnel who are needed to maintain hospital operations, including but not limited to:
  - Environmental
  - Maintenance
  - EMS
  - Nutrition
  - Information services
  - Administrative
  - Clerical
  - Medical records
  - Laboratory
  - Radiology
  - Pharmacy
  - Cardiopulmonary
  - Security
- Create a list of non-essential positions that can be re-assigned to support critical hospital services.
  - Physical Therapy
  - Oncology
  - Mammography
  - Surgery
  - Outpatient Clinics
  - Center for Heart Health
  - Education
  - Billing
  - Development

- Departments should consider creating and/or revising contingency staffing plans for a minimum duration of eight weeks.
- Laboratory, Radiology, and Pharmacy should expect no decrease in their typical baseline demand for services.
- Define what would constitute a "staffing crisis" that would enable the use of emergency staffing and alternative medical care levels, and that would meet State approval.
- Determine what the ***ideal*** minimum staffing would be for the numbers of patients with pandemic influenza.

- Nursing	*(4:1)*
- CNA	*(6:1)*
- Medical Providers	*ER – 4/day*
	In-house – 3/day
- Ancillary personnel	*EMS (2 per station per shift),*
	Laboratory (_____ per shift)
	Radiology (_____ per shift)
	Pharmacy (_____ per shift)
	Security (_____per shift)
	Maintenance (_____per shift)
	Housekeeping (_____per shift)
	Food / Nutrition (_____per shift)
	MIS (_____per shift)
	IS (_____per shift)
	Materials Management (_____per shift)

Establish a plan after consulting with state health department for rapidly credentialing health-care professionals during a pandemic. Including web based licensure check for physicians, physician assistants and nurses

http://www.docboard.org/me/df/mesearch.htm
http://www.docboard.org/me-osteo/df/index.htm
https://portalx.bisoex.state.me.us/pls/msbn_nlv/bnxdev.license_search.main_page

- Badging with photo ID and title of existing personnel (coordinated by HR, IS, and Security).
- Rapid badging of new personnel

- Determine pay-scale and have established generic contracts available the use of non-facility staff.

Maine Level II and III

(Evidence of pandemic flu in local area)

- Obtain State approval to enact alternative staffing plans and medical care levels.
- Enable staffing pool that has been established and maintained by HR (see *Facilities Access, Triage, and Admission Plan*).
- Utilizing the Incident Command System, the Incident Commander will coordinate with HR, who will oversee pool of volunteers, staff, retirees, etc. to see that staffing needs are met.

- Activate plan for rapidly credentialing healthcare professionals.
- Increase cross-training of personnel to provide support for essential patient-care areas at times of severe staffing shortages (e.g. in ED, ICU, Med-Surg, etc.)
- Departments to review and update their list of essential-support personnel who are needed to maintain hospital operations.
- Review the list of non-essential positions that can be re-assigned to support critical hospital services.
- Create a list of non-essential positions that can be placed on administrative leave to limit the number of persons in the hospital
- Determine needs of outlying medical offices and facilities, per Incident Command System.

Bed Capacity

Maine Prepandemic Period

- Determine threshold when to cancel elective admissions and surgery.
- Review rapid discharge policies and procedures to expedite transfer of patients out of the hospital (see *Facility Access, Triage, and Admissions Plan*).
- Early rapid discharge may be necessary. Coordinate with Medical Director and social services where possible.
- Where possible, work with home healthcare agencies to arrange for at-home follow-up care of early discharged and deferred admission patients.
- Work with hotline to arrange follow-up calls for early discharged patients.
- Identify rooms in the hospital that could be utilized for expanded bed capacity if needed
- Identify areas that could accept overflow capacity if needed. This plan is based on the use of the second floor Day Surgery waiting room as an overflow area, and the Bass Room as a secondary such space.
- Obtain approval from hospital licensing agencies to expand bed capacity beyond 75.
- Discuss with healthcare regulators whether, how, and when "Altered Standards of Care in Mass Casualty Events" will be invoked and applied to pandemic influenza (See http://www.ahrq.gov/reasearch/altstand).
- Identify beds and supplies needed to accommodate extra patients.
- Determine the total patient bed capacity at this facility. As of January 2006, it has been determined to be approximately 100 rooms.
- Develop areas that could be used for cohorting influenza patients.
- 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.

Maine Level II and III

(Evidence of pandemic flu in local area)

- Determine if other hospitals have capacity to take non-influenza, non-critical patients in transfer. Review on a daily basis.
- Admitted influenza patients:

- Initially to be located on the third floor South Wing ("Long Hall").
- Overflow will then be located on Day Surgery rooms, South Wing
- Overflow then will be located on the second floor "Short Hall."
- Overflow will then be located on the second floor Day Surgery Waiting Room.
- Overflow will then be located on the third floor West Wing ("Short Hall")
- Any further overflow will be located in waiting rooms.

- Ventilated influenza patients:
  - Initially to be located in the ICU.
  - Overflow will be located in the Recovery Room.
  - Patients should be evaluated to determine whether they could be moved to Recovery Room to free up ICU beds.

Consumable and durable supplies

Maine Prepandemic Period

- Evaluate the existing system for tracking medical supplies to determine if it can detect rapid consumption and to respond to growing needs
- Stockpile enough consumable goods for duration of pandemic (6-8 weeks)
- Determine trigger-point to order additional supplies
- Anticipate the need for additional antibiotics to treat bacterial complications of influenza
- Determine through consulting with the State how to access the National Strategic Stockpile during an emergency
- Determine food supplies in the hospital – how many days worth in-house.
- Determine trigger-point when additional supplies are needed
- Maximize the storage capacity of fuel oil and propane gasses during this period

Maine Level II and III
(Evidence of pandemic flu in local area)

- Alert Nutrition to stockpile certain non-perishable food goods.
- Order additional antibiotics to treat bacterial complications of influenza.

Continuation of Essential Medical Services

- Determine and address how essential services will be maintained for persons with chronic medical problems served by the hospital (e.g. hemodialysis, oncology, wound clinic, etc.)
- Consider moving these services to off-site facilities to limit exposure to influenza infection (e.g. Stanley Building, Mt. Blue Building, etc.)
- Consider re-establishing these services in-house if the Pandemic Influenza appears to be waning, as per direction of Incident Command.

Occupational Health Plan

Maine Pre-pandemic

- Periodically review and revise Occupational Health Plan as appropriate.
- Plan education/training for occupational health activities (see *Education Plan*).

Maine Level 1
(Alert Period)

- Verify employee seasonal influenza vaccine status and immunize as appropriate.
- Consider administrative mandate that all Health Care Workers (HCW) will receive their annual flu shot
- Establish plan for detecting signs and symptoms of influenza in HCW
- Implement a system for early detection and treatment of healthcare personnel who might be infected with the pandemic strain of influenza.

Maine Levels II & III
(Evidence of pandemic flu outside the United States)

- Assemble Pandemic Influenza Response Team to review FCHN Pandemic Influenza Plan.
- Conduct complete staff training on protocol for early detection and treatment of HCWs.
- Instruct employees to report to Occupational Health (OH) Department and/or their PCP when exhibiting influenza-like symptoms before duty
- Influenza-like Illness include symptoms with:
  - Temperature >100.4° F
  - Cough, sore throat, or difficulty breathing
  - Other symptoms as recommended by Maine State CDC
- Immediately isolate the employees with the above symptoms using Droplet Precautions:
  - OH staff to use gown, gloves, mask when caring for employee
  - Provide private exam room or cohort if none available
- Require testing for employees who meet above criteria and have recently traveled to a place where bird flu has been identified.
- If the above criteria are met, call the Maine State CDC Disease Reporting and Consultation line at 1-800-851-5821 (24 hours a day) immediately per Infection Control Surveillance Plan.

Maine Levels II & III
(Evidence of pandemic flu in the United States)

- Continue with steps outlined above.
- Have employees research alternative daycare arrangements in anticipation of schools and/or daycare's closing.

- Personnel Committee to develop new enforcement rules, new guidelines for calling in sick, and guidelines for pay. Consider increasing earned time.

Maine Levels II & III
(Evidence of pandemic flu in local area)

- See Maine Level IV.

Maine Level IV
(Increased and sustained transmission in the general population)

- Incident Command to establish employee screening area in library under the direction of Occupational Health.
- All employees who work within a ten-mile radius must be screened at the Medical Library.
- Assign adequate appropriate personnel to Occupational Health to screen all employees, including personnel to document and alert supervisors of ill employees.
- Employee and medical staff access to be at the Main Hospital Entrance directly going to the Medical Library for screening before reporting to their workstation. Off-site screening may be conducted initially at ambulance bases outside a ten-mile radius of FMH campus.
- Message communicated to all staff explaining procedures for screening, new enforcement rules, and new guidelines for calling in sick.
- All staff will be screened by the taking of their temperature and will be questioned about having any flu-like symptoms. This will be recorded.
- Any employees who develop flu-like symptoms during their workday will return to the employee screening area for evaluation and disposition.
- Employees to use library phone number to call in to screen for symptoms if they have any concerns they are ill before they come to work.
- Screening staff will don gloves, gowns, and masks using Droplet Precautions. See Clinical Guidelines (see Appendix ___).
- Have screening personnel record the date, employee's name, date of birth, department, supervisor's name when identified with influenza-like symptoms. Screening personnel will alert supervisors to ill employees. See description of "Fit for Work" below.
- Test employees with flu symptoms for influenza per Maine State CDC protocol.
- Ill employees who cannot go to work will either go home with instructions (see Quarantine/Self-Care brochure) or will be medically evaluated at Patient Triage.
- All non-ill employees will report to their workstation after screening. If pandemic vaccination/ antivirals available, give to these employees (as *per Pandemic Influenza Medications Plan*).
- All personnel at high risk of complications (e.g. pregnant, immunocompromised persons) will be reassigned to low risk duties (e.g. non-influenza patient care,

administrative duties that do not involve patient care, phone bank/triage or placed on furlough).

- ***Fit for Work***

  Ideally, HCWs are fit to work when one of the following conditions apply:
  - They have recovered from pandemic flu, during earlier phases of the pandemic;
  - They have been immunized against the pandemic strain of influenza as outlined in *Pandemic Influenza Medication Plan*; or
  - They are on appropriate antivirals as outlined in the Medication Plan.
  - Such HCWs may work with all patients and may be selected to work in units where there are patients who, if infected with influenza, would be at high risk for complications.
  - Whenever possible, well, unexposed HCWs should work in non-influenza areas.
  - Asymptomatic HCWs may work even if influenza vaccine and antivirals are unavailable.

- Meticulous attention should be paid to hand hygiene and HCWs should avoid touching mucous membranes of the eye and mouth to prevent exposure to the influenza virus and other infective organisms.
- Ideally, staff with Influenza-like Illness (ILI) should be considered "unfit for work" and should not work. **However, in cases of extremely limited resources**, HCWs may be asked to work if they are well enough to do so and must follow these guidelines.
  - Such Health Care Workers must work with non-exposed patients (non-influenza areas) and should be required to wear a mask if they are coughing.
  - They must pay meticulous attention to hand hygiene.
  - They should not be redeployed to intensive care areas, nursery or an area with severely immunocompromised patients, i.e. transplant recipients, hematology/oncology patients, patients with chronic heart or lung disease, or patients with HIV/AIDS and dialysis patients.
- Establish referral from Occupational Health to Evergreen Behavioral Services (EBS) for employee/s 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.
- Contact FCHN Chaplain for the above support for those employees who prefer faith-based counseling, or the individual employee's own faith-based support.

Post-Pandemic Period (Maine Level V)

(Evidence of influenza activity returned to pre-pandemic level)

- Reinforce continuous precautionary procedures, such as hand hygiene, respiratory etiquette, etc. in anticipation of second wave.
- Maintain list of all employees and volunteers who recovered from cases of pandemic flu.

- Gather electronic numbers to report how many employees tested for influenza, and the results of those tests.
- Gather electronic numbers of all employee mortality cases from influenza and/or complications of influenza.
- Gather electronic numbers for all employees hospitalized for influenza.
- Conduct evaluation of how Occupational Health Plan worked.
- Assess the effectiveness of vaccine and antiviral distribution for employees.

Clinical Guidelines

Maine Pre-pandemic
Maine LEVEL I (*Alert*)

Case Detection and Clinical Management Figure 1

Clinical Criteria
An illness with *all* of the following:
- Temperature > 100.4 °F *and*
- Cough, sore throat, or dyspnea, *and*
- Requiring hospitalization, or nonhospitalized with epidemiological link[1]

If no to *any*, treat as clinically indicated, but reevaluate if suspicious

And

Epidemiological Criteria
The clinician should ask the patient about the following *within 10 days* of symptom onset
- History of recent *travel* to an affected area[2] and at least one of the following:
  - Direct contact with poultry or poultry products[3], *or*
  - Close contact with a person with suspected or confirmed Pandemic Flu[4], *or*
  - Close contact with a person who died or was hospitalized due to severe respiratory illness[3]
- Employment in an occupation at a particular risk for pandemic flu exposure, such as
  - A health care worker in direct contact with a suspected or confirmed Pandemic Flu case, *or*
  - A worker in a laboratory that contains live Pandemic Flu virus, *or*
  - A worker in a poultry farm, live poultry market, or poultry processing operation with a known or suspected avian influenza infection

If no to *both* criteria, treat as clinically indicated, but re-evaluate if suspicious

If *yes* to *either* criterion

- Initiate Standard and Droplet Precautions[5]
- Treat as clinically indicated[6]
- Notify State Health Department about the case[7]
- Initiate general work-up as clinically indicated[8]
- Collect and send specimens to the State Lab[9]
- Begin empiric antiviral treatment[10]
- Help identify contacts, including healthcare workers[11]

Novel influenza culture positive
- Continue Standard and Droplet Precautions[5]
- Continue antivirals[10]
- Do not cohort with seasonal influenza patients
- Treat complications, such as secondary bacterial pneumonia, as indicated[13]
- Provide clinical updates to health department

All influenza testing negative[12]
- Continue infection control precautions, as clinically appropriate[5]
- Treat complications, such as secondary bacterial pneumonia, as indicated[13]
- Consider discontinuing antivirals, if appropriate[10]

Seasonal influenza culture positive
- Continue Standard and Droplet Precautions[5]
- Continue antivirals for a minimum of 5 days[10]
- Treat complications, such as secondary bacterial pneumonia, as indicated[13]

Footnotes to Figure 1:

1. Further evaluation and diagnostic testing should also be considered for outpatients with strong
   epidemiological risk factors and mild or moderate illness.
2. Updated information on areas where novel influenza virus transmission is suspected or documented is
   available on the WHO website
   (http://www.who.int/csr/disease/avian_influenza/country/en/index.html).
3. 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.
4. Close contact includes direct physical contact, or approach within 3 feet of a person with suspected or
   confirmed novel influenza.
5. Standard and Droplet Precautions (see appendix E)
6. 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 is 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 patient and close contacts should be monitored for illness by local public health department staff.
7. Guidance on how to report suspected cases of novel influenza to the Maine CDC is provided in Surveillance Plan (1-800-851-5821).
8. The general work-up should be guided by clinical indications. Depending on the clinical presentation and the patient's underlying health status, initial diagnostic testing might include:
   - Pulse oximetry
   - Chest radiograph
   - Complete blood count (CBC) with differential
   - Blood cultures
   - Sputum (in adults), tracheal aspirate, pleural effusion aspirate (if pleural effusion is present) Gram stain and culture
   - Antibiotic susceptibility testing (encouraged for all bacterial isolates)
   - Multivalent immunofluorescent antibody testing or PCR of nasopharyngeal aspirates or swabs for common viral respiratory pathogens, such as influenza A

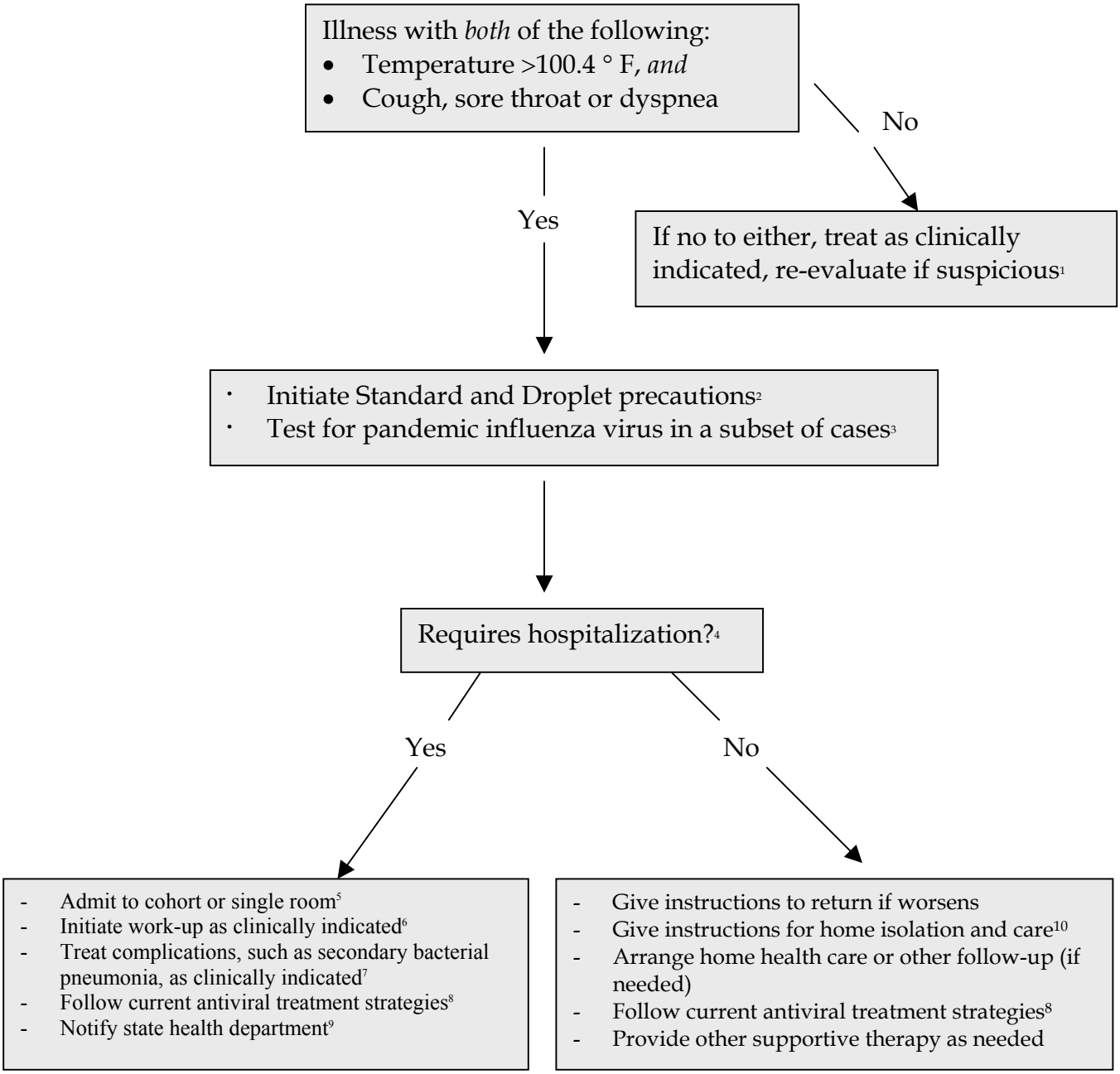
and B, adenovirus, parainfluenza viruses, and respiratory syncytial virus, particularly in children
- In adults with radiographic evidence of pneumonia, *Legionella* and pneumococcal urinary antigen testing
- If clinicians have access to rapid and reliable testing (e.g., PCR) for *M. pneumoniae* and *C. pneumoniae*, adults and children <5 yrs. with radiographic pneumonia should be tested.
- Comprehensive serum chemistry panel, if metabolic derangement or other end-organ involvement, such as liver or renal failure, is suspected.

9. Guidelines for novel influenza virus testing as per Maine State CDC. 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.
10. Strategies for the use of antiviral drugs are provided in **Pandemic Influenza Medication Plan.**
11. Guidelines for the management of contacts in a healthcare setting are provided in **Occupational Health Plan**.
12. 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:
    - Absence of strong epidemiological link to known cases of novel influenza
    - Alternative diagnosis confirmed using a test with a high positive-predictive value
    - Clinical manifestations explained by the alternative diagnosis.

Clinical Guidelines

Maine Levels II & III
(Evidence of pandemic flu in the United States)
Maine Levels II & III
(Evidence of pandemic flu in local area)
Maine Level IV
(Increased and sustained transmission in the general population)

Case Detection and Clinical Management
Figure 2



Footnotes to Figure 2:

1. Antiviral therapy and isolation precautions for pandemic influenza should be discontinued on the basis
   of an alternative diagnosis only when both the following criteria are met:
   - Alternative diagnosis confirmed using a test with a high positive-predictive value, and
   - Clinical manifestations entirely explained by the alternative diagnosis
2. Standard and Droplet Precautions (see appendix E).
3. See guidance from the state on laboratory testing during the Pandemic Period. Generally, specimens
   should include respiratory samples (e.g., nasopharyngeal wash/aspirate; nasopharyngeal, nasal or oropharyngeal swabs, or tracheal aspirates) stored at 4°C in viral transport media.

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.

4. The decision to hospitalize should be based on a clinical assessment of the patient and the availability
   of hospital beds and personnel.
5. 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.
6. The general work-up should be guided by clinical indications. Depending on the clinical presentation
   and the patient's underlying health status, initial diagnostic testing might include:
   - Pulse oximetry
   - Chest radiograph
   - Complete blood count (CBC) with differential
   - Blood cultures
   - Sputum (in adults) or tracheal aspirate Gram stain and culture
   - Antibiotic susceptibility testing (encouraged for all bacterial isolates)
   - Multivalent immunofluorescent antibody testing 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
   - In adults with radiographic evidence of pneumonia, *Legionella* and pneumococcal urinary antigen testing
   - If clinicians have access to rapid and reliable testing (e.g., PCR) for *M. pneumoniae* and *C. pneumoniae*, adults and children <5 yrs. with radiographic pneumonia should be tested.

- Comprehensive serum chemistry panel, if metabolic derangement or other end-organ involvement, such as liver or renal failure, is suspected

7. Strategies for the use of antiviral drugs are provided in **Pandemic Influenza Medication Plan**.
8. Guidance on the reporting of pandemic influenza cases is provided in **Surveillance Plan**.
9. Patients with mild disease should be provided with FCHN 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, 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, using a surgical or procedure mask by the patient or caregiver 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.

Education and Training Plan

Maine Pre-pandemic

- Periodically review and revise Education and Training Plan as appropriate.
- Identify educational resources (consistent with Maine CDC) to address needs of staff, patients, family members, and visitors.

Maine Level I
(Alert period)

- In conjunction with Communications Team, education employees, the public, colleague agencies and providers on:
    - explanation of seasonal vs. pandemic influenza and implications of pandemic influenza
    - difference between upper respiratory infection and influenza
    - prevention and control of influenza
    - benefits of annual influenza vaccination
    - review of infection control strategies including; respiratory hygiene/cough etiquette, hand hygiene, standard precautions, droplet precautions, and airborne precautions
    - role of antiviral drugs in preventing disease and reducing rates of severe influenza and its complications
    - information regarding "Quarantine/Home Care" self care (include where informational brochures may be obtained)
    - priority lists for vaccination and anti-viral prophylaxis
    - policies for restricting visitors and mechanisms for enforcing those policies
    - staffing contingency plans, including how the facility will deal with illness in personnel.
    - the risk of infection and subsequent complications in high-risk groups
    - provide information to encourage those who are symptomatic with influenza-like illness, but do not require formal healthcare to remain at home until their symptoms have been resolved; and to encourage them to avoid visiting/contact with those who are at high risk for complications if they developed influenza
    - surveillance activities in all patient intake areas, including Triage (ER)

Maine Levels II & III
(Evidence of pandemic flu outside the United States)

- Education Department to scrutinize all training in progress, and prioritize all training toward pandemic preparedness.
- Establish methods and a schedule for general education/training of all staff (and a mechanism for documenting participation) regarding each element of the FCHN-specific pandemic influenza plan.

- Train FHA and HCC staff and volunteers on hotline response:
  - telephone triage
  - answers to frequently asked questions
  - referral resources
  - documentation of calls (see Communication Plan)
- Review CDC guidelines for the care of pandemic influenza patients, including how and where these patients will be assigned (see Appendix E).
- Establish content, methods, and a schedule for the education/cross-training for clinical personnel, including outpatient healthcare workers (HCWs), who can provide support for essential patient-care areas (i.e. emergency department, ICU, medical unit).
- Establish content and schedule 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, Security duties).
- Train intake and triage staff to implement immediate containment measures to prevent transmission of influenza.

Maine Levels II & III
(Evidence of pandemic flu in the United States)

- Offer "train the trainer" sessions for influential community leaders. Subjects to include self-management/home-care and prevention of transmission.
- Continue with the steps outlined above.

Maine Levels II & III
(Evidence of pandemic flu in local area)

- See steps outlined in Maine Level IV
- Under direction of Incident Command, cancel all previous room bookings/functions.

Maine Level IV
(Increased and sustained transmission in the general population)

- Review with all FCHN personnel the FCHN Pandemic Influenza Plan.
- Continually educate and cross-train employees as needed.

Post-pandemic Period (Maine Level V)
(Evidence of influenza activity returned to pre-pandemic level)

- Review with all staff possibility of second wave.
- Assure brochures and other educational materials regarding pandemic influenza are still available to general public.
- Evaluate effectiveness of education programs, and refine as needed.
- Review Pandemic Influenza Plan modules with Response Team to assess need for revisions/updates.

Medications Plan

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

1. Pandemic Influenza Vaccine

Pre-pandemic Period

- ❑ Periodically review and revise Influenza Medications Plan as appropriate.
- ❑ Monitor Maine CDC recommendations on development, distribution, and use of vaccine.
- ❑ Coordinate with Maine State and local health departments for plans for distribution and priority use of vaccine
- ❑ Develop and update local priority list of vaccine distribution (see Appendix F).
- ❑ If available, obtain and stockpile vaccine according to Federal and State guidelines.
- ❑ Have an estimate of the numbers of vaccine needed for our established priorities.
- ❑ Develop a plan to prioritize vaccination use in the organization. Include plan for re-vaccination 1 month later to assure effectiveness. Plan to allocate half of available doses for first round of vaccinations, and the second half for the second round of vaccinations to the same individuals.
- ❑ Plan secure storage area for vaccine vials.
- ❑ Work with the Maine State CDC to develop plans for distribution and administering vaccine to local communities after priority groups vaccinated.
    - Plan to ramp-up list of personnel who can vaccinate. Coordinate with local public health nursing.
    - Develop an educational plan on vaccination training and adverse effects monitoring and treatment (following guidelines from CDC or Maine State CDC).
    - Develop a package for vaccination areas including: handouts (Quarantine / Self-Care information), adverse reactions, syringes, needles, alcohol swabs, needle boxes, epinephrine, Benadryl.
    - Check on legal exemptions and liability protection for healthcare workers and organization.
    - Communication plan for timelines and places of distribution of vaccine, per Maine State CDC.
    - Develop plan for security at sites and accountability of supplies.
    - Monitor distribution and use of vaccine.
    - Monitor and investigate adverse events. Report to State as per their guidelines.

Throughout Pandemic Period *(Before vaccine becomes available)*

- Meet with Pandemic Influenza Response Team.
- Review and update vaccine plan using HHS and Maine State CDC recommendations.
- Notify the medical community about status of plan and expected availability of vaccines.
- Communicate to the local community information on the production, prioritization and distribution of vaccine.
- Conduct training for personnel involved in distributing and administering vaccines.

Throughout Pandemic Period *(After vaccine becomes available)*

Working with Maine CDC and utilizing vaccination plan:

- Increase security of vaccine, including transportation, storage, distribution, etc., similar to narcotic control.
- Vaccinate persons in priority groups (See Appendix F).
- Provide second dose, if required, at recommended interval.
- Monitor vaccine supply, distribution and use.
- Monitor and investigate adverse effects. Relay to Maine State CDC.
- When enough vaccine available, phase in vaccination of population as per Maine State CDC recommendations.

Post-Pandemic Period

- Assemble Pandemic Influenza Response Team to review and critique vaccination process.
- Evaluate all response activities including vaccine tracking and delivery, adverse effects, and effectiveness of communications.
- Continue to vaccinate population following Maine State CDC guidelines.

2. Anti-Viral Medication

Pre-pandemic Period

- Establish list of priority groups to receive antiviral medication, including patients, per Maine CDC guidelines.
- Estimate the number of doses needed for addressing
  - Predetermined priority groups
  - General Public
- Identify sources of antiviral drugs
- In accordance with State plan, procure and create local stockpile

3. Seasonal Influenza Vaccine

- Increase the use of seasonal influenza vaccine to vulnerable persons.
- See current recommendations from Maine State CDC.
- See Standing Orders (see Appendix H).
- See Consent Form (see Appendix I).

4. Pneumonia Vaccine

- Increase the use of pneumococcal polysaccharide vaccine to persons vulnerable to a secondary bacterial infection. Including:
  - Persons aged >/= 65 years
  - Immunocompromised persons </= 2 years who are at increased risk for illness and death associated with pneumococcal disease because of chronic illness
  - Persons aged >/= 2 years with functional or anatomic asplenia
  - Persons >/= 2 years living in environments in which the risk of disease is high
  - Immunocompromised persons aged >/= 2 years who are at high risk for infection

5. Antibiotics

Prepandemic Phase

- Inventory stock of antibiotics for pneumonia complications (suggest maintain 3-mos. supply).

Pandemic Period

- Closely monitor use and availability of antibiotics.
- Increase stock as needed.

Psychosocial Plan

This plan has been developed to operate in conjunction with the Department of Health and Human Services "Behavioral Health Disaster Plan" to reflect the role of Evergreen as a DHHS contracted agency to provide Crisis Services in Franklin County.

Maine Pre-pandemic (WHO Levels 1 & 2)

- Inform staff of intent to use NetNews as the vehicle through which to communicate pandemic flu news with FCHN employees.
- Identify vulnerable populations, and develop preliminary plan to address their needs:
  - Children /Elderly
  - Minority populations
  - Persons with mental health and/or addiction issues
  - Persons with mental retardation and autism
- Develop plans to support emergency and medical service providers (ED staff, police, fire, EMS, Physicians, Nursing and other direct care staff).
- As local DHHS-contracted Crisis Program, Evergreen will identify community-based resources, local DHHS-funded Mental Health, Substance Abuse, organizations that can be accessed for assistance in addressing local psychosocial needs during event.
- Identify availability, interest, and training needs of private/other providers of psychosocial services who may be available to contribute assistance or support to Evergreen.
- Develop protocol for requesting and managing assistance from outside agencies.
- Provide clarification and information regarding roles during Pandemic:

  State Behavioral Health Disaster Coordinator,
  - Develops, implements and coordinates the DHHS behavioral health crisis response in a large-scale emergency, disaster or traumatic event.
  - Serves as DHHS point of contact and provides coordination for behavioral service providers.
  - Arranges for debriefing services for front-line behavioral health providers when requested.

  Evergreen Medical Director
  - Serves as point of contact for and coordinates psychiatric consultation service response to FMH.
  - Provides consultation and supervision for EBS Crisis Program.
  - Collaborates with FMH to determine need for psychotropic medication stockpiling.

  Evergreen COO
  - Serves as point of contact for FCHN leadership.
  - Provides leadership regarding EBS agency-wide response.
  - Develops protocol for and directs re-deployment of non-crisis program staff to assist in Agency response to Pandemic.

  Evergreen Crisis Program Director,
  - Provides communication link with the DHHS Behavioral Health Disaster Coordinator

- Manages and supervises day-to-day operations and activities of EBS Crisis Response Program to coordinate with local/regional emergency response activities.
- Assures that all staff has appropriate training to respond to event, as well as debriefing techniques when necessary.

Maine Level 1 (WHO Phase 3)
(Alert Period)

- Establish a provisional budget for response to Pandemic.
- Create and/or revise contingency staffing plans for a minimum duration of 8 weeks.
- Develop and maintain staffing alert roster to be activated as per FCHN Disaster plan.
- Solidify linkages with local DHHS funded Mental Health, Substance Abuse, and in-home support agencies/organizations.
- Encourage staff to develop alternate childcare arrangements in the event of school and daycare center closures.
- Create phone list of local behavioral health resources, agencies and organizations.
- Arrange training for EBS Crisis and other Behavioral Services Staff regarding disaster mental health, and debriefing techniques.
- Develop protocol and training for Behavioral Health staff regarding screening and triaging of persons needing Emergency Mental Health Services.
- Develop plan for outreach to vulnerable populations, and distribution of educational material and information regarding access to needed Emergency Mental Health or other services.
- Develop process for coordinating efforts with in-home behavioral/mental health services, home health organizations to provide follow-up and support for persons who have accessed Emergency Mental Health Services.
- Distribute phone contact numbers for the Statewide Crisis Hotline, and the Non-Crisis Peer Support Warm line.
- Identify areas that, safety permitting, could accept overflow psychiatric mental health client capacity if needed, such as the Evergreen Office at the Mt. Blue Health Center.
- Identify needed supplies, goods, and or other resources necessary to provide services at alternate location.
- Collaborate with FMH pharmacy to identify recommended psychotropic medications stocks, and estimate needed dosing. In particular to consider stocking Antipsychotics, Anxiolytics, Mood Stabilizers.
- Develop plan to address situations in which inpatient psychiatric services are needed but not immediately available.
- Identify any gaps in service delivery.

Maine Levels II & III (WHO Phases 4 & 5)
(Evidence of pandemic flu outside the United States)

- Triage/Intake to:
    - Screen routine requests for mental health services, and direct to appropriate resource or service.

- Monitor call volume and the focus of requests.
- Maintain awareness of agency non-emergency resources/capacity.

- ❑ Determine threshold for canceling routine scheduling of therapy and medication management clients, and move toward emergency response scheduling.
- ❑ Acquire/Create informational packet on psychosocial and/or medical self-care, and contact numbers for those individuals who will be returning home, away from the hospital.
- ❑ Develop plan for providing rest and recuperation sites/support for EBS direct service staff.
- ❑ EBS Leadership to meet and discuss:
  1. Key messages from DHHS, FCHN Communications Team.
  2. Issues and concerns from clients and callers.
  3. Volume of Emergency Mental Health contacts.
  4. Staffing issues, training needs, and agency response.

Maine Levels II & III (WHO Phases 4 & 5)
(Evidence of pandemic flu in the United States)

- ❑ Review plan for staff reassignments
- ❑ Determine need to activate contingency staffing plan when appropriate.
- ❑ Alert Roster to be activated at the direction of COO or Designee.
- ❑ Behavioral Health Manager to assure that rest and recuperation sites/supports are available to EBS staff.

Maine Levels II & III (WHO Phases 4 & 5)
(Evidence of pandemic flu in local area)

- ❑ Immuno-compromised employees are deployed to telephone triage/support activities.
- ❑ Determine availability and capacity of Crisis Stabilization Units for accepting clients. Review on a daily basis.
- ❑ Determine if psychiatric facilities have the capacity to accept patients who meet criteria for admission. Review on a daily basis.
- ❑ Establish communication with the State-operated mental Health Facilities, Riverview and Dorothea Dix, to determine their ability to address the needs of special at-risk clients.
- ❑ Crisis Intervention and brief supportive counseling will be provided to victims, family members, as well as to FCHN employees and first responders.
- ❑ Provide outreach and advocacy to survivors, family members, and the community at large.

Maine Level IV (WHO Phase 6)
(Increased and sustained transmission in the general population)

- ❑ EBS Leadership to meet and or communicate daily.
- ❑ Crisis Program Director to conduct daily check in with direct service staff to monitor for stress, exhaustion, need for rest/recuperation during emergency.

- Track crisis-related activities performed by EBS Crisis Program and report to DHHS Behavioral Health Disaster Coordinator.
- If necessary, contact the DHHS Behavioral Health Disaster Coordinator to request facilitation of reassigning staff from other local DHHS Programs to assist and supplement Crisis Response Services.

Post-Pandemic Period (Maine Level V)

(Evidence of influenza activity returned to pre-pandemic level)

- Crisis Program to provide continued outreach, triage and stabilization services.
- EBS leadership to Provide assistance in reintegration for EBS employees who were re-assigned or isolated from work.
- Assist in coordinating/providing debriefing services as requested.

Developed by: R. Chandler, D. Richard, M. Provost

Mortuary Plan

Prepandemic Period

- Assure adequate supply of body bags
- Determine temporary morgue facilities; refrigeration if needed
    - Establish contact with trucking companies – consider contracts
    - Plan on where to place truck – consider power /diesel fuel requirements
    - Address security concerns
    - Explore potential local storage facilities (Bass building)
- Plan for rapid removal and disposition of bodies
- Transportation of bodies
    - Licensed vs. non-licensed transportation.
    - Who can transport in emergency?
- Infection control
    - Use of body bags
    - Gloves and mask on body for transport
- Pre-determined Memorandum of Understanding (MOU) with local morticians and Franklin County Emergency Management Agency (FCEMA)
- Establish list of local funeral homes and crematories
- Keep on-going record of associated costs involved in mortuary issues

Maine Level I
(Alert period)

- Establish contracts for storage of bodies

Maine Level II & III
(Evidence of pandemic flu outside of the United States)

Maine Level II & III
(Evidence of pandemic flu inside of the United States)

- Confirm areas for body storage

Maine Level II & III
(Evidence of pandemic flu in local area)

- Establish Incident Command
- Using Incident Command System, assign responsibility for removal and transport of bodies

Maine Level IV
(Increased and sustained transmission in the general population)

- Cooperated with local funeral homes in the ultimate disposition of all bodies
- Cancel contracts as appropriate, keeping in mind the potential for a second-wave of Pandemic Influenza
- Explore reimbursement from local, state and federal sources for cost associated with emergency mortuary services.
- Review plan and adjust per recommendations

Appendices

Appendix A: Inventory

Insert when available.

Appendix B: Communication issues to during a pandemic

Adapted from Centers for Disease Control and Prevention

Goals of FCHN communication with regard to pandemic influenza:

- Orient public behavior to benefit the community (avoid panic).
- Reduce contagion.
- Control use of scarce hospital resources (human, supplies, and financial).
- Answer questions and concerns.

Key issues in communicating

- Give people things to do.
- Don't say, "Don't worry,"—give facts and let people decide for themselves.
- Uncertainty causes panic. Contradictory messages create uncertainty; information is empowering.
- Don't make promises we can't keep, be truthful.
- No jargon.
- Avoid humor.
- Refute allegations—don't repeat them.
- Discuss what you know, not what you think.
- Be regretful, not defensive.
- Acknowledge fears.

What the public wants to know

- What happened?
- What have you found that may affect me?
- What can I do to protect myself and my family?
- Who/What caused this?
- Can you fix it?
- Who is in charge?
- Has this been contained?
- Are victims being helped?
- What can I expect, right now and later?
- What should we do?
- Did you have any forewarning?

Appendix C: List of all FCHN Departments

DEPT NAME	TELEPHONE NUMBERS
MED SURG	2362, 2537
SWINGBED	2569
ICU	2569, 2510
MATERNAL CHILD HEALTH	2546
CARDIOPULMONARY	2733, 2727
ECHO	2727
OUTPATIENT CLINIC	2811, 2539
WEEKEND CLINIC	2547
SURGICAL SERVICES	2835, 2290
RECOVERY ROOM	2292, 2290
EMERGENCY ROOM	2547, 2250
ONCOLOGY	2811, 2590
LAB	2272, 2270
REFERENCE LAB	2270
PATHOLOGY	2271, 2270
RADIOLOGY	2370, 2377
ULTRASOUND	2377
NUCLEAR MEDICINE	2376
CAT SCAT	2223
RAD IOLOGY– FRANKLIN ORTHO	2377
RAD IOLOGY– RANGELEY REHAB CENTER	2377
MAMMOGRAPHY	2377
PACS	2377
PHARMACY	2426, 2532
ANESTHESIOLOGISTS	2293, 2690
PHYSICAL THERAPY	2256
PHYSICAL THERAPY-INPATIENT	2256
OCCUPATIONAL THERAPY	2257
SPEECH THERAPY	2366
ATHLETIC TRAINING	2256
PT - RANGELEY REHAB CENTER	864-2900
OCCUPATIONAL HEALTH	2368
AMBULANCES SERVICES	2770
WMCHH	2720
PHYSICAL THERAPY-SPRUCE	2256

MT	
SPRUCE MT OFFICE	2406
RADIOLOGY-SPRUCE MT	2377
NURSING ADMINISTRATION	2831, 2339
AHEC GRANT	2575
EDUCATION	2381
CLINICAL COORDINATORS	2766, 2811
DAY SURGERY	2225, 2835
INFECTION CONTROL	2508
FOOD & NUTRITION	2503, 2268
ENVIRONMENTAL SERVICES	2634, 2530
LAUNDRY	2634, 2531
MATERIALS MANAGEMENT	2246
STERILE PROCESSING	2238, 2835
SECURITY	2355
PLANT OPERATIONS	2200
MAINTENANCE	2200
PATIENT REGISTRATION	2440
SWITCHBOARD	2440
QUALITY & CARE MANAGEMENT	2828, 2518
CHAPLAINCY	2456, 2509
MEDICAL LIBRARY	2554, 2575
MEDICAL RECORDS	2341
GENERAL ACCOUNTING	2404
PATIENT ACCOUNTS	2284
INFORMATION SERVICES	2415
HUMAN RESOURCES	2574
VOLUNTEERS	2552
ADMINISTRATION	2265
HOSPITALISTS	2455
FRANKLIN ORTHOPEDIC SERVICES	4567
PINE TREE INTERNAL MEDICINE	2619
PINE TREE PEDIATRICS	2698
PINE TREE FAMILY PRACTICE	778-3326
PINE TREE WOMENS CARE	6405
PINE TREE ADMINISTRATION	2628, 2470
FCHN ADMINSTRATION	2265
FCHN COMMUNICATIONS&DEVEL	2471

FCHN PROGRAM DEVEL & RESEARCH	2830
FCHN MARKETING & PLANNING	645-3136 ext. 5100
FCHN DAYCARE	2870
FCHN FRANKLIN HEALTH ACCESS	2772
H-CAP E PRESCRIBING	3155
PTMA CARRABASSETT CLINIC	2628
HCC ELDERS COMM PROJECT	645-3136 ext. 5100
HCC AVON HEALTH EDUCATORS	645-3136 ext. 5100
HCC PROVIDERS CONTRIBUTIONS	645-3136 ext. 5100
HCC FUND FOR HEALTHY MAINE	645-3136 ext. 5100
HCC YOUTH TO YOUTH	645-3136 ext. 5100
HCC RURAL HEALTH OUTREACH	645-3136 ext. 5100
HCAP GRANT	645-3136 ext. 5100
EBS BEHAVIORAL SERVICES	2444, 2459
EBS EMERGENCY MENTAL HEALTH	750-0171
EBS WMRS AFTERSCHOOL PROGRAM	2843, 2844

Appendix D: Daily Log of Employee Symptoms   Date ________________

		Indicate with an “x”					
Employee Name	Temp.	Cough	Sore Throat	Dyspnea	Travel History	Dept./Ext.	To Work, Home, Further Action

Appendix E: Isolation Precaution Standards

SUMMARY OF INFECTION CONTROL RECOMMENDATIONS FOR CARE OF PATIENTS WITH PANDEMIC INFLUENZA
***Adapted from CDC. See* http://www.hhs.gov/pandemicflu/plan/pdf/S05.pdf**

COMPONENT	RECOMMENDATIONS
STANDARD PRECAUTIONS See www.cdc.gov/ncidod/hip/ISOLAT/std_prec_excerpt.htm.	
Hand Hygiene	Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items; after removing gloves; and between patient contacts. Hand hygiene includes both handwashing with either plain or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams) that contain an emollient and do not require the use of water. If hands are visibly soiled or contaminated with respiratory secretions, they should be washed with soap (either non-antimicrobial or antimicrobial) and water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience.
Personal protective equipment (PPE) **• Gloves** **• Gown** **• Face/eye protection (e.g., surgical or procedure mask and goggles or a face shield)**	• For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and nonintact skin • During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated • During procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, excretions.
Safe work practices	Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to patient care (e.g., door knobs, keys, light switches).

Patient resuscitation	Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.
Soiled patient care equipment	Handle in a manner that prevents transfer of microorganisms to oneself, others, and environmental surfaces; wear gloves if visibly contaminated; perform hand hygiene after handling equipment.
Soiled linen and laundry	Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.
Needles and other sharps	Use devices with safety features when available; do not recap, bend, break or hand-manipulate used needles; if recapping is necessary, use a one-handed scoop technique; place used sharps in a puncture-resistant container.
Environmental cleaning and disinfection	Use EPA-registered hospital detergent-disinfectant; follow standard facility procedures for cleaning and disinfection of environmental surfaces; emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces).
Disposal of solid waste	Contain and dispose of solid waste (medical and non-medical) in accordance with facility procedures and/or local or state regulations; wear gloves when handling waste; wear gloves when handling waste containers; perform hand hygiene.
Respiratory hygiene/cough etiquette Source control measures for persons with symptoms of a respiratory infection; implement at first point of encounter (e.g., triage/reception areas) within a healthcare setting.	Cover the mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacles; perform hand hygiene after contact with respiratory secretions; wear a mask (procedure or surgical) if tolerated; sit or stand as far away as possible (more than 3 feet) from persons who are not ill.

DROPLET PRECAUTIONS See www.cdc.gov/ncidod/hip/ISOLAT/std_prec_excerpt.htm	
Patient placement	Place patients with influenza in a private room or cohort with other patients with influenza.* Keep door closed or slightly ajar; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet precautions to all persons in the room. *During the early stages of a pandemic, infection with influenza should be laboratory-confirmed, if possible.
Personal protective equipment	Wear a surgical or procedure mask for entry into patient room; wear other PPE as recommended for standard precautions.
Patient transport	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
Other	Follow standard precautions and facility procedures for handling linen and laundry and dishes and eating utensils, and for cleaning/disinfection of environmental surfaces and patient care equipment, disposal of solid waste, and postmortem care.
AEROSOL-GENERATING PROCEDURES	During procedures that may generate small particles of respiratory secretions (e.g., endotracheal intubation, bronchoscopy, nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator or other appropriate particulate respirator.

RESPIRATORY HYGIENE/COUGH ETIQUETTE

- To contain respiratory secretions, all persons with signs and symptoms of a respiratory infection, regardless of presumed cause, should be instructed to:
  - Cover the nose/mouth when coughing or sneezing.
  - Use tissues to contain respiratory secretions.
  - Dispose of tissues in the nearest waste receptacle after use.
  - Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.
- Healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene/cough etiquette in waiting areas for patients and visitors:
  - Provide tissues and no-touch receptacles for used tissue disposal.
  - Provide conveniently located dispensers of alcohol-based hand rub.
  - Provide soap and disposable towels for hand washing where sinks are available.
- During periods of increased respiratory infection in the community, persons who are coughing should be offered either a procedure mask (i.e., with ear loops) or a surgical mask (i.e., with ties) to contain respiratory secretions.
- Coughing persons should be encouraged to sit as far away as possible (at least 3 feet) from others in common waiting areas.
- Some facilities may wish to institute this recommendation year-round.

Appendix F: Prioritization of those receiving Pandemic Influenza Vaccination

Tier	Sub-tier	Population
1	A	■ Vaccine and antiviral manufacturers and others essential to manufacturing and critical support *Rationale: Need to assure maximum production of vaccine and antiviral drugs*
		■ Medical workers and public health workers* who are involved in direct patient contact, other support services essential for direct patient care, and vaccinators *Rationale: Healthcare workers are required for quality medical care (studies show outcome is associated with staff-to-patient ratios). There is little surge capacity among healthcare sector personnel to meet increased demand.*
	B	■ Persons >_ 65 years with 1 or more influenza high-risk conditions, not including essential hypertension
		■ Persons 6 months to 64 years with 2 or more influenza high-risk conditions, not including essential hypertension
		■ Persons 6 months or older with history of hospitalization for pneumonia or influenza or other influenza high-risk condition in the past year *Rationale: These groups are at high risk of hospitalization and death. Excludes elderly in nursing homes and those who are immunocompromised and would not likely be protected by vaccination*
	C	■ Pregnant women *Rationale: In past pandemics and for annual influenza,* pregnant women have been at high risk; vaccination will also protect the infant who cannot receive vaccine.
		■ Household contacts of severely immunocompromised persons who would not be vaccinated due to likely poor response to vaccine
		■ Household contacts of children <6 month olds *Rationale: Vaccination of household contacts of immunocompromised and young infants will decrease risk of exposure and infection among those who cannot be directly protected by vaccination.*
	D	■ Public health emergency response workers critical to pandemic response *Rationale: Critical to implement pandemic response such as providing vaccinations and managing/monitoring response activities*

■ Key government leaders

Rationale: Preserving decision-making capacity also critical for managing and implementing a response

2 A ■ Healthy 65 years and older

■ 6 months to 64 years with 1 high-risk condition

■ 6-23 months old, healthy

Rationale: Groups that are also at increased risk but not as high risk as population in Tier 1B

B ■ Other public health emergency responders

■ Public safety workers including police, fire, 911 dispatchers, and correctional facility staff

■ Utility workers essential for maintenance of power, water, and sewage system functioning

■ Transportation workers transporting fuel, water, food, and medical supplies as well as public ground public transportation

■ Telecommunications/IT for essential network operations and maintenance

Rationale: Includes critical infrastructure groups that have impact on maintaining health (e.g., public safety or transportation of medical supplies and food); implementing a pandemic response; and on maintaining societal functions

3 ■ Other key government health decision-makers

■ Funeral directors/embalmers

Rationale: Other important societal groups for a pandemic response but of lower priority

4 ■ Healthy persons 2-64 years not included in above categories

Rationale: All persons not included in other groups based on objective to vaccinate all those who want protection

* This is inclusive of federal healthcare providers to Indian nations and tribes.

Appendix G: Pandemic Influenza Vaccine Consent Form

(insert pandemic influenza consent form as available)

Appendix H: Standing Order for Seasonal Influenza Vaccine

STANDING ORDER FOR SEASONAL INFLUENZA VACCINE

Policy:
Patients with no contraindications will be allowed to have the annual Influenza vaccine.

Warnings/Contraindications:

1. History of allergies to egg products or previous Influenza immunizations.
2. Pregnant patients in their first trimester should consult their doctor first.
3. History of Guillian Barre Syndrome.

Procedure:

1. Patients will be asked about contraindications and those with confirmed contraindications will be referred to their family provider for advice on receiving the Influenza vaccine.
2. Those without contraindications will be given a CDC Vaccine Information Sheet dated for 2002-2003 and asked to sign the consent form.
3. The immunization will be given 0.5ml IM in one of the deltoid regions.
4. Patients will be observed for 15 minutes before leaving.
5. EpiPen 0.3mg auto-injector IM, prn anaphylaxis with immediate provider evaluation.
6. Acetaminophen is recommended for soreness at the sight of administration or for a low-grade fever after receiving the vaccine.

As Medical Director (or designee) of Franklin Memorial Hospital, I hereby authorize the FMH Employee Health Nurse/ designee, to administer the above vaccine according to the above policy and procedure.

Created: 11/02 Reviewed: 11/03,02/05

_____
Medical Director/Designee Signature

Appendix I: Seasonal Influenza Vaccine Consent Form

Franklin Community Health Network
Occupational Health /Employee Health
779-2367 -- 779-2508
111 Franklin Health Commons
Farmington ME 04938

Seasonal Influenza Vaccine

Name: _____ Employer: _____
Social Sec. No.: _____ D.O.B _____

History

1. Have you ever received influenza vaccination in the past? **Yes** ☐ **No** ☐
   If yes, when: _____ Did you have any problems? **Yes** ☐ **No** ☐
2. Do you have an allergy to egg products? **Yes** ☐ **No** ☐
3. Is there a possibility of pregnancy? **Yes** ☐ **No** ☐
4. Are you suffering from any cold or flu symptoms currently? **Yes** ☐ **No** ☐
   If yes, what:
5. Have you ever had Guillian Barre Syndrome? **Yes** ☐ **No** ☐

Consent for Vaccination

I have been provided with the 07/18/05 Influenza VIS that pertains to benefits and risks of receiving influenza vaccination. As with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine, or a mild case of flu-like symptoms. I request that the vaccine be given to me.

Signature: _____ Date: _____

Date	Manufacture	Lot No.	Exp. Date	Inject. Site	Dose 0.5 ml.	Provider Signature

Appendix J: Home Care Kit Contents

- Brochure about self-care and access to health care services
- Information and educational material on access to emergency mental health
- Thermometers
- Masks
- Hand washing towelettes
- Recipe for making a rehydration drink
- FCHN Flu Hotline
- Statewide Crisis hotline and non-crisis peer support warmline