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Guidance for Educational Institutions Pandemic Influenza Response

I. Background

Influenza is a highly infectious respiratory illness caused by influenza viruses. Influenza viruses are distinctive in their ability to cause sudden, pervasive illness in all age groups worldwide. Previous pandemics, caused by novel virus strains against which the population had no previous immunity, caused disproportionate illness and death in young, previously healthy adults.

The recent avian influenza reports are reminders that the potential for efficient person-to-person transmission of a novel virus strain is approaching. Pandemic influenza would be a unique public health emergency due to the fact that outbreaks are expected to occur simultaneously throughout much of the country and in the State, preventing shifts in human and material resources that normally occur in most other natural disasters.

II. Purpose

The purpose of this document is to assist educational institutions in their development of institution-specific pandemic influenza preparedness & response plans.

A. Assumptions

The development of this document is based on the following assumptions:

- In the event of an influenza pandemic the State will have minimal resources available for on-site local assistance, and therefore local authorities and institutions will be responsible for community-specific pandemic response plans, including the modification of this document so that it is institution-specific.
- Local communities may have emergency preparedness plans and/or pandemic influenza plans in place. Local community leaders and institutions will communicate so that each is aware of the others' plans.
- The federal government has limited resources allocated for State and local plan implementation, and therefore the State will provide supplementary resources in the event of a pandemic, which may include the redirection of personnel and monetary resources from other programs.
- The federal government has assumed the responsibility for developing materials and guidelines, including basic communication materials for the general public on influenza, influenza vaccine, antiviral agents, and other relevant topics in various languages; information and guidelines for health care providers; and training modules. Until these

materials are developed, the State has the responsibility to develop such materials for its citizens.

- A novel influenza virus strain will likely emerge in a country other than the United States, but could emerge first in the United States and possibly in New Hampshire.
- It is highly likely that moderate or severe shortages of vaccine will exist early in the course of the pandemic and also possible that no vaccine will be available.
- The supply of antiviral medications used for prevention and treatment of influenza will be limited.

World Health Organization (WHO) Phases

The pandemic phases described in this document are those that have been established by the World Health Organization. The most recent publication of the phases is summarized in Table 1 below. The State's response to a pandemic will be guided by the WHO phase declaration (see *State of New Hampshire Influenza Pandemic Public Health Preparedness and Response Plan* [currently in draft form and available at http://www.dhhs.state.nh.us/DHHS/CDCS/flu-provider.htm]). This response will include specific considerations during each phase of the pandemic regarding surveillance, vaccine delivery, administration of antivirals, and communications. In addition, there must be actions taken on the local level in each phase, particularly with respect to community-based containment measures. This plan for educational institutions provides recommendations for activities in response to WHO phases and also notes the corresponding alert matrix system being used in the hospital-developed Epidemic Respiratory Infection (ERI) plan (see Table 2 and process below for further explanation of the ERI plan). It should be noted that at the time of writing this document (January 2006), we are in WHO Phase 3.

Table 1. WHO Pandemic Phases

WHO PANDEMIC PHASES
Interpandemic period
Phase 1. No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk[a] of human infection or disease is considered to be low.
Phase 2. No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk[a] of human disease.
Pandemic alert period
Phase 3. Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.
Phase 4. Small cluster(s) with limited human- to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.[b]
Phase 5. Larger cluster(s) but human-to- human spread still localized, suggesting the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).[b]
Pandemic period
Phase 6. Pandemic phase: increased and sustained transmission in general population.[b]
Postpandemic period
Return to phase interpandemic period.

[a] The distinction between *phase 1* and *phase 2* is based on the risk of human infection or disease resulting from circulating strains in animals. The distinction would be based on various factors and their relative importance according to current scientific knowledge. Factors may include: pathogenicity in animals and humans; occurrence in domesticated animals and livestock or only in wildlife; whether the virus is enzootic or epizootic, geographically localized or widespread; other information from the viral genome; and/or other scientific information.

[b] The distinction between *phase 3*, *phase 4* and *phase 5* is based on an assessment of the risk of a pandemic. Various factors and their relative importance according to current scientific knowledge may be considered. Factors may include: rate of transmission; geographical location and spread; severity of illness; presence of genes from human strains (if derived from an animal strain); other information from the viral genome; and/or other scientific information.

Reference: WHO/CDS/CSR/GIP/2005.5: WHO global influenza preparedness plan. World Health Organization, Department of Communicable Disease Surveillance and Response. Global Influenza Programme. 2005.

Table 2. Epidemic Respiratory Infection (ERI) Alert Matrix

Six levels of alert corresponding to the type of transmission and the location of the cases.

What type of transmission is confirmed?	Where are the cases?	Are there cases at the educational institution?	Alert Level
None or sporadic cases only	Anywhere in the world	No	Ready
Person-to-person transmission	Anywhere outside the US and bordering countries (Canada, Mexico)	No	Green
Person-to-person transmission	In the US, Canada, or Mexico	No	Yellow
Person-to-person transmission	In NH or bordering states; at educational facility	Doesn't matter; efficient transmission from known sources	Orange
Person-to-person transmission	At educational facility	Yes, with efficient transmission, sources not clear	Red

III. Process

The first New Hampshire Influenza Pandemic Preparedness Plan was completed in 2001 and was modeled on the CDC guidance, Pandemic Influenza: Planning Guide for State and Local Officials, Version 2.1, January 1999. As the State's plan changed and progressed, it became clear that educational institutions, including those that are residential, require specific attention to issues such as surveillance, infection control, and case management. Therefore, this guidance was adapted from both the current *State of New Hampshire Influenza Pandemic Public Health Preparedness and Response Plan* and the *Readiness Plan for Epidemic Respiratory Infection* (ERI), the latter of which is now used by multiple hospitals throughout the State. The ERI plan was developed by the DHMC Emergency Preparedness team and was disseminated in 2005. It establishes a user-friendly alert matrix distinctive to respiratory infection outbreaks, which may be applicable in the event of an influenza pandemic.

This document has been developed by the NH Department of Health and Human Services (DHHS), Division of Public Health Service's Communicable Disease Control Section (CDCS).

IV. Authority/Legal Preparedness

The State of NH has designated DHHS to oversee the influenza pandemic planning process in cooperation with local health agencies and other partners. During a pandemic, DHHS will have primary responsibility for:

- Making recommendations to local health departments, health care providers and facilities, and the general public to aid in controlling the spread of influenza
- Maintaining surveillance systems to monitor the spread of disease
- Keeping the public informed

While no provision of law addresses pandemic influenza specifically, numerous statutory provisions authorize relevant actions. For institutions to effectively plan and respond to an influenza pandemic, they should be knowledgeable of the following legal issues:

- NH's laws and procedures on quarantine, isolation, closing premises, and suspending public meetings, which can be implemented to help control an epidemic
- Statutes for mandatory vaccination during an infectious disease emergency
- Medical volunteer licensure, liability, and compensation laws for in-state, out-of-state, and returning retired and non-medical volunteers
- Workers' compensation laws as they apply to health care workers and other essential workers who have taken antivirals for prophylaxis

The corresponding statute descriptions are summarized in the *State of NH Public Health Emergency Preparedness Plan* (currently in draft form).

V. Response Activities by Level of Alertness

Level Ready-Green (ERI alert matrix)/Interpandemic period (WHO)

When cases of an Epidemic Respiratory Infection (ERI) are occurring in countries other than the U.S., but have yet to be reported domestically or in neighboring countries, your institution should maintain a level of preparedness in the event that the ERI begins to spread globally. This is the level your institution should be maintaining currently. During this level, we recommend your institution take the actions listed below.

A. Access Control

- The institution will develop a plan and a timeline for implementing a policy that enables them to control access to the institution. There should be a plan to lock down certain entrances and exits, and to monitor use of others, if necessary. If applicable, institutions should involve their security personnel to accomplish these tasks.
- The institution will also develop a plan to close down or curtail campus transportation, including school buses and campus shuttles if necessary.

B. Surveillance, Screening and Triage

- The institution's health services personnel will screen all individuals at the time of registration at health services or nurse's office. For younger children, personnel may observe for cough. With older children, they may ask the following question: "Do you have a new cough that has developed over the last 10 days?" and will
    - Provide patients who have a new cough with a surgical mask and/or tissues.
    - Document data at time of screening and review each week for analysis of trends.
    - Clinical staff/school nurse will
        - Evaluate individuals who have a new cough for fever (temperature ≥100.4).
        - Place all individuals who have fever and a new cough on droplet precautions, pending further evaluation.
    - If private rooms are available, and evaluation requires isolation, individuals with fever and cough will be placed in a private room with droplet precautions. Otherwise, such individuals should be referred to local community health

providers or hospitals for evaluation, with health services personnel calling ahead to alert staff of patient symptoms.

- The institution's health services staff have the authority to restrict individuals (staff and students) who have fever and a new cough from work, class, or any other group gathering. They also have the authority to send any student or staff home that they suspect may have a communicable disease that puts others in the institution at risk. The legal authority for exclusion from school is under RSA 200:39. This RSA is under Title XV, Education; 200, Health & Sanitation; 39, Exclusion from School, and is accessible on-line at http://gencourt.state.nh.us/rsa/html/XV/200/200-39.htm.

- Health services clinicians will screen individuals who report pneumonia or respiratory infection to identify possible clusters, or groups of ill individuals who may be linked.
    - Possible clusters will be reported to the State's Communicable Disease Control Section by calling (603) 271-4496 M-F 8AM-4:30 PM.
- Informative infection control signs will be placed at all campus building entrances and common areas to encourage all persons entering the campus to self-screen (rotating the posters periodically to maintain impact). Posters are available for download on the DHHS website: http://www.dhhs.state.nh.us/DHHS/CDCS/flu-provider.htm.
    - Via posters, campus staff will ask persons who have a new cough to wear a surgical mask or use tissues to cover their mouth and nose when coughing, and to use good hand hygiene during the time they need to be on-campus.
    - The institution will advise all persons, including staff, students, and visitors, who have fever and cough to defer attending school or visiting the institution until their illness has resolved.
- Monitoring surveillance data
    - The health services personnel will monitor national, regional, and local data related to ERI. Information will be posted on the NH DHHS website.

C. Infection control/Precautions

- All staff, students, and visitors will use ***Droplet Precautions (private room and surgical mask within 3 feet of patient)*** for all contact with any individual who has a new cough and fever, until a diagnosis of a non-contagious respiratory illness, or an infection requiring a higher level of precautions, is made.
- If students, staff or visitors present with symptoms while at school, they should be provided a mask while awaiting transportation away from the facility.
- The institution's health services staff will use or provide for use a visible doorway "precautions sign" system to allow persons entering the room to know what type of protective equipment is needed.
- The institution will maintain adequate supplies at all times of surgical masks, waterless hand rub, and tissues throughout public areas, classrooms, and meeting rooms, as well as within the Health Services facility.
- If possible, the institution will identify key areas throughout the campus which need to maintain core groups of N-95 respirator fit-tested personnel
    - Each director is responsible for maintaining the appropriate number of trained and fit-tested staff

- The institution will display hand-washing posters (can be downloaded from: www.dhhs.state.nh.us) in high-traffic areas and classrooms.

D. Communication/Education

- The institution will develop a sustainable and effective plan for communication and promotion of messages relating to ERI to internal and external audiences.
- A sustainable plan should be developed to orient and educate staff regarding basic readiness activities at the institution, and a strategy for activities to provide timely information to health services providers in the event of ERI.

E. Additional Preparedness Activities

The following recommendations for vaccination campaigns apply to the regular influenza season. This is separate from vaccination campaigns that may take place during a pandemic. The purpose in the following recommendations for influenza vaccination during the regular influenza season is: to reduce morbidity from seasonal influenza transmission in vital workers if pandemic strain emerges, to reduce diagnostic confusion if a pandemic strain emerges (one may have a higher suspicion for pandemic strain if the patient is known to have been vaccinated against seasonal influenza), and to prepare communities for providing vaccination clinics in the event that vaccination for a pandemic strain is necessary.

- Offer all eligible staff, students, and visitors the opportunity to receive influenza vaccine on-site. This may be facilitated by holding vaccination clinics on designated days.
- If your institution cannot hold clinics on-site, refer to local clinics or collaborate with community health organizations to hold clinics to provide influenza vaccine to all eligible institution members of any age.
- Develop educational and promotional materials to promote availability and desirability of influenza vaccine for all.
- The administering provider of flu vaccine will document administration of influenza vaccine, preferably in a computerized database.
- Administrative, educational, and clinical leaders will promote maximum participation of staff and students in influenza vaccine program.

In addition to the above vaccination recommendations, the following are other preparedness activities to take place during the Level Ready-Green phases of a pandemic:

- Many institutions already have an Emergency Preparedness team. If the institution does not have an existing Emergency Preparedness team, one should be formed following Incident Command Structure (ICS). If additional training and/or help is needed in creating this team with adherence to ICS, please contact the NH Bureau of Emergency Management at (800)852-3792 or (603)271-2231.
- The team will designate an Incident Command core including senior administration, health services, communications, safety, engineering, and security, as applicable, with 7-day a week availability to respond to a potential outbreak of an ERI.
- The Emergency Preparedness team will be in charge of regular updates to staff, students, and parents. The team should meet approximately once a month.
- The Emergency Preparedness team will monitor the Health Alert Network and other communications from public health officials to review changes in recommendations

about screening criteria and will communicate changes to clinicians via some combination of email, intranet, or radiographic or laboratory reporting.

Level Yellow-Orange (ERI plan)/Pandemic Alert Period (WHO)

In the event that a case of Epidemic Respiratory Infection (ERI) affects a community member or a close contact of a community member of your institution, activities will be modified to reflect increased risk of exposure and disease spread within your community. The following are recommendations regarding activities of your institution that should be addressed in the event that a case of ERI is suspected or has been confirmed in your institution, but there is no documented community spread from this person to others. For example, this would include a student who returned to the institution with cough and fever after travel to an area known to have ERI, but has not spread the illness to anyone else.

Activities are cumulative through the phases, and therefore, those activities from the Level Ready-Green/Interpandemic Period should be carried over to this phase and supplement the recommendations below.

A. Access Control

- Review possible need to restrict vendors, visitors, and conferences/group activities.

B. Surveillance, Screening and Triage

- Infection control signs are posted at all entrances, and in all common areas (in dormitories, libraries, gymnasium, auditoriums, cafeterias, classrooms, restrooms). Posters should include specific risk factors for the targeted infection, to encourage all persons in the institution to self-screen for infection.
- Persons who self-identify as at-risk for the designated infection are instructed to don surgical mask and should go to campus health services or school nurse office for clinical evaluation.
- Health services personnel who suspect, after initial clinical evaluation, that a patient may have an ERI should immediately consult with DHHS.
- Staff or students traveling to designated high risk areas must register with campus health services or school nurse upon return and report any symptoms of fever or cough that occur during a specified time period. Health services will maintain a list of people under surveillance for this reason.
- Staff and students who have had contact with suspected patients must register with health services and be screened daily for fever or respiratory symptoms.
- Surveillance data will be electronically transmitted to DHHS daily using the form provided by DHHS. This form is currently under development.

C. Infection Control/Precautions

- Airborne, droplet, and contact precautions are required for all contact with any person who has screened as a possible ERI case, until an alternate diagnosis is made.
- Droplet precautions are required for any person who has a new cough and fever, but no risk factors for ERI, until a diagnosis of a non-contagious respiratory illness, or an infection requiring a higher level of precautions, is made. Health services has the authority to exclude any individual with new cough and fever until diagnosis of non-contagious respiratory illness is made.

D. Communication/Education

- A knowledgeable staff member may need to be present at high-traffic areas on site to answer questions and direct persons to evaluation at campus health services as needed.
- The institution should use the mode of communication used most by students, staff, and parents (e-mail, flyers, phone messages) to keep the community informed and to provide education about prevention and symptom surveillance. The institution should also consider creating a designated phone line to campus health services (ERI hotline) for callers with specific questions about ERI.

E. Additional Preparedness Activities

- At Level Orange the Emergency Preparedness team should meet daily to review situation and strategies.

Level Red (ERI plan)/Pandemic period (WHO)

There is evidence of institutional transmission of ERI or there is widespread human-to-human transmission in the region of the institution.

Red indicates the highest level of alert, with restrictions on access to the institution, more active screening, and a shift away from normal operations of the institution. At this level, the institution will consider implementing each of the additional actions.

A. Access Control

- All entrances to the institution will be locked except for the main entrance. Those that cannot be locked will be guarded by security personnel.
- Entry into facility will be restricted to the following:
    - Staff and students with a valid ID
    - Parents of students
- Activities of campus eateries (cafeteria, commercial) and other shops may be suspended.
    - A plan should exist for delivering meals to students if cafeteria or group-style dining is closed. This may take the form of delivery of boxed meals to dormitories.
- There may be some degree of suspension of activities, including sporting events, arts performances, and classes as determined by the Emergency Preparedness team in consultation with DHHS.
- Campus transportation, including buses transporting students on and off campus, may be suspended.
- The decision to close the institution may also be made as a means to prevent the further spread of an epidemic, either by the Emergency Preparedness team or BDCS. In the event of institution closure, a plan should be in place for residential institutions to provide meals to those who cannot leave the institution immediately. There also should be in place a tracking system so that those who leave the area can be tracked.

B. Surveillance, Screening and Triage

- Persons in residential institutions will be instructed to call campus health services if they require any medical appointment. This call is required to screen for new cough developing over the past 10 days. Persons who answer yes will be phone triaged to a health services clinician, who can do further screening for ERI risk factors and determine the need for the patient to be evaluated in person.
- Those allowed into the facility must be screened for fever or cough and have their temperature taken, and if cleared, given something to indicate that they have been cleared to enter the facility (e.g. a sticker, a card, a stamp on their hand).
- Those who are identified to have fever and/or cough will be instructed to don a surgical mask, use waterless hand rub, and go to campus health services or school nurse. Alternatively, in a non-residential institution, they may be excluded from entry into the institution and instructed to call their primary care provider for evaluation. DHHS may elect to gather contact information and follow-up plans made before the person is released into the community.
- In a residential institution, after clinical evaluation, a person who has fever or cough may be allowed to remain at a residential institution if they are a resident unless the person requires further medical evaluation.
- The name and phone number/address of all persons seen with suspected ERI by campus health services will be recorded and reported to DHHS within 24 hours.
- If the person warrants evaluation in a hospital setting, health services staff should alert the referral hospital that a suspect or confirmed case needs evaluation so that the referral center can make arrangements for infection control precautions.

C. Infection Control/Precautions

- An N-95 mask and contact precautions are required for all campus health services medical staff having contact with any person who has fever and/or a new cough, until an alternate diagnosis is made (this includes staff who conduct screening at institution entrances).
- Adequate supplies of personal protective equipment, waterless hand rub, and tissues will be maintained through the institution by a designated group.
- Everyone providing patient care will be N-95 respirator fit-tested.
- If the suspect or confirmed case does not require hospitalization, he/she should be isolated from other community members, including exclusion from events such as sporting events, group meals, working out in the gym, and classes until he/she is proven to not be a case, or he/she has passed the time of infectivity (2 days before illness onset to five days after illness ons*et [this may be modified when more is known about the pandemic strain]*). If the case shares a room with other students in a residential institution, arrangements should be made for the case to be given a private room (for example, to remain in health services in a private patient room or in an empty dorm room). Arrangements should be made to provide the students with necessary daily items, including meals, water, hygiene, and telephone.
- The institution, with guidance from DHHS, will identify close contacts in the institution to a suspect or confirmed case of ERI. Contacts are defined as those who spent >15 minutes within 3 feet of the case during his/her infectious period (2 days before illness

onset to five days after illness onset). In a dormitory setting, where contact will be less clearly delineated, contacts are defined as those who meet the above definition or those who live on the same dormitory floor as the case.

- Staff and students who have had contact with suspected patients must register with campus health services and be screened daily for fever or respiratory symptoms
- With guidance from DHHS, recommendations will be made for quarantine of non-ill contacts. Guidance will be provided regarding details of quarantine in a residential institution, including cohorting of contacts, sites to use for quarantine, and legal authority. As with a case in isolation, arrangements should be made to provide those quarantined with necessary daily items, including meals, water, hygiene, and telephone.

D. Communication/Education

- Daily or more frequent updates to community members and parents will be provided as determined by the Emergency Preparedness team.

Appendix 1: Suggested Sign Off Sheet for Planning Committees

School Pandemic Influenza Preparedness & Response Plan

This policy has been reviewed and accepted by:

Superintendent of School _____

Principal _____

Vice Principal _____

School Nurse/Clinician _____

Parent-Teacher Organization Representatives _____

_____

_____

Custodial Services _____

Security _____

Transportation _____

Appendix 2: Suggested Checklist

School Pandemic Influenza Preparedness & Response Checklist

Level Ready-Green (ERI alert matrix)/Interpandemic period (WHO)

_____ Form an Emergency Preparedness team, if one does not already exist.

_____ Have Emergency Preparedness team members perform authority/legal preparedness activities

A. Access Control

_____ Develop a plan and a timeline for implementing a policy that enables controlling access to the institution.

_____ Develop a plan to close down or curtail campus transportation, including school buses and campus shuttles if necessary.

B. Surveillance, Screening and Triage

_____ Have the institution's health services personnel screen all individuals at the time of registration at health services or nurse's office, following NH DHHS recommended precautions

_____ Provide patients who have a new cough with a surgical mask and/or tissues

_____ Document data at time of screening and review each week for analysis of trends

_____ Restrict individuals (staff and students) who have fever and a new cough from work, class, or any other group gathering

_____ Send any student or staff home that is suspected of having a communicable disease that puts others in the institution at risk

_____ Report possible clusters to the State's Communicable Disease Control Section by calling (603) 271-4496 M-F 8AM-4:30 PM.

_____ Post informative infection control signs at campus building entrances and common areas

_____ Rotate the infection control signs periodically

_____ Monitor national, regional, and local data related to pandemic influenza

C. Infection control/Precautions

_____ Follow NH DHHS recommended precautions for contact with any individual who has a new cough and fever

_____ Provide mask or tissues to any students, staff or visitors who present with symptoms while at school and awaiting transportation from the facility

_____ Maintain adequate supplies of surgical masks, waterless hand rub, and tissues throughout public areas, classrooms, and meeting rooms

_____ Identify who should be N-95 respirator fit-tested personnel

_____ Maintain the appropriate number of trained and N-95 fit-tested staff

_____ Display hand-washing posters (can be downloaded from: www.dhhs.state.nh.us) in high-traffic areas and classrooms.

D. Communication/Education

_____ Develop a plan for communication and promotion of messages relating to ERI to internal and external audiences

_____ Develop a plan to orient and educate staff regarding basic readiness activities at the institution

E. Additional Preparedness Activities

_____ Implement vaccination campaign (offer vaccine on-site or provide references to area clinics)

_____ Develop educational and promotional materials to promote availability and desirability of influenza vaccine for all

_____ If administering flu vaccine on-site, document administration of vaccine, preferably in a computerized database

_____ Have Emergency Preparedness Team designate an Incident Command core with 24/7 availability to respond to a potential outbreak

_____ Provide regular updates to staff, students, and parents

_____ Have Emergency Preparedness Team meet approximately once a month.

_____ Monitor the Health Alert Network and other communications from public health officials and communicate changes to clinicians

Level Yellow-Orange (ERI plan)/Pandemic Alert Period (WHO)

_____ Continue applicable activities from Level Green/Interpandemic Period

A. Access Control

_____ Review possible need to restrict vendors, visitors, and conferences/group activities

B. Surveillance, Screening and Triage

_____ Consult with DHHS when suspect, after initial clinical evaluation, that a patient may have an ERI

_____ Register staff or students traveling to designated high risk areas and report any symptoms of fever or cough that occur (monitor NH DHHS website for high risk areas, symptoms, and time period for surveillance)

_____ Register staff and students who have had contact with suspected patients and screen daily for fever or respiratory symptoms.

_____ Submit surveillance data electronically to NH DHHS daily using the form provided by DHHS (currently under development)

C. Infection Control/Precautions

_____ Expand precautions for clinicians to include airborne, droplet, and contact precautions for suspect cases with risk factors

_____ Follow droplet precautions for suspect cases with no risk factors

D. Communication/Education

_____ Place staff at high-traffic areas to answer questions and direct persons to health services as needed

_____ Keep the community informed and provide education about prevention and symptom surveillance

_____ Consider creating a designated phone line to campus health services

E. Additional Preparedness Activities

_____ Emergency Preparedness team should meet daily to review situation and strategies

Level Red (ERI plan)/Pandemic period (WHO)

_____ Continue applicable activities from Level Green/Interpandemic Period and Level Yellow-Orange/Pandemic Alert Period

A. Access Control

_____ Restrict access to the institution to staff, students, and parents of students

_____ Consider suspension of campus eateries (cafeteria, commercial), shops, and other group activities, including sporting events, arts performances, and classes as determined by the Emergency Preparedness team in consultation with DHHS.

_____ Implement plan for delivering meals to students if cafeteria or group-style dining is closed

_____ Consider suspension of campus transportation (ie., buses)

_____ Consider closure of the institution

_____ In the event of institution closure of a residential institution, implement plan for to provide meals to those who cannot leave immediately, and track/register those who leave the area

B. Surveillance, Screening and Triage

_____ For residential institutions, instruct symptomatic persons to call ahead to health services clinicians – implement phone triage system

_____ Screen those allowed into the facility for fever or cough and have their temperature taken – implement signage (sticker, card, stamp) system to track status

_____ Record the name and phone number/address of all persons seen with suspected ERI and reported to DHHS within 24 hours unless already alerted that need for notification to DHHS has ceased

C. Infection Control/Precautions

_____ Continue practice of airborne precautions, including staff who conduct screening at institution entrances

_____ Implement isolation & quarantine guidelines as they are made available by NH DHHS

_____ Isolate suspect or confirmed cases if they do not require hospitalization until proven to not be a case, or until passed the time of infectivity

_____ Assist DHHS with contact investigations

D. Communication/Education

_____ Provide daily or more frequent updates to community members and parents