



# INFLUENZA PANDEMIC RESPONSE PLAN

EXECUTIVE SUMMARY

## PENNSYLVANIA'S IPRP 2005

DEPARTMENT OF  
**HEALTH**

*Edward G. Rendell, Governor*  
*Calvin B. Johnson, M.D., M.P.H., Secretary of Health*

## INFLUENZA PANDEMIC RESPONSE PLAN EXECUTIVE SUMMARY

The purpose of the Pennsylvania Department of Health's (Department) Influenza Pandemic Response Plan (IPRP) is to provide a framework, methodology and recommendations for pandemic preparedness actions at the federal, state and local levels.

- Federal - Any federal government agency that possesses a role in the planning, response or recovery phases of an influenza pandemic.
- State - Activities in which the Department has responsibility during an influenza pandemic.
- Local - Activities include those performed by the Department's six District Offices, State Health Centers and the six County and four Municipal Health Departments (CMHDs).

### AUTHORITY AND RESPONSIBILITIES

The Governor is responsible for addressing threats to the Commonwealth and its citizens presented by disasters. The responsibilities and authority of the Governor include, but are not limited to, declaration of disease emergency, activation of disaster response and suspension of certain regulatory statutes.

The Department is responsible for the health of the Commonwealth's entire population. The Secretary of Health (Secretary) has the authority to determine and employ the most efficient and practical means for the prevention and control of the spread of disease. This includes coordinating response and recovery to an influenza pandemic with the Pennsylvania Emergency Management Agency and authorizing the furnishing of aid and assistance.

The Emergency Medical Services Office (EMSO) is responsible for establishing a standard outline for a service infection control guideline program. Other services include maintaining an ambulance and quick response service infection control coordinator database and providing training for individuals nominated as service infection control coordinators.

The Department of Public Welfare (DPW) is responsible for the coordination of mental health services in the event of an emergency.

## SITUATION AND ASSUMPTIONS

Influenza usually comes on suddenly, starting with a sore throat, fever, headache and profound fatigue, followed by dry cough, body aches, prostration and possibly nausea/vomiting. There are three main types of influenza viruses: A, B and C.

Influenza pandemic is most likely when the Influenza Type A virus makes a dramatic change (i.e., antigenic "shift"). This shift results in a new or "novel" virus to which the general population has no immunity. The appearance of a novel virus is the first step toward a pandemic. A pandemic is defined as a disease affecting or attacking the population of an extensive region, country or continent.

The estimated morbidity and mortality during an influenza pandemic within 12-16 weeks, nationwide, and in Pennsylvania is as shown below:

	United States	Pennsylvania
Require Outpatient Care	50 million	1.6 million
Hospitalizations	2 million	37,800
Deaths	500,000	9,100

An influenza pandemic is inevitable and will probably give little warning. To some extent, everyone will be affected.

It will take six to eight months after the novel virus is identified and begins to spread among humans before a specific vaccine would likely be available for distribution.

The Department will depend on local, community, state and federal services to provide the public health response necessary for, and appropriate to, an influenza pandemic.

An influenza pandemic may exhaust the availability of assistance from the federal government as well as regional, state and local resources.

## INFLUENZA PANDEMIC RESPONSE ACTIONS

Influenza pandemic response activities are delineated by periods within the following components: Pandemic Influenza Surveillance, Laboratory Diagnostics, Emergency Response, Community Disease Control and Prevention, Travel Management, Distribution of Vaccines and Antivirals, Clinical Guidelines, Public Health Communications and Workforce Support. For each component, the pandemic phases are categorized as Interpandemic Period, Pandemic Alert Period, Pandemic Period and Post-Pandemic Period.

<b>Interpandemic Period</b>	<b>Phase 1:</b> No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals.
	<b>Phase 2:</b> No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.
<b>Pandemic Alert Period</b>	<b>Phase 3:</b> Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.
	<b>Phase 4:</b> 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:</b> Larger cluster(s), but human-to-human spread still localized; virus increasingly better adapted to humans, but not yet fully transmissible.
<b>Pandemic Period and Next Wave(s)</b>	<b>Phase 6:</b> Increased and sustained transmission in general population.
<b>Post-Pandemic Period</b>	Return to interpandemic period and evaluation/assessment.

- As of November 2005, cases of human H5N1 infection have been reported in Thailand, Vietnam, Cambodia, Indonesia and China.
- Reported death rate is 50%.
- Most cases occurred from direct contact with infected poultry or contaminated surfaces.
- Few instances where secondary transmission from person to person may have occurred.
- Given these events, the U.S. is currently in a Pandemic Alert Phase 3, as defined by World Health Organization (WHO) as "human infections with a new subtype but no human-to-human spread or at most rare instances of spread to a close contact." There have been no H5N1 cases identified in the U.S.
- Sustained human-to-human transmission anywhere in the world will be a triggering event to initiate a pandemic response by the U.S.



## PANDEMIC INFLUENZA SURVEILLANCE

The goals of influenza surveillance are to detect the earliest appearance of a novel influenza virus and to describe the epidemiological features of the new virus circulating in Pennsylvania.

The Bureau of Epidemiology (BOE) currently reviews a number of surveillance activities, with four main sources of information that are used for influenza surveillance:

- Influenza Sentinel Provider Surveillance Data - Outpatient influenza-like-illness (ILI) reports are collected through the US Influenza Sentinel Provider Surveillance Network (ISPN). Pennsylvania participates in the ISPN program. Approximately 60 enrolled providers regularly report the total number of patients seen and the number of those patients with ILI by age group on a weekly basis. The minimum goal for each state is one provider for every 250,000 residents.
- Influenza Reports to PA-NEDSS - The Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) receives reports of laboratory tests positive for influenza from laboratories, hospitals and physicians throughout the state. The PA-NEDSS database is scanned on a weekly basis for influenza test results and creates a report that plots trends in influenza incidence, gives breakdowns by geographic area and influenza type (A or B) and identifies deaths due to influenza by age, etc.
- RODS Data - BOE uses the Real-time Outbreak and Disease Surveillance System (RODS) as its primary syndromic surveillance system. The RODS system collects emergency department registration data in real time from participating hospitals in the Commonwealth. RODS also collects point-of-sale data for over-the-counter medications from pharmacies and grocery stores, representing about 70% of market share in Pennsylvania.
- Reports of Influenza Outbreaks - BOE receives reports of outbreaks of influenza from institutions and other sources. The information is reported to public health field staff.

## LABORATORY DIAGNOSTICS

The Department's Bureau of Laboratories (BOL) provides the framework, methodology and recommendations for actions at the Public Health laboratory testing level. The BOL is responsible for accurate and timely testing of clinical specimens for the detection of influenza. The BOL maintains local emergency response plans to assure operational integrity by addressing:

- Increased workload for individual staff during an emergency response;
- Reduced staffing resulting from effects of the emergency situation; and
- Cross training and redirection from routine responsibilities.

## **EMERGENCY RESPONSE**

An influenza pandemic will pose unique challenges:

- Medical services and health care workers will be overwhelmed.
- Health care workers may not be able to provide essential care to all patients in need.
- First responders, such as health care personnel, police, firefighters and emergency medical technicians may be more impacted by influenza than the general public.
- Community services will be impacted due to widespread absenteeism in the workforce.
- Food distribution, home meal deliveries, childcare services, garbage collection and other critical services will be affected or unavailable.

To overcome these challenges, the following activities will be conducted:

- Assessing and reviewing capacity plans and working with acute and long-term health care facilities to prepare for an increase in the patient capacity resulting from influenza stricken individuals.
- Providing technical assistance on maintaining current plans for care of mass casualties.
- Providing guidance and review emergency preparedness response plans to integrate and maintain critical business functions in the event of a pandemic.
- Reviewing pandemic plans by hospitals and nursing care facilities to ensure that they meet the needs of a pandemic.
- Developing emergency response plans with adjoining states for collaboration of public services, health care personnel and security services.

## **COMMUNITY DISEASE CONTROL AND PREVENTION**

The Department provides recommendations for state and local partners on the use of disease containment strategies to prevent or decrease transmission during different pandemic phases. Some of those strategies include:

- Reviewing statutory powers and developing legal documents to carry out isolation and quarantine procedures.
- Discussing with partners how to address issues of children and other family members of the case or contact who were left without caregivers available to take care of the family members in case of the need for isolation or quarantine of a sole caregiver.
- Discussing with partners methods of transportation to the quarantine/isolation facilities for cases and contacts if isolation and quarantine become necessary.
- Ensuring actions are coordinated between state and local health jurisdictions.
- Issuing orders and recommendations, when necessary, that persons remain in their homes and/or take precautionary measures detailed by the Department to prevent and control the spread of influenza.

- Reviewing and identifying types of alternative facilities available for quarantine and isolation.
- Monitoring influenza cases and contacts to determine the need for quarantine and isolation.
- Consulting with the Centers for Disease Control and Prevention (CDC) and local health jurisdictions to determine whether to institute quarantine and isolation procedures of contacts and cases.
- Ordering isolation of the case or quarantine of the contacts, when necessary.
- Planning should include mechanisms for communication, access to food and supplies, medication, prevent termination of utility services, other basic supplies and availability of mental health/psychological support services if quarantine or isolation of a person or group of persons in their homes is necessary.

## **TRAVEL MANAGEMENT**

The Department provides recommendations for state and local partners on travel-related containment strategies that can be used during different phases of an influenza pandemic. These strategies include:

- Improving readiness to implement travel-related disease containment measures.
- Providing public health information to travelers who visit areas where non-human influenza strains are prevalent that can infect humans or human strains with pandemic potential have been reported.
- Evaluating and managing ill arriving passengers who might be infected with influenza strains or human strains with pandemic potential.
- Minimizing travel-related disease transmission using a range of isolation and containment strategies.
- Evaluating the need to implement or terminate travel-related isolation and containment measures as the pandemic evolves.

## **DISTRIBUTION OF VACCINES AND ANTIVIRALS**

Vaccines - Influenza vaccine and influenza vaccinations have long been considered the foundation for influenza prevention and control. It takes six to nine months to manufacture an influenza vaccine. This will necessitate the use of other methods of illness prevention in the interim from disease outbreak until vaccine is available.

Antivirals - There are several antiviral agents currently available for prophylaxis or treatment of Influenza Type A. Currently, national experts are assessing the use of antivirals during an influenza pandemic.

The following activities to distribute vaccines and/or antivirals include, but are not limited to:

- Prioritizing the use of vaccines and antivirals.
- Calculating potential vaccine and antiviral needs based on priority listing.
- Maintaining a database of influenza vaccine and antiviral sites within local communities.
- Establishing backup refrigerated storage facilities for large inventory of vaccines and adequate storage facilities for antivirals.
- Monitoring vaccine development and potential mode of distribution.
- Establishing partnerships with statewide organizations.
- Maintaining community volunteer lists to identify medical professionals in communities for staffing mass vaccination sites.
- Monitoring and investigating adverse events and vaccine coverage rates.
- Preparing protocols for increased workloads and personnel.
- Identifying specific community locations, services and individuals to utilize for emergency clinics and vaccinations sites.
- Keeping the health care and public workforce informed on projected timelines for availability of vaccines.
- Reviewing modifications, if any, to recommendations on vaccinating priority groups.
- Reviewing modifications, if any, to interim recommendations on antiviral prophylaxis in selected groups or circumstances.

## **CLINICAL GUIDELINES**

The Department provides clinical procedures for the initial screening, assessment and management of patients with suspected novel influenza during the Interpandemic, Pandemic Alert and Pandemic Periods. Those activities include:

- Educating local health care providers about novel and pandemic influenza.
- Providing or facilitating testing and investigation of suspected influenza cases.
- Conducting follow-up of suspected novel influenza cases.
- Updating providers regularly as the influenza pandemic unfolds.
- Providing or facilitating testing and investigation of pandemic influenza cases.
- Working with the CDC to investigate and report special pandemic situations.

## **PUBLIC HEALTH COMMUNICATIONS**

During an emergency situation, accurate, consistent and timely messages are key to notifying, informing and educating the public; to notifying and facilitating the movement of emergency staff to their assigned duties and stations; and to implementing the IPRP as intended. Some of the key actions include:

- Designating, training and exercising Public Information Officer (PIO) support staff in local health jurisdictions.
- Designating an official spokesperson(s) to provide accurate and consistent news media updates for pandemic activities.
- Developing and disseminating clear, accurate and credible influenza, novel virus and other disease-related information.
- Providing credible continuing information, education and updates for providers, responders and the public.
- Following the CDC guidelines for public information.
- Providing key public information and messages in multi-lingual and accessible formats.
- Activating and assigning PIO support staff to respond to surge of public information needs.
- Coordinating and updating information with national, state and local partners, including the CDC, neighboring states, local health jurisdictions, city government, legislators, police, fire, emergency management, EMS and hospitals.

## **WORKFORCE SUPPORT**

The institutionalization of psychosocial support services will help workers manage emotional stress during the response to an influenza pandemic and resolve related personal, professional and family issues.

The goal of this program is to train staff and first responders on how to help victims of a disaster emergency, deal with the trauma directly associated with an emergency or disaster, provide immediate support and make appropriate referrals for continuing services.

The DPW is responsible for developing a mental health response to disaster and has been building capacity to respond to the psychosocial needs of those impacted by bioterrorism or other public health emergencies.



# INFLUENZA PANDEMIC RESPONSE PLAN

FRAMEWORK, METHODOLOGY, AND RECOMMENDATIONS FOR PANDEMIC PREPAREDNESS

## PENNSYLVANIA'S IPRP 2005

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## *Preface*

Pandemic is defined as a disease affecting or attacking the population of an extensive region, including several countries, and/or continent(s). It is further described as extensively epidemic. Before the advent of Severe Acute Respiratory Syndrome (SARS), influenza viruses were considered to be unique in their ability to cause sudden, pervasive illness in all age groups on a global scale. While the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) have not characterized SARS as a pandemic, its potential has been clearly established, adding a new dimension to the pandemic threat.

Three influenza "pandemics" occurred during the last century, one of which, the infamous "Spanish flu" of 1918, was responsible for more than 20 million deaths worldwide, including an estimated 450,000 in the United States. Many of those affected were healthy young adults. The development of vaccines, antiviral drugs and other medical advances has provided new tools in the fight against emerging diseases, but only provides limited impact. Existing influenza vaccine only protects against previously circulating strains of the disease. About six to nine months are required to develop a vaccine in response to a newly identified strain, a period during which the entire population is vulnerable. Experience with SARS (for which no effective treatment has been discovered) has reminded us of the speed at which disease can be spread throughout the world. It is generally acknowledged that production capacity for antiviral medications will not be adequate to meet worldwide demand. On the positive side, the available pneumococcal vaccine can reduce the incidence of some complications that can result from influenza.

The response to, and mitigation of, the health and social consequences of a pandemic will take place at both the state and local levels, with the Pennsylvania Department of Health (Department) assuming the lead for the public health response. The Influenza Pandemic Response Plan (IPRP) addresses the unique challenges that could rapidly unfold. The IPRP will be integrated into the Department's Emergency Preparedness and Response Plan. The IPRP details the phases of a pandemic; identifies the roles and responsibilities of key public health responders for the operational components to include surveillance; medical/emergency response; vaccine/pharmaceutical procurement, distribution and administration; and communications and education. It also identifies command and control, policy, legal authorities and organizational structures that facilitate pandemic response activities. The plan is based on the influenza model but could be adapted for use in response to other pandemic situations.

## *List of Attachments*

<u>Attachment A</u>	Department of Health's Organizational Chart
<u>Attachment B</u>	Statutory Authority
<u>Attachment C</u>	Pandemic Alert & Pandemic Period Flow Chart
<u>Attachment D</u>	Interim Guidance for the Implementation of CDC and OSHA Avian Influenza Public Health Recommendations (DRAFT)
<u>Attachment E</u>	Bureau of Epidemiology Response Tasks
<u>Attachment F</u>	Influenza Testing at the Bureau of Laboratories
<u>Attachment G</u>	Emergency Medical Services Emergency Response Plan
<u>Attachment H</u>	Points of Dispensing (POD) Template Plan
<u>Attachment I</u>	Emergency Medical Services Infection Control Guidelines
<u>Attachment J</u>	Command Center Organizational Chart
<u>Attachment K</u>	Notice to Assist Pennsylvania Hospitals to Accommodate Increased Inpatient Demands Related to Influenza 2004-05
<u>Attachment L</u>	Priority Vaccination Distribution
<u>Attachment M</u>	Priority Antiviral Distribution
<u>Attachment N</u>	Office of Communications - Chain of Command
<u>Attachment O</u>	Office of Communications – Communication Strategies

## *Abbreviations Used in This Document*

BCHS	Bureau of Community Health Systems
BOE	Bureau of Epidemiology
BOL	Bureau of Laboratories
CDC	Centers for Disease Control and Prevention
CENIC	Commonwealth Emergency Network Information Center
CISM	Critical Incident Stress Management
CMHD	County and Municipal Health Departments
CPPR	Counterterrorism Planning Preparedness and Response Act
DAAC/DNCF	Division of Acute and Ambulatory Care/Division of Nursing Care Facilities
DCORT	Disaster Crisis Outreach and Referral Teams
Department	Pennsylvania Department of Health
DPCL	Disease Prevention and Control Law
DPW	Department of Public Welfare
ED	Emergency Department
EMS	Emergency Medical Services
EpiX	Epidemic Information Exchange
EPRP	Emergency Preparedness and Response Plan
FEOC	Forward Emergency Operations Center
HRSA	Health Resources Services Administration
ICP	Infection Control Practitioner
ICS	Incident Command System

### *Abbreviations Used in This Document (cont'd)*

IDE	Infectious Disease Epidemiology
ILI	Influenza-Like Illness
IPRP	Influenza Pandemic Response Plan
ISPN	Influenza Sentinel Provider Surveillance Network
LMS	Learning Management System
NIMS	National Incident Management System
OMHSAS	Office of Mental Health and Substance Abuse Services
OTC	Over-the-Counter
PA HAN	Pennsylvania Health Alert Network
PA-NEDSS	Pennsylvania National Electronic Disease Surveillance System
PA SNS	Pennsylvania Strategic National Stockpile
PCR	Polymerase Chain Reaction
PEMA	Pennsylvania Emergency Management Agency
POD	Point of Dispensing
PPE	Personal Protective Equipment
ProMed	Program for Monitoring Diseases
RODS	Real-time Outbreak and Disease Surveillance System
SARS	Severe Acute Respiratory Syndrome
Secretary	Secretary of Health
SEOC	State Emergency Operations Center
SIIS	Statewide Immunization Information System
SNS	Strategic National Stockpile

### *Abbreviations Used in This Document (cont'd)*

UCS/ICS	Unified Command System/Incidence Command System
VAERS	Vaccine Adverse Events Reporting System
VFC	Vaccines For Children
VIS	Vaccine Information Statements
WHO	World Health Organization

DRAFT

## **I. PURPOSE**

- A. The purpose of Pennsylvania's Influenza Pandemic Response Plan (IPRP) is to provide a framework, methodology and recommendations for pandemic preparedness actions at the federal, state and local levels and is intended to provide pandemic disease prevention strategies.
- B. The IPRP uses the terms "Federal," "State" and "Local" as headings to distinguish between responsibilities carried out by various agencies during an influenza pandemic:
  - 1. Federal: Activities carried out by any federal government agency that possesses a role in the planning, response or recovery phases of an influenza pandemic.
  - 2. State: Activities carried out by the Pennsylvania Department of Health (hereinafter "the Department") during the phases of the influenza pandemic.
  - 3. Local: Activities carried out by local health jurisdictions during the phases of the influenza pandemic.
- C. For purposes of the IPRP, "local health jurisdiction" means the Department's six district Offices, the State Health Centers, and the six County and four Municipal Health Departments.

## **II. AUTHORITY AND RESPONSIBILITIES**

- A. The Governor is responsible for addressing threats to this Commonwealth and its citizens presented by disasters. Responsibilities and authority of the Governor include:
  - 1. Declaration of disaster emergency;
  - 2. Activation of disaster response;
  - 3. Suspension of certain regulatory statutes;
  - 4. Utilization and redirection of state and local government resources;
  - 5. Requisition or utilization of any public, quasi-public or private property, if necessary to cope with the disaster; and
  - 6. Direction and requirements for evacuations and access control to disaster areas.
- B. The Department (Attachment A) is responsible for the health of the Commonwealth's entire population. The Secretary of Health (hereinafter "Secretary") has the authority to determine and employ the most efficient and practical means necessary for the prevention and control of the spread of disease. (See 71 P.S. §§ 532(a) and 1403(a)). Responsibilities and authority for the Secretary include:

1. Coordinated activation of the response and recovery aspects of any and all applicable state, county and local response plans with the Pennsylvania Emergency Management Agency (hereinafter "PEMA"); and
  2. Authorization of the furnishing of aid and assistance as detailed in Attachment B.
- C. Authorities relevant to Emergency Medical Services (hereinafter "EMS") are detailed in the Department's Emergency Preparedness Response Plan.
- D. The Department of Public Welfare is responsible for the coordination of mental health services in the event of an emergency.
- E. Specific authorities in support of Commonwealth agencies, with a role in responding to an influenza pandemic, are provided in the Commonwealth Emergency Operations Plan.

### III. SITUATION AND ASSUMPTIONS

#### A. Background

1. Influenza, also known as "the flu," is a contagious disease that is caused by the influenza virus and most commonly attacks the respiratory tract in humans. The flu is not a cold. Flu usually comes on suddenly, starting with a sore throat, fever, headache, and profound fatigue, followed by dry cough, body aches, prostration, and possibly nausea/vomiting. There are three main types of influenza viruses: A, B, and C. Influenza Type C causes only mild disease and has not been associated with widespread outbreaks. Influenza Type A, however, causes epidemics yearly. Influenza Type B infrequently causes widespread flu epidemics.
2. Influenza pandemic is most likely when the Influenza Type A virus makes a dramatic change (i.e., antigenic "shift"). This shift results in a new or "novel" virus to which the general population has no immunity. The appearance of a novel virus is the first step toward a pandemic. Influenza Type B viruses do not undergo shift and do not cause influenza pandemics.

#### B. Situation

1. The estimated morbidity and mortality during an influenza pandemic within 12-16 weeks, nationwide, and in Pennsylvania is as shown below:

	United States	Pennsylvania
Require Outpatient Care	50 million	1.6 million
Hospitalizations	2 million	37,800
Deaths	500,000	9,100



2. To some extent, everyone will be affected by an influenza pandemic.
3. It will take six to eight months after the novel virus is identified and begins to spread among humans before a specific vaccine would likely be available for distribution.
4. The Department will depend on local, community, state, and federal services to provide the public health response necessary for, and appropriate response to, annual influenza epidemics.
5. Federal, state and local collaboration will be essential to appropriately respond to the next pandemic.
6. Regardless of the availability of a vaccine that protects against the influenza pandemic strain, pneumococcal vaccine will reduce the risk of complications that can result from influenza infections.

C. Assumptions

1. An influenza pandemic is inevitable and will probably give little warning. To some extent, everyone will be affected by a pandemic.
2. An influenza pandemic will cause simultaneous outbreaks across the United States limiting the ability to transfer assistance from one jurisdiction to another.
3. Effective preventive and therapeutic measures, including vaccines, antiviral agents and other antibiotics, will likely be in short supply or not available. Supplies that are available will most likely be managed by the state and distributed using the Pennsylvania SNS Implementation Plan.
4. Two doses of influenza vaccine, administered 30 days apart, may be needed to develop full immunity to the novel influenza virus.
5. The Department may need to identify funds to purchase the vaccine for Pennsylvania's citizens.
6. Widespread illness in communities may increase the likelihood of significant shortages of personnel who provide other essential community services.
7. An influenza pandemic may exhaust availability of assistance from the federal government.
8. The first wave of pandemic influenza will be followed by a second wave arriving three to nine months after the first wave.

#### IV. CONCEPT OF OPERATIONS

##### A. Command and Management

1. Command and Management functions are outlined in the Command Center Manual. The purpose of this Command Center Manual is to provide management guidance to users in order to establish, operate, and evaluate the Department's response to public health threats. The Command Center Manual is intended to be a companion to the Department's "all hazard" Disaster EPRP and all associated plans.
2. The Command Center serves as the most efficient and coordinated approach for the Department to coordinate with PEMA and public health entities on all health-related emergency preparedness, response and recovery activities.
3. Command and Control are based upon three guiding principles:
  - a. While PEMA coordinates the overall response, the Department has the lead role in ensuring the health of Commonwealth citizens during any emergency event.
  - b. When responding to a large event, using a focused organizational structure ensures that all issues are considered and addressed in proper perspective. The Secretary is responsible for the activities of the Department. The use of the National Incident Management System (NIMS) in areas such as the Unified Command System/Incidence Command System (UCS/ICS) to organize a large multi-faceted response ensures that all issues are addressed and appropriate actions are taken.
  - c. Communication and coordination are essential. Many of the activities accomplished by the Department are done in conjunction with county/municipal health departments, other state agencies, the federal government, private and public health organizations and professional associations.
4. The Command Center manual includes a basic plan, Command Center Position Checklists, and forms. It describes how strategic policy is determined and how it differs from emergency operations and coordination; three levels of activation of the Command Center; and infrastructure required to operate the Command Center.

##### B. Roles and Responsibilities

1. Federal:
  - a. Coordinate national influenza pandemic response planning.
  - b. Develop a national information database/exchange clearinghouse.

- c. Develop generic guidelines and information templates for modification and adaptation of pandemic response planning, as needed.

2. State:

- a. Maintain data management systems, such as the National Electronic Disease Surveillance System (NEDSS), the Real-time Outbreak and Disease Surveillance System (RODS) and the Statewide Immunization Information System (SIIS) to implement the IPRP.
- b. Incorporate the IPRP with the Commonwealth's and the Department's existing emergency response plans.
- c. Review and exercise the IPRP on an annual basis.
- d. Develop and maintain legal documents for volunteer resources, quarantine, etc.
- e. Coordinate agreements with the State Police.
- f. Develop a plan to close and reopen schools, businesses and other public places/events.
- g. Prepare to activate operations for a pandemic appropriate for the occurring infectious disease.

3. Local:

- a. Coordinate security provisions for vaccine, human resources and clinic locations.
- b. Identify local administrative and medical decision makers.
- c. Develop local preparedness plans that correspond to statewide plans.
- d. Identify local surveillance teams.
- e. Meet with local stakeholders and review major elements of local emergency response preparedness.
- f. Modify local Points of Dispensing (PODs) to account for updates on recommended target groups, projected vaccine supply and available human resources.
- g. Secure written agreements from hospitals, pharmacies and other identified community properties that will be utilized to establish storage, security and transport for bulk amounts of vaccines/antivirals.
- h. Elicit written commitments from agencies and institutions that will provide volunteers.
- i. Maintain a current plan for local surveillance, medical/emergency response, vaccine/ antiviral administration and communications.
- j. Develop a plan utilizing communication templates, in languages common for the area, to educate the public.
- k. Communicate with schools, businesses and other venue for potential closures.
- l. Develop collaborations with adjoining counties/districts/states.
- m. Conduct local and county exercises/drills annually for an emergency influenza pandemic response.

## V. INFLUENZA PANDEMIC RESPONSE ACTIONS

Influenza pandemic response activities are delineated by periods within the following components: **Pandemic Influenza Surveillance, Laboratory Diagnostics, Emergency Response, Community Disease Control and Prevention, Distribution of Vaccines and Antivirals, Public Health Communications and Workforce Support.** For each component, the pandemic phases are categorized as Interpandemic Period, Pandemic Alert Period, Pandemic Period and Post- Pandemic Period.

Interpandemic Period	<b>Phase 1:</b> 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 of human infection or disease is considered to be low.
	<b>Phase 2:</b> No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.
Pandemic Alert Period	<b>Phase 3:</b> Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.
	<b>Phase 4:</b> 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:</b> Larger cluster(s), but human-to-human spread still localized; virus increasingly better adapted to humans, but not yet fully transmissible.
Pandemic Period and Next wave(s)	<b>Phase 6:</b> Increased and sustained transmission in general population.
Post-Pandemic Period	Return to interpandemic period and evaluation/assessment.

If a novel influenza virus would be detected at any time in the United States and/or Pennsylvania, the Interpandemic and Alert Activities could be heightened to a Pandemic Response mode. Command and Management would be activated along with federal, state and local activities for surveillance, emergency response, vaccine/antiviral administration and communications.

## VI. PANDEMIC INFLUENZA SURVEILLANCE

- A. Influenza viruses have constantly changing antigenic properties. Surveillance for a pandemic must include both virologic surveillance, in which influenza viruses are isolated for antigenic and genetic analysis; and disease surveillance, in which the epidemiological features and clinical impact of new variants are assessed. The goals of influenza surveillance are to detect the earliest appearance of a novel influenza virus and to describe the epidemiological features of the new virus circulation in Pennsylvania.
- B. The Department, through its Bureau of Epidemiology (BOE), Bureau of Laboratories (BOL) and Community Health Systems (BCHS), will:  
(Attachment C)
1. Ascertain the possible existence of cases of an illness or health condition caused by epidemic or pandemic disease or novel and highly fatal infectious influenza virus that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability.
  2. Ensure that appropriate testing, and identification of, virus isolates are performed in a timely manner.
  3. Investigate all such cases for sources of infection and ensure that they are subject to proper control measures.
  4. Define the epidemiology of the disease or health condition.
  5. Identify exposed individuals and develop information relating to the source and spread of the disease or health condition.
- C. The BOE currently engages in a number of influenza surveillance activities. There are four main sources of information that are used for influenza surveillance:
1. Influenza Sentinel Provider Surveillance Data:  
Outpatient influenza-like-illness (ILI) are collected through the US Influenza Sentinel Provider Surveillance Network (ISPN), a collaborative effort between the Centers for Disease Control and Prevention (CDC), state and local health jurisdictions and health care providers. Pennsylvania participates in the ISPN program. The enrolled providers regularly report the total number of patients seen and the number of those patients with ILI by age group on a weekly basis from week 40 to week 20 of the following year (roughly from October to May). The minimum goal for each state is one provider for every 250,000 residents.
- BOE downloads data from the Influenza Sentinel Surveillance program on a weekly basis. These data are analyzed for provider participation and trends in the percentage of total visits attributed to ILI. This information, along with

information from PA-NEDSS, is put into a report, which is disseminated to front-line public health staff every week.

A BOE physician, after reviewing the week's influenza data from all sources, reports a weekly "flu code" to CDC. This flu code characterizes Pennsylvania's flu activity as no activity, sporadic, local, regional, or widespread.

2. Influenza Reports to PA-NEDSS:

PA-NEDSS receives reports of laboratory tests positive for influenza from laboratories (including BOL), hospitals, and physicians throughout the state. The PA-NEDSS database is scanned on a weekly basis for influenza test results and a report is created that plots trends in influenza incidence, gives breakdowns by geographic area and influenza type (A or B), and identifies deaths due to influenza by age, etc.

3. RODS Data:

BOE uses RODS as its primary syndromic surveillance system. The RODS system collects emergency department (ED) registration data (primarily chief complaint information) in real time from participating hospitals in the Commonwealth. RODS uses the chief complaint to categorize visits into syndromes such as *constitutional* and *gastrointestinal*. RODS also collects point-of-sale data for over-the-counter (OTC) medications from pharmacies and grocery stores, representing about 70% of market share in Pennsylvania. Medication sales are grouped according to product code into categories such as *cough/cold* and *antidiarrheal*. Results can be viewed by RODS users via a secure website 24/7/365. The website is updated every two minutes. Aberration detection algorithms are run on the emergency room data every four hours, and on the OTC data daily. If an unusual increase in any of the categories is noted, e-mail alerts are sent to selected public health staff.

4. Reports of Influenza Outbreaks:

BOE receives reports of outbreaks of influenza from institutions and other sources. A summary of the outbreak is prepared and emailed to other public health staff via the Early Notification group list. The number of outbreaks reported is considered in the determination of the weekly "flu code."

## INTERPANDEMIC PERIOD (PHASES 1 AND 2) – KEY ACTIONS

*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 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 of human disease.*



1. Federal:

- a. Coordinate national and international surveillance.
- b. The World Health Organization (WHO) and/or CDC will issue a Novel Alert when a new strain of influenza is detected in at least one human somewhere in the world, or a virus is transmitted from another species.
- c. Issue international travel alerts and advisories when/where a novel strain is identified.
- d. Coordinate national and international surveillance.

2. State:

- a. Maintain and expand routine sentinel surveillance system through the Influenza Sentinel Surveillance Network Coordinator from October to May:
  - (i) Monitor sentinel provider data weekly for completeness and/or errors.
  - (ii) Provide feedback and maintain contact with sentinel providers weekly to encourage reporting and follow-up on unusual reports.
  - (iii) Contribute to state pandemic planning issues and activities.
  - (iv) Maintain a strong working relationship with the PA BOL.
  - (v) Encourage sentinel providers to submit specimens for viral culture to the state laboratory.
  - (vi) Conduct a weekly assessment of overall influenza activity level in the state during the normal flu season and report the data to the CDC.
- b. Conduct passive surveillance of respiratory specimens sent to the BOL for viral isolation, identification of influenza, type and subtype.
- c. Conduct passive surveillance of influenza reports in PA-NEDSS to determine, reported weekly to CDC.
- d. Conduct syndromic surveillance for ILI using RODS and other early event detection system, including evaluation of point-of-sale data for OTC medications for cough/cold codes.
- e. Continue current epidemiological surveillance methods for outbreak investigation.
- f. Investigate deaths and severe illness (encephalopathy) in children less than 18 years of age.
- g. Investigate reports of influenza outbreaks in institutions.
- h. Distribute electronic information Health Alerts through the Pennsylvania Health Alert Network (PA HAN) to sentinel surveillance physicians, hospital emergency departments, infection control practitioners in hospitals, nursing homes, and other long term care facilities, District Offices, County/Municipal Health Departments (CMHDs), and identified central offices to heighten awareness of an unusual or new influenza strain that has been identified, in addition to continuous monitoring of routine influenza activity.
- i. If a novel virus alert occurs, the BOE will:
  - (i) Expand virologic and disease-based surveillance to year-round surveillance. This could be accomplished by:
    - (a) Asking all current sentinel providers to monitor ILI year-round.
    - (b) Asking a subset of current sentinel providers to monitor ILI year-round.
    - (c) Recruiting additional providers to monitor ILI year-round.



- (ii) Recommend viral testing and case investigation for ILI outside of "typical" influenza season.
  - (iii) Submit isolates to BOL for subtyping on cases of ILI that occur outside of the peak of ILI activity.
  - (iv) In some situations, if the novel influenza virus is a highly pathogenic avian strain, such as with the H5N1 influenza virus in Asia, local hospital laboratories should not attempt viral isolation because of the potential risk that the strain could spread. Specimens should be sent to the PA BOL where isolation and subtyping would be done under more stringent bio-containment conditions. Influenza infection can be diagnosed locally using antigen detection, immunofluorescence, or polymerase chain reaction (PCR). Guidance will be provided by CDC appropriate to each specific novel virus alert.
  - (v) Monitor ILI in persons traveling from geographic areas in which novel strains have been isolated.
  - (vi) Monitor ILI in poultry and swine workers.
  - (vii) Implement the PA Avian Influenza Poultry Work Protection Plan. (Attachment D)
  - (viii) Monitor ILI in military personnel at the various military bases in PA.
  - (ix) Monitor bulletins from CDC regarding virologic, epidemiologic and clinical findings associated with new variants isolated within or outside the United States.
  - (x) PA BOL will obtain appropriate reagents from CDC to detect and identify the novel strain.
  - (xi) Request submission of specimens from laboratory directors, Infection Control Practitioners (ICPs), physicians, emergency rooms, and urgent care centers for viral culture from patients presenting with ILI or unusually severe symptoms, especially those with a recent travel history to or from the region of novel virus circulation.
  - (xii) Evaluate personnel and other resources needed to complete mass disease investigations. (Attachment E)
2. Local: The Department's District Offices, State Health Centers and CMHDs will:
- a. Be alert for unusual communicable diseases reported in local communities and discuss these with the Division of Infectious Disease Epidemiology (IDE).
  - b. Investigate/report any communicable diseases suspicious for the novel influenza virus, place in PA-NEDSS and contact IDE. Be prepared to trace contacts, if necessary.
  - c. Identify and recruit sentinel surveillance physicians when requested.
  - d. Distribute specimen testing kits and instructions to participating sentinel surveillance physicians.
  - e. Be alert for unusual communicable diseases reported by PA HAN, PA-NEDSS, and conference calls.
  - f. Develop and/or review enhanced plans for local surveillance, control, and containment of a localized outbreak of a pandemic strain. (This includes planning for increased staff requirements for interview, cultures and contact tracing.)

- g. Identify key staff and ensure proficiency in disease investigation on an annual basis.
- h. Review annually and maintain schedules for disease investigation deployment.

## PANDEMIC ALERT PERIOD (PHASES 3, 4 AND 5) – KEY ACTIONS

*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.*

*Phase 5: Larger cluster(s), but human-to-human spread still localized; virus increasingly better adapted to humans, but not yet fully transmissible.*

### 1. Federal:

- a. Provide protocols for screening travelers arriving in the U.S.
- b. Share information from quarantine stations with state and local health jurisdictions.
- c. Investigate all early cases either originating in the U.S. or that are imported into the country.
- d. Increase laboratory testing of influenza by using rapid antigen detection tests for persons with compatible clinical syndromes, particularly among those who may have had recent exposure at the site of the outbreak.
- e. Provide guidelines to assist with triage of specimens for testing and for choosing which isolates to send to CDC.
- f. Monitor for potential antiviral resistance.

### 2. State: If the Department is notified by CDC of human infection, with or without human-to-human transmission, the Department will:

- a. Fully activate the Epidemiology Response Plan.
- b. Define a case definition specific to the jurisdictions and situations where cases are occurring and work with individual hospitals to report those cases.
- c. Recommend levels of infection control measures needed for hospitals directly impacted; facilitate testing by BOL or with local hospital laboratories for preliminary testing of suspicious disease specimens. Increase capacity at the state laboratory for specimens.
- d. Identify demographic characteristics of cases and prioritize disease investigation.
- e. Provide 24/7 consultations for epidemiological investigation of disease outbreaks to the areas most affected or in danger of large numbers of mortality.
- f. Activate current surveillance methods for influenza if outside of the regular influenza season:
  - (i) Virologic surveillance.
  - (ii) Disease-based surveillance.
  - (iii) Outbreak investigations.
  - (iv) Case investigations of pediatric deaths associated with influenza.

- g. ILI surveillance in hospital emergency room by utilizing RODS.
- h. If a novel virus is identified in a Pennsylvania resident, work with the local health jurisdiction to conduct an epidemiological investigation to determine possible sources of exposure.
- i. Perform active surveillance for ILI in travelers returning to Pennsylvania from areas where novel virus has been isolated or confirmed in humans and present with clinical illness possibly caused by influenza including pneumonia, acute respiratory distress syndrome, or other severe respiratory illness. Appropriate specimens should be collected to diagnose influenza infection.
- j. Perform active surveillance in conjunction with the Department of Defense for ILI in military personnel returning from areas where novel virus has been isolated or confirmed in humans.
- k. Monitor school absenteeism due to ILI with the Division of School Health, PA Department of Education and local health jurisdictions.
- l. In some situations, if the novel influenza virus is a highly pathogenic avian strain, such as with the H5N1 influenza virus in Asia, local hospital laboratories should not attempt viral isolation because of the potential risk that the strain could spread. Specimens should be sent to the PA BOL where isolation and subtyping would be done under more stringent biocontainment conditions. Influenza infection can be diagnosed locally using antigen detection, immunofluorescence, or PCR. Guidance will be provided by CDC appropriate to each specific novel virus alert.
- m. In collaboration with the CDC and other groups at the national level, consider special studies in concert with local public health officials and clinicians to:
  - (i) Document outbreaks of influenza in different population groups.
  - (ii) Determine age-specific attack rates, morbidity and mortality.
  - (iii) Describe unusual clinical syndromes (as well as risk factors for these syndromes and appropriate treatment).
  - (iv) Describe unusual pathologic features associated with fatal cases.

## PANDEMIC PERIOD (PHASE 6) – KEY ACTIONS

*Phase 6: Increased and sustained transmission in general population.*

- 1. Federal:
  - a. Implement all relevant elements of national pandemic plan, including coordination of response and implementation of specific interventions.
  - b. Assess and publicize the current and cumulative national impact.
  - c. Provide guidance to state and local authorities in all sectors on implementation and evaluation of proposed interventions.
  - d. Implement in full pandemic contingency plans.
  - e. If resources permit, collect available data on effectiveness and safety of clinical interventions and share these with states and local public health authorities.
  - f. Monitor and assess national impact (morbidity, mortality, workplace absenteeism, regions affected, risk groups affected, health-care worker availability, essential

worker availability, health-care supplies, bed occupancy/availability, admission pressures, use of alternative health facilities, mortuary capacity, etc.).

- g. Assess uptake and impact of: treatments and countermeasures, including vaccine/antiviral efficacy and safety and emergence of antiviral resistance, nonpharmaceutical interventions, etc.
- h. As disease activity intensifies and becomes more widespread, adjust surveillance (e.g., reduce virological surveillance, discontinue case management database) and adjust case definition to reflect increasing certainty of clinical diagnoses in absence of virological confirmation; switch to aggregate data collection on morbidity, mortality.
- i. Maintain sufficient virological surveillance to detect antigenic drift.
- j. Monitor geographical spread of disease from point(s) of introduction/first detection.
- k. Use enhanced surveillance and case management database to identify initial cases/contacts and track initial geographical spread.
- l. Monitor for possible changes in epidemiology, clinical presentation and virological features.

2. State:

- a. Fully activate the Epidemiology Response Plan.
- b. Define a case definition specific to the jurisdictions and situations where cases are occurring and work with individual hospitals to report those cases.
- c. Recommend levels of infection control measures needed for hospitals directly impacted; facilitate testing by BOL or with local hospital laboratories for preliminary testing of suspicious disease specimens; increase capacity at the state laboratory for specimens.
- e. Identify demographic characteristics and prioritize disease investigation.
- f. Positive cases will require community wide interventions. If an effective vaccine is available, this will become the Department's priority. The other specific interventions recommended, until vaccination is fully implemented, will be based upon the best epidemiology as it becomes available, but could include a range of interventions ranging from hand and respiratory hygiene to avoidance of all face-to-face contact, post-exposure prophylaxis for close contacts, including providing medications and medical care, home isolation and quarantine, including the provision of food, medicine, and Personal Protective Equipment (PPE) for non-hospital caregivers..
- g. Provide 24/7 consultations for epidemiological investigation of disease outbreaks to the areas most affected or in danger of large numbers of mortality.
- h. Current systems of ILI surveillance and lab testing will likely be overwhelmed.
- i. As disease activity intensifies and becomes more widespread, adjust surveillance (e.g., reduce virological surveillance, discontinue case management database) and adjust case definition to reflect increasing certainty of clinical diagnoses in absence of virological confirmation; switch to aggregate data collection on morbidity, mortality.

- j. If sentinel providers are unable to keep a record of the number of patients seen, have them estimate a level of ILI in their practice on a weekly basis (50-100 cases, 100-200 cases, etc.).
- k. Age-specific attack rates can be extrapolated from the types of providers submitting information (pediatric providers versus internal medicine providers, for example).
- l. The BOE will coordinate expanded targeted surveillance statewide; utilize RODS for syndromic surveillance and to identify areas with greatest activity.
- m. Virologic surveillance will be conducted in consultation with the BOE and the BOL.
- n. PA-NEDSS will be utilized with obtaining inpatient data to establish age-specific attack rate, morbidity and mortality.

## Second Wave

### 1. State:

- a. After the first pandemic wave ends, surveillance methods utilized during the phases before the pandemic wave can be reactivated:
  - Virologic surveillance.
  - Disease-based surveillance.
  - Outbreak investigations.
  - Case investigations of pediatric deaths associated with influenza.
  - Syndromic surveillance in hospital EDs.
- b. Maintaining this level of surveillance will help to determine the onset of a subsequent pandemic wave.
- c. Encourage sentinel providers to continue monitoring for ILI even if the first pandemic wave ends outside of normal influenza season.
- d. Continue to monitor ILI across the state through the Sentinel Surveillance Network.
- e. Prepare hospitals, providers and health departments for the possibility of a second wave.
- f. If a second pandemic wave occurs, the surveillance efforts will be focused on those activities listed under the "Pandemic Period" above.
- g. Continue communication with local emergency preparedness organizations regarding potential for a second wave, and to report resumption of local community disease outbreak activity.
- h. Communicate with the CDC and other professional organizations, as needed, to keep abreast of the potential second wave.

### 2. Local:

- a. Fully activate local Epidemiological Response Plan.
- b. Utilize the Infectious Disease Epidemiology Contact List.
- c. Increase case detection among persons who recently traveled to the outbreak area and present with clinical illness possibly caused by influenza, including pneumonia, acute respiratory distress syndrome, or other severe respiratory illness.



- d. Prioritize testing selected patients to determine geographic distribution as determined at the state/federal level.
- e. Prioritize communication and information to reach the greatest number of the medical community via PA HAN, PA-NEDSS and other resources.
- f. Issue guidance for self-quarantine and self-isolation policies to health care providers, using all available communication methods.
- g. Implement and enforce nonvoluntary quarantine and isolation if deemed necessary for the public good after consultation with the IDE and the Office of Legal Counsel.
- h. Maintain continuous communication with Departments' partners regarding resource needs, quarantine sites, alternative medical treatment locations, vaccination sites, and infection control guidance.
- i. Be prepared to support post-exposure prophylaxis for close contacts, including providing medications and medical care, home isolation and quarantine, including medicine and PPE for non-hospital caregivers.
- j. Activate the Epidemiological Response Plan for second wave pandemic.
- k. Prioritize testing of selected patients for second wave pandemic.
- l. Provide local guidance for self-quarantine and self-isolation policies to health care providers and the general public.

## POST-PANDEMIC PERIOD – KEY ACTIONS

*Return to interpandemic period and evaluation/assessment.*

1. Federal:
  - a. Coordinate national and international surveillance in preparation of second wave pandemic.
  - b. Assess the need to continue screening travelers arriving in the U.S.
  - c. Investigate all additional cases, either originating in the U.S. or that are imported into the country.
  - d. Continue the increased laboratory testing for influenza, including the use of rapid antigen detection tests, particularly for those who may have had recent exposure at the site of the outbreak.
  - e. Continue to provide guidelines to assist with triage of specimens for testing and for choosing which isolates to send to CDC.
  - f. Resume routine national and international surveillance when pandemic ends.
2. State
  - a. Return to routine influenza surveillance system outlined in the Interpandemic Period.
  - b. Review and analyze epidemiological data obtained during the influenza pandemic, including:
    - Age-specific mortality, morbidity and attack rates.
    - Vaccine efficacy.
    - Antiviral efficacy.
    - Community containment measures.

- c. Continue enhanced epidemiological investigation of disease outbreaks.
  - d. Continue providing technical assistance to local health jurisdictions.
  - e. Coordinate targeted and tailored surveillance, as needed, based upon the needs of the community.
  - f. Monitor international events and follow-up of information provided by the Epidemic Information Exchange (EpiX), Program for Monitoring Diseases (ProMed), and CDC.
  - g. Continue communication through the PA HAN and Epi-X with public and private health partners.
  - h. Maintain readiness of the Epidemiological Response Plan; reactivate when needed.
  - i. Communicate state and national disease information with local health jurisdictions and neighboring states.
  - j. Continue testing selected patients to determine geographic distribution of remaining disease.
  - k. Assess resources and re-stock supplies and equipment.
  - l. Continue epidemiological and laboratory surveillance on a routine basis when the pandemic has ended.
  - m. Monitor bulletins from the CDC and the WHO regarding virologic, epidemiological and clinical findings associated with new variants isolated within and outside of the United States on a routine basis.
  - n. Distribute electronic health information through the PA HAN regarding any new or unusual influenza strains.
  - o. Reinforce utilization of PA-NEDSS for disease reporting within the private medical community.
  - p. Maintain routine assessment for syndromic surveillance using RODS and/or the National Retail Data Monitor (if available).
  - q. Evaluate lessons learned worldwide, nationally, and in Pennsylvania.
  - r. Evaluate individual and economic costs of the pandemic.
  - s. Examine and revise emergency Epidemiological Response Plan as a result of lessons learned.
  - t. Resume routine surveillance and normal work schedule.
3. Local:
- a. Maintain continuous communication with local partners regarding resource needs, quarantine sites, alternative medical treatment locations, vaccination sites, and infection control guidance.
  - b. Resume local surveillance activities at the end of the pandemic.



## VII. LABORATORY DIAGNOSTICS

- A. The Department's BOL provides the framework, methodology and recommendations for actions at the Public Health laboratory testing level. The BOL is responsible for accurate and timely testing of clinical specimens for the detection of influenza, providing results to clients, and communicating with the CDC on matters of technical testing. (Attachment F)
- B. The BOL maintains local emergency response plans to assure operational integrity by addressing:
  - 1. Increased workload for individual staff during an emergency response;
  - 2. Reduced staffing resulting from effects of the emergency situation; and
  - 3. Cross training and redirection from routine responsibilities.
- C. The following position with the BOL will have key responsibilities throughout a Pandemic:
  - 1. Director, Bureau of Laboratories who will coordinate all phases of the laboratory response.
  - 2. Director, Division of Laboratory Improvement, who will be responsible for logistics, communications and the laboratory command center.
  - 3. Administrative Officer who will be responsible for facility management and procurement of testing supplies and reagents.
  - 4. Director, Division of Clinical Microbiology who will be responsible for the technical aspects of testing.
  - 5. Director, Division of Chemistry and Toxicology who will provide management oversight to any ongoing routine operations.
  - 6. BOL Employees who will perform duties as assigned.

### INTERPANDEMIC PERIOD (PHASES 1 AND 2) – KEY ACTIONS

*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 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 of human disease.*

- 1. State
  - a. Complete laboratory testing and report results on an annual basis.
  - b. Distribute specimen testing kits and instructions for data entry to participating sentinel surveillance physicians on an annual basis.
  - c. Monitor bulletins from the CDC, PA HAN, and the WHO regarding virologic, epidemiological and clinical findings associated with new variants isolated within and outside of the United States.

- d. Identify key staff and ensure proficiency in disease influenza testing on an annual basis.
  - e. Review process for obtaining new test reagents, validate methodology, and order additional supplies on an annual basis.
2. Local
- a. Recruit local sentinel surveillance providers on an annual basis.
  - b. Communicate with local sentinel surveillance providers for timely and regular reporting on a weekly basis.

## **PANDEMIC ALERT PERIOD (PHASES 3, 4 AND 5) – KEY ACTIONS**

*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.*

*Phase 5: Larger cluster(s), but human-to-human spread still localized; virus increasingly better adapted to humans, but not yet fully transmissible.*

- 1. State
  - a. Based on novel strain global activity, increase testing of selected patient test specimens to detect emergence of the novel strain of disease in Pennsylvania.
  - b. Obtain appropriate new test reagents and validate testing methodology when available.
  - c. Update staff about the new influenza strain or other newly identified pathogen and train additional staff for surge capacity in the event of a global pandemic.
  - d. In the event of an imminent disease in the United States/Pennsylvania, implement increased testing to detect emergence of the new strain in Pennsylvania.
  - e. Monitor international events and follow-up of information provided by EpiX, ProMed, and the CDC.
  - f. Increase, as needed, communication through the PA HAN with public and private health partners.
  - g. Review surge capacity plans and work with other health laboratories to prepare for an increase in their sick patient capacity resulting from influenza stricken individuals.
  - h. Maintain BOL staffing availability for the State Emergency Operations when needed.
  - i. Review the protocols of the BOL and Department Command Center on an annual basis.
  - j. Keep current emergency staffing lists and phone tree.
- 2. Local
  - a. Communicate with infection control practitioners in hospitals, nursing homes, and other long-term care facilities and provide guidance to facilitate testing by Bureau of Laboratories or, with local hospital laboratories, for preliminary testing of suspicious disease specimens.

- b. Review expansion plans for local surveillance of the emergence of a pandemic strain on an annual basis.

## **PANDEMIC PERIOD (PHASE 6) – KEY ACTIONS**

### *Phase 6: Increased and sustained transmission in general population.*

#### **1. State**

- a. Activate the BOL's Command Center.
- b. Increase laboratory testing of influenza by using rapid antigen detection tests, for persons with compatible clinical syndromes, particularly among those who may have had recent exposure at the site of the outbreak.
- c. Obtain updated guidelines to assist with triage of specimens for testing and for choosing which isolates to send to CDC.
- d. Communicate with the CDC and other professional organizations on a daily basis to keep abreast of the novel strain disease nuances
- e. Track international events and follow-up of information provided by EpiX, ProMed and the CDC.
- f. Continue the increased laboratory testing for influenza, including the use of rapid antigen detection tests, particularly for those who may have had recent exposure at the site of the outbreak.
- g. Continue providing technical assistance to local health jurisdictions.
- h. Monitor international events and follow-up of information provided by EpiX, ProMed, and CDC.
- i. Continue testing selected patients to determine geographic distribution of remaining disease.
- j. Assess resources and re-stock supplies and equipment.
- k. Communicate with the CDC and other professional organizations on a daily basis to keep abreast of the potential second wave.
- l. Prepare for resurgence.
- m. Address shortfalls in supplies and personnel
- n. De-activate BOL Command Center at Pandemic end.

#### **2. Local**

- a. Continue enhanced epidemiological investigation of disease outbreaks.

## **POST-PANDEMIC PERIOD – KEY ACTIONS**

#### **1. State**

- a. Continue laboratory surveillance on a routine basis when the pandemic has ended.
- b. Monitor bulletins from the CDC and the WHO regarding virologic, epidemiological and clinical findings associated with new variants isolated within and outside of the United States on a routine basis.
- c. Evaluate lessons learned worldwide, nationally, and in Pennsylvania.
- d. Evaluate individual and economic costs of the pandemic.

- e. Examine and revise emergency Epidemiological Response Plan as a result of lessons learned.
- f. Resume routine surveillance and normal work schedule.
- g. Evaluate effectiveness of plans.
- h. Modify BOL-IPRP and begin planning and training protocols for future pandemic response.

2. Local

- a. Attend a statewide meeting of stakeholders to discuss all the Pandemic actions and plans utilized during the Pandemic for their input of needed revisions.

## VIII. EMERGENCY RESPONSE

An influenza pandemic will pose unique challenges. These challenges include:

- Medical services and health care workers who will be overwhelmed.
- Health care workers may not be able to provide essential care to all patients in need.
- First responders, such as health care personnel, police, firefighters and emergency medical technicians, may be more impacted by influenza than the general public. (Attachment G)
- Community services will be impacted due to widespread absenteeism in the workforce.
- Food distribution, home meal deliveries, childcare services, garbage collection and other critical services will be affected or unavailable.

### INTERPANDEMIC PERIOD (PHASES 1 AND 2) – KEY ACTIONS

*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 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 of human disease.*

1. Federal:
  - a. Develop recommendation guidelines and information templates that can be adapted and used, as needed, at state and local levels.
  - b. Develop pandemic planning training modules and tabletop exercise templates for state and local use.
2. State:
  - a. Develop Emergency Response plans with adjoining states for collaboration of public services, health care personnel, and security services. Meet with key state planners to review and revise, at a minimum, on an annual basis.
  - b. Provide technical assistance to CMHDs on maintaining current plans for care of mass casualties.
  - c. Provide guidance to CMHDs, community emergency response organizations and health care providers to sustain critical business and health care functions during a pandemic.
  - d. Work with acute and long-term care facilities to review their infection control, surveillance and influenza pandemic response strategies during annual facility contacts.
  - e. Maintain the 24/7 electronic Learning Management System (LMS) for training, education, announcements and conferencing with public and private health care providers across the Commonwealth, to ensure information provided is the most up-to-date version.

- f. Provide guidance and training to CMHDs and community health care providers for influenza pandemic response preparations for special health care needs groups, culturally diverse groups, non-English-speaking groups, poor and minority populations, and senior citizens confined to their homes.
  - g. Develop language for a Governor's Declaration of Emergency, permitting temporary exceptions to EMS regulations and protocols.
  - h. Review capacity plans and work with actual health care facilities to prepare for an increase in the sick patient capacity resulting from influenza stricken individuals.
  - m. During Department's state licensing inspections of health care facilities, verify that each health care facility has a public health preparedness plan for "all hazards" including pandemic influenza, and verify that the health care facility participates in community or regional public health planning exercises.
  - n. Maintain the Facility Resource Emergency Database to monitor surge capacity for bed availability, ventilators and other equipment.
  - k. Establish ongoing communications with PEMA for notification of a novel influenza virus.
  - o. Maintain Department staffing availability for the State Emergency Operations Center (SEOC), when needed.
  - p. Review the protocols and test the activation of the Department Command Center on an annual basis.
  - q. Provide Regional EMS Councils with current information about an impending pandemic.
3. Local:
- a. Develop and coordinate emergency response plans with adjoining counties.
  - b. Review existing jurisdictional response linkages to prepare deployment of community groups and services to respond to a mass disease outbreak on an annual basis. If needed, reestablish linkages.
  - c. Provide education and training to community emergency response groups for response to a mass disease outbreak on an annual basis.
  - d. Identify specific community locations, services, and individuals to utilize for emergency response to an influenza pandemic. Review and update annually. (Attachment H)
  - e. Develop emergency staffing lists and update on a quarterly basis.
  - f. Provide up-to-date information for staff answering the toll-free health line.
  - g. Provide current disease outbreak education and training to local public health professionals, infectious disease specialists, emergency department personnel, and other health care providers.
  - h. Provide updated infection control materials to EMS practitioners. Review and update on an annual basis. (Attachment I)
  - i. Provide guidance to ambulance services regarding alternative work schedules and surge capacity.

#### **PANDEMIC ALERT PERIOD (PHASES 3, 4 AND 5) – KEY ACTIONS**



*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.*

*Phase 5: Larger cluster(s), but human-to-human spread still localized; virus increasingly better adapted to humans, but not yet fully transmissible.*

1. State:

- a. Provide current CDC-produced novel disease education and training to public health professionals, infectious disease specialists, emergency department personnel, and other health care providers for response to a pandemic disease outbreak in their jurisdictions.
- b. Update emergency staffing protocols.
- c. Activate the PA SNS Implementation Plan
- d. Prepare directions/standing orders for pandemic response actions based on CDC recommendations.
- e. Provide education and training to community emergency response groups for mass disease outbreak response using LMS. LMS has 24/7 access for courses, resources, announcements, conferencing, and can target special groups for specific training.
- f. Coordinate with the Offices of Communications and EMS, the BOE, BCHS, and the Bureau of Communicable Disease to research, design, produce, and distribute public education materials.
- g. Notify essential personnel, via Virtual Alert, that the Department's Command Center may be activated if the novel disease outbreak enters Pennsylvania. (Attachment J)
- h. Assess the framework and preparedness of Division of Acute and Ambulatory Care/Division of Nursing Care Facilities (DAAC/DNCF) to respond to regulatory issues presented by influenza pandemic, by determining how to interpret or impose regulations during a pandemic and permit facilities to respond to extraordinary conditions while protecting patient health and safety.
- i. Review emergency preparedness response plan to integrate and maintain critical business functions in the event of a pandemic.
- j. Assess acute care facilities' ability to expand their sick patient capacity and to provide appropriate medical care for influenza stricken individuals.
- k. Review pandemic plans by hospitals and nursing care facilities to ensure that they meet the needs of a pandemic and report results of this review in accordance with the Bureau of Facility Licensure and Certification requirements. (Attachment K)
- l. Support effective implementation of disease and syndromic surveillance in hospitals and nursing care facilities through ongoing efforts to inform facilities of the implementation of the system and encourage participation. Participation will also be assessed during routine survey activities.

- m. Calculate distribution percentage of vaccine or anti-viral medications needed by the District Offices and CMHDs in anticipation of limited supplies during a pandemic (based on population weighted by high-risk factors).
  - n. Compile a current, unduplicated list of providers using information from managed care organizations to facilitate information dissemination and to serve as a provider contact list. This information will be forwarded to the BOE for inclusion in the PA HAN.
2. Local:
- a. Review the District Offices' and CMHDs' existing jurisdictional response linkages and reestablish linkages, if needed, to prepare deployment of community groups, services, actions for a mass disease outbreak, and vaccination/pharmaceutical administration delivery program.
  - b. Identify (designated District Office and CMHD staff) specific community locations, services, and individuals to utilize for emergency clinics, vaccination sites, and shelters for disease contacts in accordance with the PA SNS Implementation Plan. Distribute copies of the PA SNS Implementation Plan as needed.
  - c. Ensure that staff answering the toll-free health line has current information.
  - d. Alert hospitals and nursing care facilities to review their infection control, surveillance and emergency preparedness functions during regular facility contacts, Plans of Correction and Event Reporting System messages, and written, email, and faxed communications.
  - e. Support effective implementation of disease and syndromic surveillance in hospitals and nursing care facilities through ongoing efforts to inform facilities of the implementation of the system and encourage participation. Participation will also be assessed during routine survey activities.

## PANDEMIC PERIOD (PHASE 6) – KEY ACTIONS

*Phase 6: Increased and sustained transmission in general population.*

- 1. Federal:
  - a. Activate the Federal Emergency Management Agency.
- 2. State:
  - a. Activate the Department's Command Center.
  - b. Activate the Department's Emergency Preparedness Liaison Team at SEOC, Forward EOC, or any other identified location established for emergency operations.
  - c. Reinforce quarantine and isolation policies to health care providers.
  - d. Direct the Regional EMS Council to implement their Catastrophic Casualty Plans.
  - e. Coordinate availability of EMS services and practitioners to provide emergency response.
  - f. Issue guidance on quarantine and isolation policies as it impacts delivery of EMS.

- g. Request PEMA to activate a Governor's Declaration of Emergency permitting exceptions to EMS Regulations/Protocols to allow EMS providers to assist in vaccination of the general public, if requested, and if they can be diverted from other EMS duties/responsibilities.
  - h. Review the framework and preparedness of regulatory issues to respond to a pandemic while protecting patient health and safety.
3. Local:
- a. Activate partnerships with community resources regarding quarantine sites, alternative medical treatment locations, PODs, and infection control guidance.
  - b. Notify regional EMS Councils regarding infection control precautions specific to the outbreak for EMS practitioners, their vehicles, and equipment.
  - c. Coordinate mutual aid with surrounding jurisdictions using existing system protocols.

## **POST-PANDEMIC PERIOD – KEY ACTIONS**

### *Return to interpandemic period and evaluation/assessment*

1. State:
- a. Prepare for resurgence.
  - b. Address shortfalls in supplies and personnel.
  - c. Restore essential functions and return to the Influenza Pandemic Response phase.
  - d. Evaluate effectiveness of the implemented plans and revise, as needed, as a result of lessons learned and stakeholder suggestions.
  - e. Adjust protocols and response plans in anticipation of second wave.
  - f. Support restocking ambulances through Regional EMS Councils with medications, supplies, and equipment as funding becomes available.
  - g. Communicate with Regional EMS Councils regarding planning for possible second wave.
  - h. Coordinate potential mutual aid with adjoining state EMS systems, in-state jurisdictions, and 911 centers.
  - i. Coordinate with PEMA to ready the Regional Incident Support Teams, if required, during second wave.
  - j. Conduct a statewide meeting of stakeholders to discuss all the pandemic actions and plans utilized during the outbreak for their input of needed revisions.
  - k. Evaluate all emergency response plans utilized during the pandemic.
  - l. Modify IPRP and begin planning and training protocols for future pandemic response.
  - m. Determine social and economic costs of the outbreak.
  - n. De-activate Department Command Center.
2. Local:
- a. Collect outbreak-associated costs of staff and supplies.
  - b. Reinforce the need for EMS workers to continue adherence to enhanced infection control measures.
  - c. Resume routine medical and response activities.

### *Health Care Planning*

The Department will provide guidance to health care partners for developing plans to respond to an influenza pandemic.

**A DETAILED PLAN IS CURRENTLY UNDER DEVELOPMENT**

DRAFT

## IX. COMMUNITY DISEASE CONTROL AND PREVENTION

### *Isolation and Quarantine/Community Containment*

#### INTERPANDEMIC PERIOD (PHASES 1 AND 2) – KEY ACTIONS

*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 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 of human disease.*

##### 1. State

- a. Review statutory powers for isolation and quarantine measures.
- b. Develop legal documents to carry out isolation and quarantine procedures.
- c. Discuss with partners how to address issues of children or other family members of the case or contact left without caregivers available to take care of the family members in case of the need for isolation or quarantine of a sole caregiver.
- d. Discuss with partners methods of transportation to the quarantine/isolation facilities for cases and contacts if isolation and quarantine become necessary.
- e. Consult with local health jurisdictions regarding isolation and quarantine measures to ensure coordination of actions.

#### PANDEMIC ALERT PERIOD (PHASES 3, 4 AND 5) – KEY ACTIONS

*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.*

*Phase 5: Larger cluster(s), but human-to-human spread still localized; virus increasingly better adapted to humans, but not yet fully transmissible.*

##### 1. State

- a. Review types of alternative facilities available for quarantine and isolation, taking into consideration the following requirements:
  - (i) Separate rooms for cases.
  - (ii) Independent ventilation for each room.
  - (iii) Access control to each room.
  - (iv) Availability of potable water, bathroom and shower facilities.
  - (v) Capacity for providing basic needs to patients.
  - (vi) Rooms and corridors easily disinfected.

- (vii) Facilities for collecting and disposing of waste materials.
- (viii) Facilities for collecting and laundering items.
- (ix) Ease of access for deliver of supplies.
- (x) Legal/property considerations.
- (xi) Ability to support appropriate infection control measures.
- (xii) Availability of food services and supplies.
- (xii) Ability to provide an environment that supports the social and psychological well-being of patients.
- (xiii) Ability to support appropriate medical care.
- (xiv) Access to communication systems that allow for dependable communication within and outside the facility (telephone).
- b. Manage cases and contacts through either active or passive monitoring and without any restriction of movement, unless they develop symptoms of disease. Consideration would be given to quarantine of contacts with high-risk exposures even in the absence of symptoms.
- c. Advise contacts of an influenza case to:
  - (i) Remain vigilant for fever or respiratory symptoms for 6 days after exposure. Temperature readings should be taken and recorded twice a day.
  - (ii) Seek health care if symptoms (cough, fever, shortness of breath) become severe.
  - (iii) Inform a health care provider in advance of going to a clinic or hospital that the contact has been exposed to influenza and is now symptomatic.
- d. For active monitoring, communicate with cases and contacts and make certain prescribed disease control measures are being followed.
- e. Quarantine may be used for persons in close contact with a case, or who are household members of a contact.
- f. Provide community information about influenza, its spread, and how to prevent transmission.
- g. Promote practices of "respiratory hygiene" as a means for the general public to protect itself.
- h. Issue an order that persons stay in their homes, or take certain sanitary precautions (through print and broadcast media).
- i. Consult with the CDC and local health jurisdictions and determine, based on the extent of the outbreak, the type of influenza, and the availability of resources, whether to institute quarantine and isolation procedures of contacts and cases.
- j. If the case is in the care of a provider, and the provider is able to take infectious disease precautions, remain in contact with the provider.
- k. Proceed under the Disease Prevention and Control Law (DPCL) to order isolation of the case or quarantine of the contacts.
- l. Petition a court for isolation or quarantine under the DPCL if the individual is noncompliant.
- m. Consult with the Governor and request that the Governor proceed under the Counterterrorism Planning, Preparedness and Response Act (CPPR) to immediately isolate the case and/or quarantine the contacts for a designated period.



- (i) If further isolation or quarantine is needed, to file a petition to extend the quarantine and/or isolation with a court within 24 hours or the next court business day
  - (ii) The court must hold a hearing on the petition not more than 72 hours after the filing of the petition to determine whether continued isolation or quarantine is necessary.
  - (iii) If the court determines further isolation or quarantine is warranted, the court shall order the isolation or quarantine and fix the time and duration, but in no event for more than 30 days.
  - (iv) After 30 days, petition the court to review the quarantine or isolation period to determine if further isolation or quarantine is warranted.
  - (v) Make reports to the court during the extended isolation or quarantine period.
- n. Consult with the Governor and request that the Governor isolate or quarantine a group of people if that is the recommended disease control measure.
- o. Quarantine or isolate a person or group of persons in their homes, if the situation warrants it, depending upon whether there were immunosuppressed persons also inhabiting the home, or whether monitoring in an alternate, non-hospital facility were necessary.
- (i) The home should be assessed to determine whether it has the features necessary for the provision of proper care and proper infection control measures. The primary caregiver, the case himself or herself, or a public health worker may conduct this assessment.
    - (a) A primary care giver, if available, to assist the patient with basic needs.
    - (b) For a case, there should be a separate bedroom that will be occupied only by the influenza case and with a door that can be kept closed at all times.
    - (c) For a case, should be a separate bathroom that is designated for use only by the influenza case.
    - (d) Access to educational materials about influenza and quarantine.
    - (e) Ability to monitor one's own symptoms, or have them monitored regularly by a parent, guardian or caregiver.
    - (f) Basic utilities (water, electricity, functional plumbing/septic system, garbage collection, and heating and air conditioning) as appropriate.
    - (g) Mechanisms for communication, including telephone (for monitoring by health staff, reporting symptoms, and accessing support services) and a computer if possible.
    - (h) Access to food and food preparation.
    - (i) Access to health care providers, health care centers, and ambulance personnel.
    - (j) Access to supplies such as thermometers, fever logs, phone numbers for reporting symptoms or accessing services, emergency numbers, etc.
    - (k) Availability of mental health/psychological support services.

- (ii) Relocate household members who are not providing care if possible.
  - (a) If relocation is not possible, there should be consideration given to relocating the case to another site within the community.
  - (b) If relocation is not possible, then interactions between the influenza case and the household members should be minimized. Persons at risk for serious influenza complications (underlying heart or lung disease, diabetes mellitus, the elderly) should have no contact with the case.
  - (c) All persons in contact with the influenza case should be educated regarding appropriate infection control practices, including hand hygiene and environmental decontamination. See <http://www.cdc.gov/handhygiene/> for more details.
  - (d) Influenza cases should wear a surgical mask during close contact (less than 3 feet) with uninfected persons to prevent the spread of infectious droplets. If an influenza case is unable to wear a surgical mask, then household members should don a surgical mask when interacting with the case.
- (iii) Monitor the person or group of persons in isolation or quarantine and make certain disease control measures prescribed by the Department were followed.
- (iv) Seek assistance from partners to ensure that the person or group of persons remain in isolation or quarantine.
- (v) Provide the disease control measures for the contacts in quarantine, including whether the quarantine should be a modified quarantine.
- p. Isolate and quarantine cases and contacts in alternative facilities in the community if there is a surge of influenza cases which overwhelms existing capacity to carry out home isolation, or if home isolation is not feasible for certain patients.
- q. Isolate and quarantine cases and contacts in health care facilities if recommended by CDC and if capacity allows.
- r. Follow CDC guidelines for isolation/quarantine in a facility:
  - (i) When possible, place patients with documented or suspected influenza in a private room.
  - (ii) When the number of patients with influenza exceeds the available private rooms, try to place influenza cases together in multi-bed rooms or wards.
  - (iii) When patients with and without influenza must be placed in a room together, try to avoid including uninfected patients most susceptible to influenza complications.
  - (iv) When multiple influenza cases are admitted, minimize the number of staff having contact with infected patients by assigning all influenza patients to a single or small group of health care personnel, who have been vaccinated and/or are taking antiviral medications for prophylaxis, if medications are available and appropriate.
  - (v) When numerous cases are identified, consider placing all patients with documented or suspected influenza in one designated unit or ward, i.e., an influenza cohort, and assign vaccinated health care personnel to work there.

2. Local

- a. Collaborate to monitor cases or contacts in each local health jurisdiction.
- b. Collaborate to move cases and contacts to quarantine and isolation facilities.
- c. Collaborate to identify alternative quarantine/isolation facilities within each jurisdiction.
- d. Provide assistance in isolating and quarantining cases and contacts within each jurisdiction.

**PANDEMIC PERIOD (PHASE 6) – KEY ACTIONS**

*Phase 6: Increased and sustained transmission in general population.*

1. State

- a. Consult with the CDC and local health jurisdictions and determine, based on the extent of the outbreak, the type of influenza, and the availability of resources, whether to institute quarantine and isolation procedures of contacts and cases.
- b. Issue an order that persons stay in their homes, or take certain sanitary precautions (through print and broadcast media).
- c. If the case is in the care of a provider, and the provider is able to take infectious disease precautions, remain in contact with the provider.
- d. Consult with the Governor and request that the Governor proceed under the Counterterrorism Planning, Preparedness and Response Act (CPPR) to immediately isolate the case and/or quarantine the contacts for a designated period.
  - (i) If further isolation or quarantine is needed, to file a petition to extend the quarantine and/or isolation with a court within 24 hours or the next court business day
  - (ii) The court must hold a hearing on the petition not more than 72 hours after the filing of the petition to determine whether continued isolation or quarantine is necessary.
  - (iii) If the court determines further isolation or quarantine is warranted, the court shall order the isolation or quarantine and fix the time and duration, but in no event for more than 30 days.
  - (iv) After 30 days, petition the court to review the quarantine or isolation period to determine if further isolation or quarantine is warranted.
  - (v) Make reports to the court during the extended isolation or quarantine period.
- e. Consult with the Governor and request that the Governor isolate or quarantine a group of people if that is the recommended disease control measure.
- f. Quarantine or isolate a person or group of persons in their homes, if the situation warrants it, depending upon whether there were immunosuppressed persons also inhabiting the home, or whether monitoring in an alternate, non-hospital facility were necessary.
  - (i) The home should be assessed to determine whether it has the features necessary for the provision of proper care and proper infection control measures. The primary caregiver, the case himself or herself, or a public health worker may conduct this assessment.
    - (a) A primary care giver, if available, to assist the patient with basic needs.

- (b) For a case, there should be a separate bedroom that will be occupied only by the influenza case and with a door that can be kept closed at all times.
- (c) For a case, should be a separate bathroom that is designated for use only by the influenza case.
- (d) Access to educational materials about influenza and quarantine.
- (e) Ability to monitor one's own symptoms, or have them monitored regularly by a parent, guardian or caregiver.
- (f) Basic utilities (water, electricity, functional plumbing/septic system, garbage collection, and heating and air conditioning) as appropriate.
- (g) Mechanisms for communication, including telephone (for monitoring by health staff, reporting symptoms, and accessing support services) and a computer if possible.
- (h) Access to food and food preparation.
- (i) Access to health care providers, health care centers, and ambulance personnel.
- (j) Access to supplies such as thermometers, fever logs, phone numbers for reporting symptoms or accessing services, emergency numbers, etc.
- (k) Availability of mental health/psychological support services.
  - (i) Relocate household members who are not providing care if possible.
    - (a) If relocation is not possible, there should be consideration given to relocating the case to another site within the community.
    - (b) If relocation is not possible, then interactions between the influenza case and the household members should be minimized. Persons at risk for serious influenza complications (underlying heart or lung disease, diabetes mellitus, the elderly) should have no contact with the case.
    - (c) All persons in contact with the influenza case should be educated regarding appropriate infection control practices, including hand hygiene and environmental decontamination. See <http://www.cdc.gov/handhygiene/> for more details.
    - (d) Influenza cases should wear a surgical mask during close contact (less than 3 feet) with uninfected persons to prevent the spread of infectious droplets. If an influenza case is unable to wear a surgical mask, then household members should don a surgical mask when interacting with the case.
  - (ii) Monitor the person or group of persons in isolation or quarantine and make certain disease control measures prescribed by the Department were followed.
  - (iii) Seek assistance from PEMA and other partners for security to ensure that the person or group of persons remain in isolation or quarantine.
  - (iv) Provide the disease control measures for the contacts in quarantine, including whether the quarantine should be a modified quarantine.

- g. Isolate and quarantine cases and contacts in alternative facilities in the community if there is a surge of influenza cases which overwhelms existing capacity to carry out home isolation, or if home isolation is not feasible for certain patients.
- h. Isolate and quarantine cases and contacts in health care facilities if recommended by CDC and if capacity allows.
- i. Follow CDC guidelines for isolation/quarantine in a facility:
  - (i) When possible, place patients with documented or suspected influenza in a private room.
  - (ii) When the number of patients with influenza exceeds the available private rooms, try to place influenza cases together in multi-bed rooms or wards.
  - (iii) When patients with and without influenza must be placed in a room together, try to avoid including uninfected patients most susceptible to influenza complications.
  - (iv) When multiple influenza cases are admitted, minimize the number of staff having contact with infected patients by assigning all influenza patients to a single or small group of health care personnel, who have been vaccinated and/or are taking antiviral medications for prophylaxis, if medications are available and appropriate.
  - (v) When numerous cases are identified, consider placing all patients with documented or suspected influenza in one designated unit or ward, i.e., an influenza cohort, and assign vaccinated health care personnel to work there.
- j. Consider quarantining asymptomatic contacts as a means of interrupting disease transmission.
- k. Consider quarantining persons who are household members of a contact.
- l. Recommend in conjunction with PEMA that the Governor take (with compensation) private, quasi public, and public property necessary to cope with the disaster emergency, for example, schools, hospitals, suitable for use as alternative sites.
- m. Recommend, in conjunction with PEMA that the Governor limit egress and ingress into the disaster emergency area.
- n. Recommend, in conjunction with PEMA, that the Governor restrict travel within the disaster emergency area.
- o. Suspend public gatherings.
- p. Monitor fever in public places.
- q. Cancel public events.
- r. Close non-essential government functions.
- s. Close public buildings and public spaces.

## 2. Local

- a. Collaborate to monitor cases or contacts in each local health jurisdiction.
- b. Collaborate to move cases and contacts to quarantine and isolation facilities.
- c. Collaborate to identify alternative quarantine/isolation facilities within each jurisdiction.
- d. Provide assistance in isolating and quarantining cases and contacts within each jurisdiction.

### *Travel Management*

The Department provides recommendations for state and local partners on travel-related containment strategies that can be used during different phases of an influenza pandemic. These strategies include:

- Improve readiness to implement travel-related disease containment measures.
- Provide public health information to travelers who visit counties where influenza strains can infect humans or human strains with pandemic potential have been reported.
- Evaluate and manage arriving ill passengers who might be infected with influenza strains or human strains with pandemic potential.
- Minimize travel-related disease transmission using a range of containment strategies.
- Evaluate the need to implement or terminate travel-related containment measures as the pandemic evolves.

**A DETAILED PLAN IS CURRENTLY UNDER DEVELOPMENT**



## **X. DISTRIBUTION OF VACCINES AND ANTIVIRALS**

### **A. Vaccines**

Influenza vaccine and influenza vaccinations have long been considered the foundation for influenza prevention and control. During a typical influenza season, vaccine strains are selected by early spring when licensed vaccine manufacturers in the United States begin the manufacturing process. However, it takes six to nine months to manufacture an influenza vaccine that will necessitate the use of other methods of illness prevention in the interim from disease outbreak until available vaccine.

### **B. Antivirals**

There are several antiviral agents currently available for prophylaxis or treatment of Influenza Type A. Currently, national experts are assessing the use of antivirals during an influenza pandemic.

## **INTERPANDEMIC PERIOD (PHASES 1 AND 2) – KEY ACTIONS**

*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 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 of human disease.*

### **1. Federal:**

- a. Monitor trends in occurrences and unexpected events from vaccinated populations.
- b. Evaluate scientific logic for vaccination and/or use of antivirals.
- c. Facilitate vaccine research and development.
- d. Assess and enhance vaccine and antiviral capacity.
- e. Devise a suitable liability program for vaccine manufacturers and persons administering the vaccine.
- f. Develop reference strains and reagents for vaccines.
- g. Work toward decreasing the time for vaccine and antiviral production and licensure.
- h. Evaluate vaccine and antiviral safety.
- i. Develop a national vaccine adverse events report system.
- j. Determine priority populations to receive vaccine and/or antivirals.
- k. Coordinate national vaccine and/or antiviral supplies.

### **2. State:**

- a. Provide doses of the influenza vaccine to public and private providers, including Vaccines For Children (VFC) providers for children and adults on a regular basis.
- b. Monitor and track vaccine usage, handling and storage on a regular basis.

- c. Monitor and track reported adverse events through the Vaccine Adverse Events Reporting System (VAERS).
  - d. Maintain a database of influenza sites within local communities.
  - e. Educate providers that the Vaccine Information Statements (VIS) must be provided with influenza and pneumococcal immunizations.
  - f. Promote influenza and pneumococcal immunizations on an annual basis.
  - g. Communicate and establish linkages with key individuals from the CDC and neighboring states to monitor available vaccine.
  - h. Establish backup refrigerated storage facility for large inventory of vaccines/antivirals.
  - i. Monitor vaccine development and potential mode of distribution.
  - j. Provide guidance for local health jurisdictions to have appropriate refrigeration storage.
  - k. Confirm consistency of local vaccination plans with the PA SNS Implementation Plan.
  - l. Establish partnerships with statewide organizations for collaborative responses during mass vaccination clinics.
  - m. Review the PA SNS Implementation Plan protocols for needed revisions on an annual basis.
  - n. Train Department staff on current vaccine/antiviral administration on an annual basis.
  - o. Update vaccine/antiviral distribution protocols according to the PA SNS Implementation Plan.
  - p. Calculate potential vaccine needs based on priority vaccine distribution. (Attachment L)
  - r. Calculate potential antiviral needs based on priority antiviral listing. (Attachment M)
  - r. Prioritize for use and procedure to access antivirals. (Attachment M)
3. Local:
- a. Promote influenza and pneumococcal immunizations according to state recommendations.
  - b. Provide annual influenza immunizations to persons within their jurisdiction.
  - c. Maintain community volunteer lists to identify medical professionals in communities for staffing mass vaccination sites. Partners to include Red Cross, school nurses and hospitals.

### **PANDEMIC ALERT PERIOD (PHASES 3, 4 AND 5) – KEY ACTIONS**

*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.*

*Phase 5: Larger cluster(s), but human-to-human spread still localized; virus increasingly better adapted to humans, but not yet fully transmissible.*

1. State:
  - a. Review and update the POD Plan on an annual basis. (Attachment H)
  - b. Train staff regarding the current VAERS, or a specific Pandemic VAERS, system on an annual basis.
2. Local:
  - a. Develop a communication diagram based on chain of command based on the Department's Incident Command Structure. (Attachment H)
  - b. Identify emergency response team members by position and contact information. Update on an annual basis.
  - c. Prepare protocols for increased workloads and/or personnel shortages and update annually.
  - d. Develop routine workplace strategies to continue routine work in the event staff is deployed for mass vaccination clinics.
  - e. Identify sites to reserve refrigeration space for reception of bulk vaccine/antiviral supplies.
  - f. Procure supplies and equipment for mass immunization/antiviral distribution clinics according to needs. (Attachment H)
  - g. Identify appropriate staff resources and logistics to be in place to begin vaccination. (Attachment H)
  - h. Identify specific community locations, services, and individuals to utilize for emergency clinics, vaccinations sites, and shelter for disease contacts.

## **PANDEMIC PERIOD (PHASE 6) – KEY ACTIONS**

### *Phase 6: Increased and sustained transmission in general population.*

1. Federal:
  - a. Provide recommendations for priority population vaccinations/treatment with available vaccines/antivirals.
  - b. Allocate available vaccines/antivirals nationally.
  - c. Provide protocols for administering an unlicensed vaccine.
  - d. Activate a national electronic vaccine tracking system.
  - e. Provide expert medical consultation regarding vaccine indications, contraindications and side effects.
  - f. Provide information to major national media systems.
  - g. Provide daily communications with states regarding vaccine supplies and availability.
2. State:
  - a. Activate the PA SNS Implementation Plan for receiving bulk supplies of vaccines/antivirals and for distribution for the mass vaccination clinics. (Attachment H)
  - b. Distribution of bulk amounts of vaccines/antivirals will be coordinated in conjunction with Tab H of PA SNS Implementation Plan.

- c. Implement Pennsylvania's POD Plan. (Attachment H)
  - d. Using SIIS, track and monitor inventory of vaccine and pharmaceuticals procured and distributed.
  - e. Monitor vaccine supply information and communicate with the CDC on a daily basis regarding disease trends and vaccine availability.
  - f. Establish, as needed, conference calls with internal and external partners, as well as bordering states, to discuss available supplies of vaccines/antivirals.
  - g. Activate VAERS through SIIS.
  - h. Provide standing orders for recommended vaccines/antivirals.
  - i. Activate the surge vaccines/antivirals storage site (if needed).
  - j. Activate the PA SNS Implementation Plan to access other federal supply resources to augment state supplies of vaccines/antivirals (if needed).
3. Local:
- a. Activate local partnerships for vaccination resources.
  - b. Provide "Just-in-time" onsite training and education for staff and volunteers to implement vaccine administration in mass vaccine clinics.
  - c. Activate plan for individuals who are contraindicated to receive vaccines/antivirals. (Attachment H)
  - d. Assign staff that has access to SIIS responsibility for tracking vaccine distribution, administration, inventory, adverse events and recall for a second dose.
  - e. Activate the PA SNS Implementation Plan, including distribution, administration, monitoring of vaccine distribution and administration, and tracking of dose, appropriate storage and handling, and safety monitoring. (Attachment H)
  - f. Coordinate security and transportation of staff, vaccines/antivirals and supplies.
  - g. Provide daily information to staff answering the toll-free health lines regarding available vaccines/antivirals and where clinics sites are located.
  - h. Activate local storage depots for vaccines/antivirals.
  - i. Conduct training for relevant agencies and partner groups regarding vaccine delivery protocols and procedures.
  - j. Coordinate vaccine administration activities with bordering jurisdictions.
  - k. Coordinate the vaccine distribution plan with bordering jurisdictions.

## POST-PANDEMIC PERIOD – KEY ACTIONS

### *Return to interpandemic period and evaluation/assessment*

- 1. Federal:
  - a. Monitor trends in occurrences and unexpected events from vaccinated populations.
  - b. Evaluate the results of vaccinations and/or antivirals.
  - c. Evaluate and report on the national cost and outcomes of the influenza pandemic.

2. State:

- a. Inventory vaccines/antivirals left from pandemic and request/order additional supplies to prepare for a Second Wave.
- b. Evaluate/modify POD protocols and procedures, as needed, to better facilitate Second Wave vaccinations.
- c. Review inventories of vaccines/antivirals distributed in response to pandemic influenza and prepare to redistribute to areas that experience a Second Wave resurgence of the disease.
- d. Review all VAERS reports and evaluate to determine any patterns of reactions specific to vaccine/antiviral lot numbers, populations, or geographic area.
- e. Continue to provide vaccines/antivirals to those groups still in need and provide routine influenza immunizations.
- f. Resume routine promotion of pneumococcal and influenza vaccine immunizations.
- g. Return to routine vaccine tracking and monitoring.
- h. Determine costs and geographical quantities of vaccines/antivirals distributed and administered.
- i. Evaluate community resources and recommend revisions for local emergency response plans from lessons learned.
- j. Determine social, economic, and professional staffing costs of the pandemic.

3. Local:

- a. Evaluate PODs and revise plans and protocols from lessons learned.
- b. Close PODs that were not sufficiently utilized and establish sites that better serve the population during the Second Wave.
- c. Inventory available professional and nonprofessional staff and develop schedules to work the Second Wave vaccination clinics.
- d. Re-establish routine influenza and pneumococcal vaccination activities.
- e. Work with local and community agencies to re-establish partnerships for emergency response.

### *Clinical Guidelines*

The Department provides clinical procedures for the initial screening, assessment and management of patients with suspected novel influenza during the Interpandemic and Pandemic Alert Periods and for patients with suspected pandemic influenza during the Pandemic Period. Those activities include:

- Educate local health care providers about novel and pandemic influenza.
- Provide or facilitate testing and investigation of suspected influenza cases.
- Conduct follow-up of suspected novel influenza cases.
- Update providers regularly as the influenza pandemic unfolds.
- Provide or facilitate testing and investigation of pandemic influenza cases.
- Work with the CDC to investigate and report special pandemic situations.

**A DETAILED PLAN IS CURRENTLY UNDER DEVELOPMENT**



## **XI. PUBLIC HEALTH COMMUNICATIONS**

During an emergency situation, accurate, consistent and timely messages are key to notify and educate the public, to notify and facilitate movement of emergency staff to their assigned duties and stations and in the implementation of the IPRP as intended.

### **INTERPANDEMIC PERIOD (PHASES 1 AND 2) – KEY ACTIONS**

*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 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 of human disease.*

1. Federal:
  - a. Provide information on seasonal influenza, new influenza virus subtypes and risk of new viruses to humans
2. State:
  - a. Maintain routine communication activities, news conferences, and public education campaigns regarding influenza and other health concerns.
  - b. Monitor information updates from WHO and CDC regarding influenza and new influenza subtypes.
  - c. Designate, train and exercise Public Information Officer support staff at District Offices and CMHDs. (Attachment N)
  - d. Conduct annual review of the Department Crisis Communication Plan, protocols, and resources and update as required.
3. Local:
  - a. Maintain routine communication activities and public outreach efforts regarding flu and other health concerns.
  - b. Conduct annual review of local crisis communication plans, protocols and resources and update as required.

### **PANDEMIC ALERT PERIOD (PHASES 3, 4 AND 5) – KEY ACTIONS**

*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.*

*Phase 5: Larger cluster(s), but human-to-human spread still localized, virus increasingly better adapted to humans, but not yet fully transmissible.*

1. Federal:
  - a. Provide information on novel diseases that could become a pandemic in the U.S.
  - b. Provide information on what is known and not known about a national outbreak and the public health response.
  - c. Assist with the coordination of messages among international, federal, state and local health officials about a pandemic and protective actions through CDC's Emergency Communication System.
2. State:
  - a. Designate an official spokesperson(s) to provide accurate and consistent news media updates for pandemic activities. (Attachment N)
  - b. Develop and disseminate clear, accurate and credible influenza, novel viruses and other disease-related information specifically for the general public, special populations and news media. (Attachment O)
  - c. BOE, BOL and BCHS will provide credible and continuing information, education and updates specifically for providers, responders and other stakeholders. (Attachment O)
  - d. Follow CDC guidelines for public information campaigns and effective media relations; modify as necessary for use in Pennsylvania.
  - e. Monitor information updates from the WHO and the CDC. Develop and/or adapt CDC-provided education materials specific to the influenza, novel viruses and other disease information for the public, special populations, news media, providers, responders and other stakeholders.
  - f. Provide key public information and messages regarding the novel virus and required public protective actions in multi-lingual and accessible formats.
  - g. Maintain regular communication and provide updates to Public Information Officer support staff.
  - h. Review Department Crisis Communication Plan. Brief Office of Communications and public information support staff on preparing for plan activation.
  - i. Review procedures for activating and utilizing the Commonwealth Emergency News and Information Center (CENIC) to provide statewide coordination and dissemination of public information. (Attachment O)
  - j. Prepare and implement letters of agreement with other Commonwealth agencies so that communications systems can be shared.
  - k. Collaborate with the Bureau of Information Technology to expand and post updated pandemic information on the Department website.
  - l. Provide training and informational resources to District Office hotline staff and CMHDs on pandemic communication procedures, handling high volume calls, scripted responses for answering pandemic-related public inquiries, FAQs and other relevant information.
  - m. Provide education and informational resources to 911 staff regarding Department pandemic procedures and other specifics related to influenza and novel viruses.
  - n. Address rumor control by establishing central sources of public information including: website, 1-877-PA-HEALTH, or special hotline. Prepare these resources for surge of public information requests.

- o. The Department will make available NIMS and ICS procedure education and training programs for providers, responders and other stakeholders.
3. Local:
- a. Identify specific communication channels and needs in the local area.
  - b. District Offices and CMHDs, in coordination with the Department, will assist in developing and disseminating clear, accurate and credible influenza, novel viruses and other disease-related information for the general public, special populations and news media in the local area.
  - c. District Offices and CMHDs, in coordination with the Department, will provide credible and continuing pandemic information and updates specifically for providers, responders and other stakeholders.
  - d. Review and exercise local crisis communication plans.

## **PANDEMIC PERIOD (PHASE 6) – KEY ACTIONS**

*Phase 6: Increased and sustained transmission in general population.*

- 1. Federal:
  - a. Provide information on national pandemic status and public protective actions.
  - b. Provide on-site public information and community outreach assistance at state or local government established Joint Information Center.
  - c. Assist with the coordination of messages among international, federal, state and local health officials about a pandemic and protective actions.
- 2. State:
  - a. Activate Department Crisis Communication Plan.
  - b. Develop and disseminate clear, accurate and credible influenza, novel viruses and other disease-related information specifically for the general public, special populations and news media. (Attachment O)
  - c. BOE, BOL and BCHS will provide credible and continuing information, education and updates specifically for providers, responders and other stakeholders. (Attachment O)
  - d. Activate the CENIC, if required. Mobilize personnel for the CENIC, as required. (Attachment O)
  - e. Activate and assign Public Information Officer support staff to respond to surge of public information needs at District Offices, vaccination clinics or other established sites, as required. (Attachment N)
  - f. Monitor information updates from the WHO and the CDC. Develop and/or adapt CDC-provided education materials specific to the influenza, novel viruses and other disease information for the public, special populations, news media, providers, responders and other stakeholders.
  - g. Provide emergency information and other relevant media materials in multi-lingual and other accessible formats for persons with special needs, as required.
  - h. Publicize special rumor control telephone number and web address for public, special populations, news media, providers, responders and stakeholders.

- i. Post regular pandemic updates on Department website and provide updated information to public inquiry hotline staff.
  - j. Coordinate and update information with national, state and local partners, including CDC, neighboring states, local health jurisdictions, city government, legislators, local police, fire, emergency management, EMS, and hospitals.
3. Local:
- a. Provide staff and resources to address a surge of local public information needs and news media inquiries during a pandemic.
  - b. Provide staffing and activate procedures to handle high volume of calls to 1-877-PA-HEALTH or special hotline regarding the pandemic.
  - c. Coordinate public information about the local status of an outbreak and protective actions with Department and local partners.
  - d. Assist state with dissemination of educational materials during an outbreak to the public, special populations, news media, providers, responders, and stakeholders.
  - e. Direct public, special populations, news media, providers, responders and stakeholders to established public information resources, such as the Department website or hotline.

## POST-PANDEMIC PERIOD – KEY ACTIONS

*Return to interpandemic period and evaluation/assessment.*

- 1. Federal:
  - a. Provide information on national pandemic status and recovery.
  - b. Assist with the coordination of messages among international, federal, state and local health officials about a pandemic and protective actions.
- 2. State:
  - a. Deactivate CENIC and Department Crisis Communication Plan.
  - b. Review public information staffing needs and communication procedures.
  - c. Deactivate public information support staff or reassign as required.
  - d. Develop and disseminate messages and information to the general public, special populations, news media, providers, responders, and other stakeholders on the status of the pandemic, recovery and the potential for a second wave.  
(Attachment O)
  - e. Coordinate public information and communication with national, state and local partners, including the CDC, local health jurisdictions, city government, legislators, local police, fire, emergency management, EMS, and hospitals.
  - f. Maintain a consistent source of public information and provide updates available on a centralized website and hotline.
  - g. Evaluate best practices and areas for improvement through after-action review of communication activities, media coverage and public perceptions.
  - h. Determine media costs as a result of the pandemic.

3. Local:

- a. Assist Department with developing and disseminating coordinated public information about the local status of the pandemic, recovery and protective actions for the public, special populations, news media, providers, responders and other stakeholders.
- b. Continue to direct public and providers to established public information resources, such as a website or hotline.
- c. Continue to provide staff and resources to address local public information needs during pandemic recovery.

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## XII. WORKFORCE SUPPORT

1. The Department, through its Office of Public Health Preparedness and Bureau of Drug and Alcohol Programs, has provided to the Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (DPW-OMHSAS), funds from the CDC and Health Resources Services Administration (HRSA) grant to help the Commonwealth build capacity to respond to the psychosocial consequences related to bioterrorism or other public health emergencies.
2. The OMHSAS in its responsibility to develop a mental health response to disaster utilizes the guidelines set by the Substance Abuse and Mental Health Services Administration publication, *Mental Health All-Hazards Disaster Planning Guidance*.
3. Since September 11, 2001, the OMHSAS has been building capacity to respond to the psychosocial needs of those impacted by bioterrorism or other public health emergencies by training people from a number of groups. Those groups include county mental health/mental retardation offices, state hospital staff, fire and police personnel, emergency room staff, emergency medical services staff, single county authority drug and alcohol abuse prevention and treatment staff, state police and others. This training provides Disaster Crisis Outreach and Referral Teams (DCORT) procedures and Critical Incident Stress Management (CISM) curricula. DCORT and CISM training, as well as Disaster Psychiatry training, are only a few of the OMHSAS initiatives funded by the CDC/HRSA grants.
4. The focus of this training and intervention is to train how to help victims, including first responders, deal with the trauma directly associated with an emergency or disaster by providing immediate support and making appropriate referrals for continuing services.
  - a. DCORT, formerly called Mental Health Response Teams, are trained to provide psychological first aid to persons affected by disaster, natural or manmade. DCORT is called out through a disaster incident command structure and may deal with persons affected by flood and fires or a criminal event. They are not necessarily at the site of a disaster but may be assigned to a location near a disaster site. As an example, DCORT may help persons who are arriving at Disaster Relief Centers to help people deal with stress.
  - b. CISM teams are generally peers, such as police or fire fighters, who help first responders deal with stress related to their jobs. As an example, a CISM team was dispatched to the site of a multi vehicle crash site to help ambulance and police personnel cope with the events. The OMHSAS has trained DCORT members and others in the emergency response community, in Critical Incident Stress Management. Those trained in CISM are certified and may volunteer to be part of the CISM team deployment that occurs through a



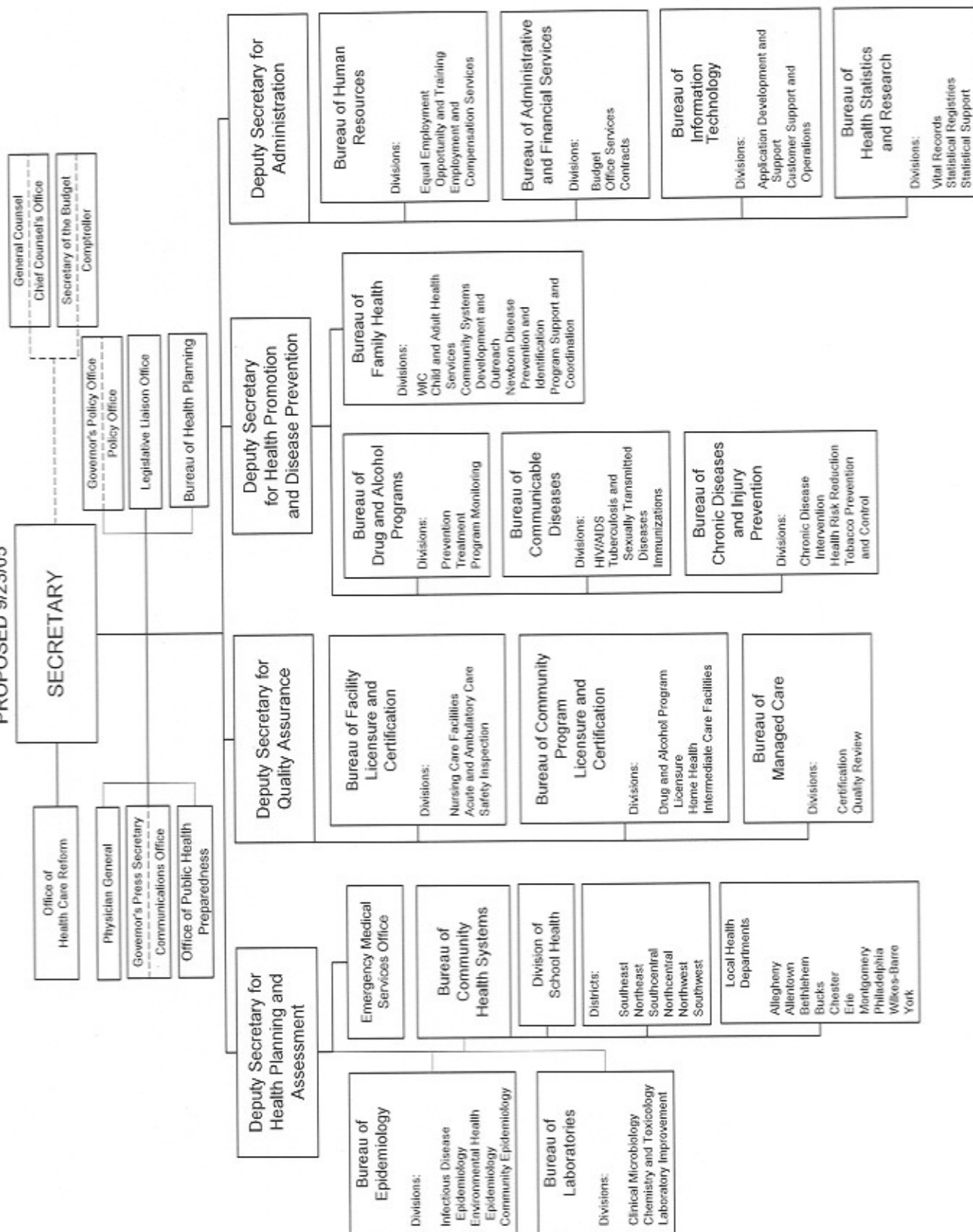
Memorandum of Understanding between Department of Health and the Pennsylvania Emergency Health Services Council, which maintains a database of CISM-trained volunteers.

- c. The OMHSAS continues to provide best practice disaster response training to Pennsylvania psychiatrists in order to build capacity to respond to those Pennsylvanians, including first responders and their families.
- d. The OMHSAS sponsors tabletop exercises to include partnering agencies that are working to enhance capacity to respond to psychosocial needs of Pennsylvanians, including first responders and others.

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ATTACHMENT A  
DEPARTMENT OF HEALTH'S ORGANIZATIONAL CHART

DEPARTMENT OF HEALTH  
PROPOSED 9/23/05



ATTACHMENT B  
STATUTORY AUTHORITY

# STATUTORY AUTHORITY

Statute	Regulations	Agency	Authority
Section 2106 of the Administrative Code of 1929 (71 P.S. §536)		DOH	<p>(a) With the approval and concurrence of the Advisory Health Board, to declare certain diseases to be communicable, in addition to those by law declared so to be, and to establish such regulations for the prevention of the spread of such disease as the Department and the Advisory Health Board shall deem necessary and appropriate.</p> <p>(b) To establish and enforce quarantines, in such manner, for such period, and with such powers, as may now or hereafter be provided by law, to prevent the spread of diseases declared by law or by the Department to be communicable diseases.</p> <p>(c) To administer and enforce the laws of this Commonwealth with regard to vaccination and other means of preventing the spread of communicable diseases.</p>
Section 2102 of the Administrative Code of 1929 (71 P.S. §532)		DOH	<p>(a) To protect the health of the people of this Commonwealth, and to determine and employ the most efficient and practical means for the prevention and suppression of disease.</p> <p>(b) To cause examination to be made of nuisances, or questions affecting the security of life and health, in any locality, and, for that purpose, without fee or hindrance, to enter, examine and survey all grounds, vehicles, apartments, buildings and places, within the Commonwealth, and all persons, authorized by the department to enter examine and survey such grounds, vehicles, apartments, buildings and places, shall have the powers and authority conveyed by law upon constables.</p> <p style="text-align: center;">* * *</p> <p>(g) To promulgate its rules and regulations.</p>
71 P.S. §1402		DOH	<p>The [Secretary of Health] may, from time to time, employ competent persons to render sanitary service and make or supervise practical and scientific investigations and examinations requiring expert skill, and prepare plans and reports relative thereto, and he may purchase such supplies and materials as may be necessary in carrying on the work of his department.</p> <p>He may issue subpoenas to secure the attendance of witnesses, and compel them to testify in any manner or proceeding before him or his authorized agent.</p> <p>He may issue warrants to any sheriff, constable, or policeman to apprehend and arrest such persons who disobey the quarantine orders or regulations of the Department of Health. Every warrant shall be forthwith executed by the officer to whom directed, who shall make due return of the execution thereof to the [Secretary of Health].</p>

<p>71 P.S. § 1403(a)</p> <p>Disease Prevention and Control Law of 1955 (35 P.S. § 521.1 et seq.)</p>	<p>28 Pa. Code Ch. 27</p>	<p>DOH</p> <p>DOH and local health departments</p>	<p><b>Duty to protect health of the people.</b></p> <p>It shall be the duty of the [Secretary of Health] to protect the health of the people of the state, and to determine and employ the most efficient and practical means for the prevention and suppression of disease.</p> <p style="text-align: center;">* * *</p> <p><b>35 P.S. § 521.3. Responsibility for disease prevention and control.</b></p> <p>(a) Local boards and departments of health shall be primarily responsible for the prevention and control of communicable and non-communicable disease, including disease control in public and private schools, in accordance with the regulations of the board and subject to the supervision and guidance of the Department.</p> <p>(b) The department shall be responsible for the prevention and control of communicable and non-communicable disease in any municipality which is not served by a local board or department of health, including disease control in public and private schools.</p> <p>(c) If the secretary finds that the disease control program carried out by any local board or department of health is so inadequate that it constitutes a menace to the health of the people within or without the municipalities served by the local board or department of health, he may appoint agents of the department to supervise or to carry out the disease control program of the particular local board or department of health until he determines that the menace to the health of the people no longer exists and that the local board or department of health is able to carry out an adequate disease control program. The secretary shall require that any reasonable expenses incident to the administration of a local disease control program under this subsection, which are incurred by the department, shall be paid to the State by the local board or department of health or by the municipalities or counties which it serves.</p> <p><b>35 P.S. § 521.4. Reports</b></p> <p>(a) Every physician who treats or examines any person who is suffering from or who is suspected of having a communicable disease, or any person who is or who is suspected of being a carrier, shall make a prompt report of the disease in the manner prescribed by regulation to the local board or department of health which serves the municipality where the disease occurs or where the carrier resides, or to the Department if so provided by regulation.</p> <p>(b) The Department or local boards or departments of health may require the heads of hospitals and other institutions, the directors of laboratories, school authorities, the proprietors of hotels, roentgenologists, lodging houses, rooming houses or boarding houses, nurses, midwives, householders, and other persons having knowledge or suspicion of any communicable disease, to make a prompt report of the disease in a manner prescribed by regulation to the local board or department of health which serves the municipality</p>
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where the disease occurs, or to the Department if so provided by regulation.

(c) Local boards or departments of health shall make reports of the diseases reported to them to the department at such times and in such manner as shall be provided for by regulation.

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**35 P.S. §521.5. Control measures.**

Upon the receipt by a local board or department of health or by the department, as the case may be, of a report of a disease which is subject to isolation, quarantine, or any other control measure, the local board or department of health or the department shall carry out the appropriate control measures in such a manner and in such place as is provided by rule and regulation.

**§521.7. Examination and diagnosis of persons suspected of being infected with venereal disease, tuberculosis or any other communicable disease, or of being a carrier.**

Whenever the secretary or a local qualified medical health officer has reasonable grounds to suspect any person of being infected with a venereal disease, tuberculosis or any other communicable disease, or of being a carrier, he shall require the person to undergo a medical examination and any other approved diagnostic procedure, to determine whether or not he is infected with a venereal disease, tuberculosis or any other communicable disease, or is a carrier. In the event that the person refuses to submit to the examination, the secretary or the local qualified medical health officer may (1) cause the person to be quarantined until it is determined that he is not infected with a venereal disease, tuberculosis or any other communicable disease, or of being a carrier or (2) file a petition in the court of common pleas of the county in which the person is present, which petition shall have appended thereto a statement, under oath, by a physician duly licensed to practice in the Commonwealth, that such person is suspected of being infected with venereal disease, tuberculosis or any other communicable disease, or that such person is suspected of being a carrier. Upon filing of such petition, the court shall, within 24 hours after service of a copy thereof upon the respondent, hold a hearing, without a jury, to ascertain whether the person named in the petition has refused to submit to an examination to determine whether he or she is infected with venereal disease, tuberculosis or any other communicable disease, or that such person is a carrier. Upon a finding that the person has refused to submit to such examination and that there was no valid reason for such person so to do, the court shall forthwith order such person to submit to the examination. The certificate of the physician appended to the petition shall be received in evidence and shall constitute prima facie evidence that the person therein named is suspected of being infected with venereal disease, tuberculosis or any other communicable disease, or that such person is a carrier. The examination ordered by the court may be performed by a physician of his own choice at his own expense. The examination shall include physical and laboratory tests performed in a laboratory approved by the secretary, and shall be conducted in accordance with accepted professional practices, and the results thereof shall be reported

to the local health board or health department on forms furnished by the department of health. Any person refusing to undergo an examination, as herein provided, may be committed by the court to an institution in this Commonwealth determined by the Secretary of Health to be suitable for the care of such cases

**35 P.S. §521.11. Persons refusing to submit to treatment for venereal disease, tuberculosis or any other communicable disease.**

(a.1) If the secretary or any local health officer finds that any person who is infected with venereal disease, tuberculosis or any other communicable disease in a communicable stage refuses to submit to treatment approved by the department or a local board or department of health, the secretary or his representative or the local medical health officer may cause the person to be isolated in an appropriate institution designated by the department or by the local board or department of health for safekeeping and treatment until the disease has been rendered noncommunicable.

(a.2) The secretary or the local health officer may file a petition in the court of common pleas of the county in which the person is present to commit such person to an appropriate institution designated by the department or by the local board or department of health for safekeeping and treatment until such time as the disease has been rendered non-communicable. Upon filing of such petition, the court shall, within 24 hours after service of a copy thereof upon the respondent, hold a hearing, without a jury, to ascertain whether the person named in the petition has refused to submit to treatment. Upon a finding that the person has refused to submit to such treatment, the court shall forthwith order such person to be committed to an appropriate institution or hospital designated by the Department or by the local board or department of health.

(a.3) For the purpose of this section, it is understood that treatment approved by the department or by a local board or department of health shall include treatment by a duly accredited practitioner of any well recognized church or religious denomination which relies on prayer or spiritual means alone for healing: Provided, however, That all requirements relating to sanitation, isolation, or quarantine are complied with.

(b) Any county jail or other appropriate institution may receive persons who are isolated or quarantined by the department or by a local board of department of health by reason of a venereal disease for the purpose of safekeeping and treatment. The department or the local board or department of health shall reimburse any institution which accepts such persons at the rate of maintenance that prevails in such institutions, and shall furnish the necessary medical treatment to the persons committed to such institution.

**35 P.S. §521.15. Confidentiality of reports and records.**

State and local health authorities may not disclose reports of diseases, any records maintained as a result of any action taken in consequence of such reports, or any other records maintained pursuant to this act or any regulations, to any person who is not a member of the Department or of a local board or department of

35 Pa. C.S.A. §7301 (General authority of Governor)		Governor	<p>health, except where necessary to carry out the purposes of this act. State and local health authorities may permit the use of data contained in disease reports and other records, maintained pursuant to this act, or any regulation, for research purposes, subject to strict supervision by the health authorities to insure that the use of the reports and records is limited to the specific research purposes.</p>
			<p>(a) <b>Responsibility to meet disasters.</b> – The Governor is responsible for meeting the dangers to this Commonwealth and people presented by disasters.</p> <p>(b) <b>Executive orders, proclamations and regulations.</b> – Under this part, the Governor may issue, amend and rescind executive orders, proclamations and regulations which shall have the force and effect of law.</p> <p>(c) <b>Declaration of disaster emergency.</b> – A disaster emergency shall be declared by executive order or proclamation of the Governor upon finding that a disaster has occurred or that the occurrence or the threat of a disaster is imminent. The state of disaster emergency shall continue until the Governor finds that the threat or danger has passed or the disaster has been dealt with to the extent that emergency conditions no longer exist and terminates the state of disaster emergency by executive order or proclamation, but no state of disaster emergency may continue for longer than 90 days unless renewed by the Governor. The General Assembly by concurrent resolution may terminate a state of disaster emergency at any time. Thereupon, the Governor shall issue an executive order or proclamation ending the state of disaster emergency. All executive orders or proclamations issued under this subsection shall indicate the nature of the disaster, the area or areas threatened and the conditions which have brought the disaster about or which make possible termination of the state of disaster emergency. An executive order or proclamation shall be disseminated promptly by means calculated to bring its contents to the attention of the general public and, unless the circumstances attendant upon the disaster prevent or impede, shall be promptly filed with the Pennsylvania Emergency Management Agency and the Legislative Reference Bureau for publication under Part II of Title 45 . . . .</p> <p>(d) <b>Activation of disaster response.</b> – An executive order or proclamation of a state of disaster emergency shall activate the disaster response and recover aspects of the Commonwealth and local disaster emergency plans applicable to the political subdivision or area in question and shall be authority for the deployment and use of any forces to which the plan or plans apply and for use or distribution of any supplies, equipment and materials and facilities assembled, stockpiled or arranged to be made available pursuant to this part or any other provision of law relating to disaster emergencies.</p> <p>(e) <b>Commander in chief of the military forces.</b> – During the continuance of any state of disaster emergency, the Governor is commander in chief of the PA military forces. To the greatest extent practicable, the Governor shall delegate or assign command authority by prior arrangement embodied in appropriate executive orders or regulations, but this does not restrict the authority of the Governor to do so by orders issued at the time of the disaster emergency.</p>

			<p>(f) <b>Additional powers.</b> – In addition to any other powers conferred upon the Governor by law, the Governor may:</p> <ol style="list-style-type: none"> <li>(1) Suspend the provisions of any regulatory statute prescribing the procedures for conduct of any Commonwealth business, or the orders, rules or regulations of any Commonwealth agency, if strict compliance with the provisions of any statute, order, rule or regulation would in any way prevent, hinder or delay necessary action in coping with the emergency.</li> <li>(2) Utilize all available resources of the Commonwealth Government and each political subdivision of this Commonwealth as reasonably necessary to cope with the disaster emergency.</li> <li>(3) Transfer the direction, personnel or functions of Commonwealth agencies or units thereof for the purpose of performing or facilitating emergency services.</li> <li>(4) Subject to any applicable requirements for compensation under section 7313(10) (relating to powers and duties) commandeer or utilize any private, public or quasi public property if necessary to cope with the disaster emergency.</li> <li>(5) Direct and compel the evacuation of all or part of the population from any stricken or threatened area within this Commonwealth if this action is necessary for the preservation of life or other disaster mitigation, response or recovery.</li> <li>(6) Prescribe routes, modes of transportation and destinations in connection with evacuation.</li> <li>(7) Control ingress and egress to and from a disaster area, the movement of persons within the area and the occupancy of the premises therein.</li> </ol> <p style="text-align: center;">* * *</p>
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35 Pa. C.S.A. §7313	Pennsylvania Emergency Management Agency (PEMA)	<p><b>Powers and duties</b></p> <p>The agency shall have the following powers and duties:</p> <p>(1) To prepare, maintain and keep current a Pennsylvania Emergency Management Services Plan for the prevention and minimization of injury and damage caused by disaster, prompt and effective response to disaster and disaster emergency relief and recovery. The plan may include provisions for . . .</p> <p style="text-align: center;">* * *</p> <p>(10) To plan and make arrangements for the availability and use of any private facilities, services and property and, if necessary and if in fact used, provide payment for use under terms and conditions agreed upon.</p> <p style="text-align: center;">* * *</p> <p>(13) To administer grant programs to political subdivisions for disaster management.</p> <p>(14) To accept and coordinate assistance provided by federal agencies in major disasters or emergencies. . .</p>
35 Pa. C.S.A. §7601	Emergency Management Assistance Compact	<p><b>Article V. Licenses and Permits</b></p> <p>Whenever any person holds a license, certificate or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise.</p>
42 Pa. C.S.A. §8331	Immunity	<p><b>Medical good Samaritan civil immunity</b></p> <p>(a) <b>General rule.</b>—Any physician or other practitioner of the healing arts or any registered nurse, licensed by any state, who happens by chance upon the scene of an emergency or who arrives on the scene of an emergency by reason of serving on an emergency call panel or similar committee of a county medical society or who is called to the scene of an emergency by the police or other duly constituted officers of a government unit or who is present when an emergency occurs and who, in good faith, renders emergency care at the scene of the emergency, shall not be liable for any civil damages as a result of any acts or omissions by such physician or practitioner or registered nurse in rendering the emergency care, except any acts or omissions intentionally designed to harm or grossly negligent acts or omissions which result in harm to the person receiving emergency care.</p>

<p>42 Pa. C.S.A. §8332.4</p>		<p>Immunity</p>	<p><b>(b) Definition.</b>—As used in this section “good faith” shall include, but is not limited to, a reasonable opinion that the immediacy of the situation is such that the rendering of care should not be postponed until the patient is hospitalized.</p> <p><b>Volunteer-in-public-service negligence standard</b></p> <p><b>(a) General rule.</b>— Except as provided otherwise in this section, no person who, without compensation and as a volunteer, renders public services for a nonprofit organization . . . or for a Commonwealth or local government agency conducting or sponsoring a public service program or project shall be liable to any person for any civil damages as a result of any acts or omissions in rendering such services unless the conduct of such person falls substantially below the standards generally practiced and accepted in like circumstances by similar persons rendering such services and unless it is shown that such person did an act or omitted the doing of an act which such person was under a recognized duty to another to do, knowing or having reason to know that such act or omission created a substantial risk of actual harm to the person or property of another. It shall be insufficient to impose liability to establish only that the conduct of such person fell below the ordinary standards of care.</p> <p style="text-align: center;">* * *</p> <p><b>(b) Exceptions.</b>—</p> <p>(1) Nothing in this section shall be construed as affecting or modifying the liability of such person for acts or omissions relating to the transportation of participants in a public service program or project or others to or from a public service program or project.</p> <p>(2) Nothing in this section shall be construed as affecting or modifying any existing legal basis for determining the liability, or any defense thereto, of any person not covered by the standard of negligence established by this section.</p>
<p>42 Pa. C.S.A. §8332</p>		<p>Immunity</p>	<p><b>Nonmedical good Samaritan civil immunity</b></p> <p><b>(a) General rule.</b>—Any person who renders emergency care, first aid or rescue at the scene of an emergency, or moves the person receiving such care, first aid and rescue to a hospital or other place of medical care, shall not be liable to such person for any civil damages as a result of any acts or omissions in rendering the emergency care, first aid or rescue, or moving the person receiving same to a hospital or other place of medical care, except any acts or omissions intentionally designed to harm or any grossly negligent acts or omissions which result in harm to the person receiving the emergency care, first aid or rescue or being moved to a hospital or other place of medical care.</p> <p><b>(b) Exceptions.</b> —</p> <p>(1) This section shall not relieve a driver of an ambulance or other emergency or rescue vehicle from</p>



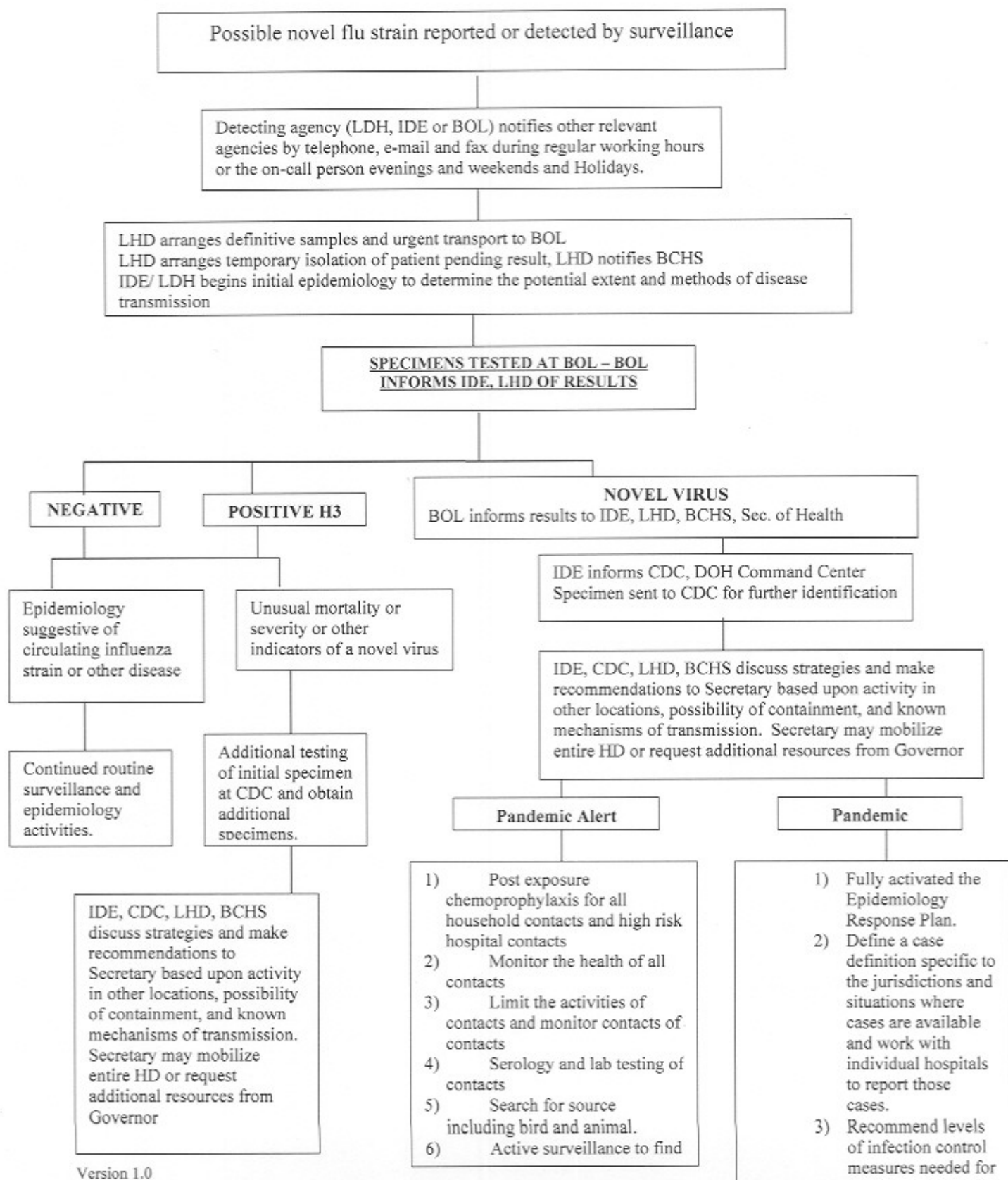
			<p>liability arising from operation of such a vehicle.</p> <p>(2) In order for any person to receive the benefit of the exemption from civil liability provided for in subsection (a), he shall be, at the time of rendering the emergency care, first aid or rescue or moving the person receiving emergency care, first aid or rescue to a hospital or other place of medical care, the holder of a current certificate evidencing the successful completion of a course in first aid, advanced life saving or basic life support sponsored by the American National Red Cross or the American Heart Association or an equivalent course of instruction approved by the Department of Health in consultation with a technical committee of the Pennsylvania Emergency Health Services Council and must be performing techniques and employing procedures consistent with the nature and level of training for which the certificate has been issued.</p>
42 P.S. §8334		DOH	<p><b>Civil immunity in mass immunization projects</b></p> <p><b>(a) General rule.</b>— Any physician who does not receive remuneration for his services in a mass immunization project approved in writing by the Department of Health or its designee . . . and any registered nurse, or practical nurse licensed to practice in this Commonwealth who shall participate in such project and any State, county or local medical society, medical or health facility, agency or clinic approved by the department shall not be liable, except for gross negligence, to any person for illness, reaction, or adverse effect arising from or out of the use of any drug or vaccine in such project by such physician or such nurse. Neither the department nor its designee shall approve any such project unless the department or its designee finds that the project conforms to good medical and public health practice.</p> <p><b>(b) Exception</b> — This section shall not exempt any drug manufacturer from liability for any drug or vaccine used in such project.</p>
Section 301 of the Counterterrorism Planning, Preparedness and Response Act (CPPRA) (35 P.S. § 2140.301)		Governor, in consultation with DOH	<p><b>(a) Temporary isolation or quarantine.</b> — In the case of an actual or suspected outbreak of a contagious disease or epidemic due to an actual or suspected bioterrorist or biohazardous event, the Governor, in consultation with the Secretary of Health, may temporarily isolate or quarantine an individual or groups of individuals through a written order if delay in imposing the isolation or quarantine through judicial proceedings currently available to the department and local health departments would significantly jeopardize the department's ability to prevent or limit the transmission of a contagious or potentially contagious disease to others. This subsection shall not require the declaration of a disaster emergency by the Governor in order to be effective.</p> <p><b>(b) Judicial review.</b> —</p> <p>(1) After issuing the written order, the department or local health department shall promptly file a petition with the court within 24 hours or the next court business day after the issuance of the order for a hearing to authorize the continued isolation or quarantine.</p> <p>(2) The court shall hold a hearing on the petition not more than 72 hours after the filing of the petition to</p>

			<p>determine whether continued isolation or quarantine is warranted.</p> <p>(3) Reasonable notice, either oral or written, stating the time, place and purpose of the hearing shall be given to the isolated or quarantined individual. The court may determine the manner in which the hearing shall occur, including the use of closed-circuit television.</p> <p>(4) An isolated or quarantined individual is entitled to representation by legal counsel at all stages of any proceedings under this section and, if the individual is without financial resources or otherwise unable to employ counsel, the court shall provide counsel for him.</p> <p>(5) If the court determines continued isolation or quarantine is warranted, the court shall so order the continued isolation or quarantine and shall fix the time and duration of the isolation or quarantine, which in no case shall exceed 30 days except as set forth in paragraph (6).</p> <p>(6) Where an individual has been isolated or quarantined for a period of 30 days, the department shall ask the court to review the order to determine if further isolation or quarantine is warranted.</p> <p>(7) The department or local health department shall provide the court with ongoing reports on the isolated or quarantined individual during the period of isolation or quarantine.</p> <p><b>(c) Relation to other laws.</b>— Nothing in this section shall be construed to limit the existing authority of the Secretary of Health or the department or a local health department.</p>
Section 302 of the CPPRA (35 P.S. §2140.302)		Immunity	<p>The provisions of 42 Pa.C.S. 8331 (relating to medical good Samaritan civil immunity), 8332 (relating to nonmedical good Samaritan civil immunity) or 8332.4 (relating to volunteer-in-public-service negligence standard) shall apply to any person who provides assistance in carrying out the provisions of this chapter.</p>

ATTACHMENT C

PANDEMIC ALERT & PANDEMIC PERIOD FLOW CHART

# **PANDEMIC ALERT AND PANDEMIC PERIOD FLOW CHART**



ATTACHMENT D

INTERIM GUIDANCE FOR THE IMPLEMENTATION OF CDC AND OSHA  
AVIAN INFLUENZA PUBLIC HEALTH RECOMMENDATIONS (DRAFT)

# Interim Guidance for the Implementation of CDC and OSHA Avian Influenza Public Health Recommendations

Pennsylvania Poultry Industry and Pennsylvania Department of  
Health Joint Working Group on the Response to  
Highly Pathogenic Avian Influenza

November 1, 2005

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We wish to acknowledge and gratefully thank the Delmarva Poultry Industries –  
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Pennsylvania Poultry Industry and Pennsylvania Department of  
Health Joint Working Group on the Response to  
Highly Pathogenic Avian Influenza - Participants

- Pennsylvania Poultry Industry
- Pennsylvania Department of Health
- Pennsylvania Department of Agriculture
- Pennsylvania State University
- University of Pennsylvania
- United States Department of Agriculture

# Interim Guidance for the Implementation of CDC and OSHA Avian Influenza Public Health Recommendations

## Pennsylvania Poultry Industry and Pennsylvania Department of Health Joint Working Group on the Response to Highly Pathogenic Avian Influenza

### Summary:

- In response to the identification of Avian Influenza (AI) in poultry on the Eastern Shore of Maryland and Delaware, in addition to reports of human illness in other countries related to Highly Pathogenic Avian Influenza (HPAI) outbreaks, an ad hoc working group was convened in Pennsylvania to develop procedures based on U.S. Centers for Disease Control and Prevention (CDC) and federal Occupational Safety and Health Administration (OSHA) recommendations.
- This document provides practical guidance on the training of workers and emergency response personnel, basic infection control, use of personal protective equipment (PPE), decontamination measures, vaccine and antiviral usage, surveillance for illness, and appropriate evaluation of persons who become ill.
- For the maximum protection of workers, procedures follow the guidelines recommended by the CDC.
- Poultry companies will work in conjunction with state and local public health authorities.
- The medical departments of the poultry companies will closely monitor workers after their involvement with depopulation efforts for one week after last exposure as recommended by the CDC.
- Workers not employed, or contracted by a particular poultry company, will be monitored by the health agency of the jurisdiction for their place of residence.

**Background:**

Avian Influenza (AI) viruses are responsible for outbreaks that mainly affect birds (eporniths). The principle hosts of AI viruses are waterfowl. AI viruses can be classified into low pathogenic (LPAI) and highly pathogenic (HPAI) forms based on their virulence and the severity of the illness they cause. Most AI virus strains are of low pathogenicity, and typically cause little or no clinical signs in infected birds (1). However, some LPAI virus strains can mutate, under field conditions, into HPAI viruses (H5 and H7 hemagglutinin subtypes), which are extremely infectious and fatal, and once established, can spread rapidly from flock to flock (1). Rare cases of human illness caused by AI have been documented throughout the world, including in the United States. In most cases, human illnesses have been associated with laboratory confirmed HPAI viruses, suggesting a zoonotic potential of the virulent strain.

The documented human illnesses resulting from infection with AI viruses have been with HPAI viruses. The clinical signs have ranged from severe, sometimes fatal, respiratory infections, such as those caused by the avian influenza A subtype H5N1 virus in Asia during 2004-2005, to mild illnesses such as conjunctivitis (an inflammation of the lining of the eye). To date, most human HPAI infections have been acquired from direct contact with infected birds; person-to-person transmission may have occurred in several cases, but appears to be extremely uncommon. Although person-to-person transmission of HPAI appears to be rare, one major concern is that a person infected with HPAI could also become co-infected with a normal human influenza virus. Genetic material could be exchanged between the HPAI virus and the human influenza virus, which could result in an influenza virus that is transmitted easily from person-to-person. If this were to happen, a severe worldwide epidemic of influenza (pandemic) may ensue (2,3). Vaccines and antiviral drugs are important in reducing the morbidity and mortality associated with a pandemic, but the emergence and exposure of an immunologically naïve population to a new virus may expose the inadequacy of the manufacturing capacity and distribution of effective vaccines and antiviral agents.

To protect persons exposed to HPAI from becoming infected and ill, and to prevent an AI-associated pandemic, guidelines have been developed by several organizations, including the CDC (4) in February 2004, and more recently by OSHA (5). On July 25, 2005, representatives from the Pennsylvania Poultry Industry, Pennsylvania Department of Health, Pennsylvania Department of Agriculture, Pennsylvania State University and the University of Pennsylvania convened in response to recent outbreaks of LPAI in the nearby states of Delaware and Maryland (2004; H7N2), Virginia (2002; H7N2), and a prior HPAI outbreak in Pennsylvania (1983; H5N2) that killed over 11 million chickens. A plan of action was formulated using CDC and OSHA recommendations, and the Delmarva Poultry Industries – Health Departments Joint Task Force (6) guidance as a basis. This interim document represents the product of the Pennsylvania working group, and provides operational guidance for a Pennsylvania HPAI response plan based. This guidance will be updated as new and significant information becomes available.

Pennsylvania Poultry Industry and Pennsylvania Department of Health Joint Working Group on the Response to Highly Pathogenic Avian Influenza (HPAI)

**Target Human Populations:**

- I. Poultry company workers tasked with depopulation (e.g. service personnel, company veterinarians).
- II. Equipment operators contracted by poultry companies.
- III. Composters (e.g. equipment operators).
- IV. Farm caretakers and their families.
- V. Employees of state, federal, private agencies or organizations not associated with poultry companies (i.e., Pennsylvania Department of Agriculture, university, and United States Department of Agriculture field personnel, laboratory workers, FBI field personnel, etc.).

Not considered at an increased risk are litter truck drivers, who dump the litter outside the poultry houses. Group I, II, and III will be identified in advance.

**Procedures:**

Select personnel from each poultry company will form "Primary Response Teams." A "Team Leader" will head each Primary Response Team. These groups will be trained, educated, vaccinated, and prepared to mobilize and receive antiviral therapy when the occasion arises. The poultry companies will maintain a central listing of the workers along with their contact information.

A Safety Officer and a Public Health Representative will be identified to assure on-site compliance with procedures. A Safety Officer is an individual designated by the poultry company with the knowledge base regarding operations, with the task of ensuring that safety procedures are followed. A Public Health Representative is an individual designated by the Pennsylvania Department of Health with the task of ensuring that preventive health measures are followed.

**I. Training.**

- a. Workers will be trained and required to complete the "Training Checklist" for exposure to HPAI (see Attachment 1)

**II. Basic Infection Control**

- a. Team leaders will use this document to educate workers about the importance of strict adherence to and proper use of hand hygiene after contact with infected or exposed poultry, contact with contaminated surfaces, or after removing gloves. Hand hygiene should consist of washing hands with hot soap and water for 10-15 seconds (7), or the use of other standard hand-disinfection procedures as specified by the poultry company medical department. This will happen at all breaks (including, but not limited to smoking, snacking, lunch and bathroom), and prior to leaving the affected farm.

### III. Personal Protective Equipment (PPE)

- a. Cloth gloves over nitrile disposable gloves should be worn. Gloves must be changed if torn or otherwise damaged. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces.
- b. "Throwaway clothes," clothing that is inexpensive and that shall be discarded after the event. No special protective clothing need be worn. Clean clothes will be brought and changed into after showering out of the environment. Suitable and approved disposable overgarments that remain intact during service may be used in lieu of throwaway garments if approved by the on site Public Health Representative.
- c. Disposable shoes, protective shoe covers, or rubber or polyurethane boots that can be cleaned and disinfected, should be worn.
- d. Safety goggles shall be worn to protect the mucous membranes of the eyes.
- e. Disposable particulate respirators will be worn (i.e., N-95, N-99, or N-100). Fit testing will be required initially, and annually.
- f. Disposable PPE shall be properly discarded, and non-disposable PPE shall be cleaned and disinfected after use. Hand hygiene measures shall be performed after removal of PPE.

### IV. Decontamination

- a. All personnel who work in the interior of poultry houses will shower at the end of the work shift, either on site at a decontamination trailer, or through arrangements with local hotels (utilizing a dirty room for removal of clothing and showering and a clean room for dressing in clean clothing to be worn home). Separate sex showering facilities should be provided.
- b. No clothing worn inside the poultry houses can be worn home; this includes shoes, underwear, etc. Shoes do not have to be discarded if they are worn inside boots that are disinfected or covered by disposable covers that remain intact.

### V. Vaccine and Antiviral Drugs

- a. All Response Team members will receive the seasonal human flu vaccine from their respective companies in order to reduce chance of co-infection with human influenza virus that might recombine with the AI virus.
- b. Follow current CDC guidelines for prophylaxis, the recommended antiviral drug of choice is currently Oseltamavir (Tamiflu), 75 mg once a day on any day the person is involved on-site with depopulation efforts on

laboratory confirmed HPAI-positive farms. The attending physician may require a minimum treatment of three days. Each company will arrange antiviral prophylaxis with their respective medical professionals (i.e., physicians). Individuals that are not associated with a poultry company will be provided a letter (Anticipated Exposure to HPAI) and will consult with their primary care provider for a prescription (see Attachment 2).

#### **VI. Monitoring of Workers attached to a Poultry Company**

- a. Before going to a site, all workers will complete the HPAI Exposure Symptom Questionnaire (see Attachment 3); anyone answering "yes" to any question on the health assessment section Baseline (i.e., Day 0) of the matrix will be excluded from that depopulation episode.
- b. The questionnaire will be administered again by the poultry company to which that individual is attached to, on or about day seven, and again on the 14<sup>th</sup> day after depopulation. State or local health departments of residence will recommend evaluation and treatment of poultry workers and their families by their medical providers, accordingly.

#### **VII. Monitoring of Individuals not attached to a specific poultry company**

- a. Monitoring of individuals not attached to a specific poultry company (e.g. Pennsylvania Department of Agriculture and USDA field personnel, laboratory workers, poultry growers, FBI field personnel, etc.) will be the responsibility of the state or local health department of residence.
- b. The state or local health departments where the affected farm is located will collect baseline data. This will be sent to the health department of residence for follow-up surveillance.
- c. Any person who is in the category as defined in (a.) above will be contacted by the state or local health department and asked to complete the HPAI questionnaire (attached); anyone answering "yes" to any question on the health assessment section of the matrix will be followed up by the state or local health department, including identification of additional contacts of these individuals, for further evaluation and specimen collection.
- d. A letter of instruction for medical providers (Request for Post-Exposure Prophylaxis) will be given to the poultry grower and their family members (see Attachment 4).
- e. State or local health departments of residence will recommend evaluation and treatment of poultry growers and their families by their medical providers, accordingly.



#### VIII. Evaluation of Ill persons

- a. Reports of ill workers will be submitted to the state or local health department of their place of residence.
- b. Medical follow up will be the responsibility of the poultry companies who employ or contract the individuals or agency employee health/worker's compensation for state agency employees.
- c. A letter of instruction for medical providers for evaluation of illness (Symptomatic) will be given to the poultry grower and their family members (see Attachment 5).
- d. Specimen collection will be coordinated by the state or local health department and will include nasopharyngeal swab and acute serum (convalescent serum may be obtained 2-8 weeks later if appropriate).
- e. Workers are instructed to be vigilant for the development of fever, respiratory symptoms, and/or conjunctivitis (i.e., eye infections) for one week after the last exposure to avian influenza-infected or exposed birds or to potentially avian influenza-contaminated environmental surfaces. Workers will be instructed who to contact regarding questions or symptoms of illness

**References:**

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2. CDC. "Avian Influenza Infection in Humans." January 19, 2005. Downloaded from <http://www.cdc.gov/flu/avian/gen-info/avian-flu-humans.htm>
3. CDC. "Key facts about Avian Influenza (Bird Flu) and Avian Influenza A (H5N1) Virus." March 18, 2005. Downloaded from <http://www.cdc.gov/flu/avian/gen-info/facts.htm>
4. CDC. "Interim Guidance for Protection of Persons Involved in U.S. Avian Influenza Outbreak Disease Control and Eradication Activities." February 17, 2004. Downloaded from <http://www.cdc.gov/flu/avian/pdf/protectionguid.pdf>
5. OSHA. "Avian Influenza Protecting Poultry Workers at Risk. Safety and Health Information Bulletins 12-13-2004." December 13, 2004. Downloaded from <http://www.osha.gov/dts/shib/shib121304.html>
6. Delmarva Poultry Industries – Health Departments Joint Task Force. "Interim Guidance for Implementation of CDC and OSHA Avian Influenza Recommendations." March 8, 2004.
7. CDC. "An ounce of prevention: Keeps germs away." April 5, 2000. Downloaded from <http://www.cdc.gov/ncidod/op/handwashing.htm>

# Training Checklist for Workers Exposed to Highly Pathogenic Avian Influenza

Attachment D

## Attachment 1

### Pennsylvania Poultry Industry- Department of Health Joint Working Group on the Response to Highly Pathogenic Avian Influenza

Please read and initial each item below. Sign form at bottom when completed.

\_\_\_\_\_ 1. I **understand** that these guidelines provided by my employer, are the recommendations of the Centers for Disease Control and Prevention (CDC) for maximum protection for workers exposed to Highly Pathogenic (HPAI) viruses, and that these precautions are being taken for my personal protection against the extremely low risk of human infection with the HPAI virus.

\_\_\_\_\_ 2. I **have** completed and passed the "Highly Pathogenic Avian Influenza Exposure Symptom Questionnaire" prior to being exposed to HPAI infected poultry or premises contaminated with HPAI virus.

\_\_\_\_\_ 3. I **have** received the seasonal human flu vaccine at least two weeks prior to today and I **understand** that this vaccination will not prevent human infection by HPAI viruses but is intended to minimize the likelihood of an HPAI virus from recombining with human influenza viruses.

\_\_\_\_\_ 4. I **have** been offered antiviral medications and **agree** to take them as directed by medical professionals.

\_\_\_\_\_ 5. I **agree** to wear the personal protective equipment (PPE) recommended by my employer at all times during possible exposure to HPAI virus. This PPE includes but is not limited to: cloth gloves over nitrile disposable gloves (replace gloves immediately if torn or otherwise damaged), discardable clothing and shoe wear or washable boots that can be cleaned and disinfected on site, safety goggles, disposable particulate N-95 type respirator (or better), and hair bonnet.

\_\_\_\_\_ 6. I **have** been instructed on how to properly remove contaminated PPE to prevent cross contamination.

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\_\_\_\_\_ 7. I **have** been fit tested and approved to wear an N-95 (or better) respirator during the completion of physically strenuous activities.

\_\_\_\_\_ 8. I **have** been instructed about the importance of strict adherence to and proper use of hand hygiene after contact with HPAI infected poultry or HPAI virus contaminated surfaces. After removing protective gloves I **agree** to thoroughly wash my hands with soap and water for at least 20 seconds or to use other hand disinfection procedures as specified by the Public Health Representative.

\_\_\_\_\_ 9. I **agree** to shower at the end of the work shift in a decontamination unit on site or via arrangements with local hotels using a dirty room for clothing removal and showering and a clean room for dressing in clean clothing to be worn home. Under no circumstances will I wear clothing worn in an HPAI contaminated environment home: this includes shoes, underwear, etc.

\_\_\_\_\_ 10. I **agree** to complete the attached health questionnaire on or about day 7 and again on day 14 after possible exposure to HPAI virus. If I answered "yes" to any question I **agree** to be referred to the Public Health Representative and to follow their instructions for further examination and specimen collection as needed. I understand that my personal health information may be shared with appropriate county and state health departments and **agree** to follow additional directions from these agencies if requested to do so.

\_\_\_\_\_ 11. I **understand** that both the Safety Officer and the Public Health Representative will be on site to answer any questions that I may have concerning these guidelines.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# LETTER HEAD

Attachment 2

## MEMO

To: (Medical Provider)

From: \_\_\_\_\_ PA State, County, and/or Municipal Health  
Department

Date: \_\_\_\_\_

Re: \_\_\_\_\_ (patient name)

The person identified above is referred to you for consideration of prophylaxis therapy for potential exposure to laboratory confirmed Highly Pathogenic Avian Influenza. The duties leading to this potential exposure will include: \_\_\_\_\_. The duties stated will be performed on (date).

This patient ( ) has ( ) has not been vaccinated with the current season's influenza vaccine.

*CDC Interim Guidance for Protection of Persons Involved in US Avian Influenza Outbreak Disease Prevention and Control and Eradication Activities ([www.cdc.gov/flu/avian/professional/protect-guid.htm](http://www.cdc.gov/flu/avian/professional/protect-guid.htm)) recommends the following: "Workers receive an influenza antiviral drug daily for the duration of time during which direct contact with infected poultry or contaminated surfaces occurs." "A neuraminidase inhibitor (oseltamavir) is the first choice..."*

Please consider this patient for prophylaxis with antiviral therapy.

If you would like a copy of the CDC guidelines, have questions or need additional information, please contact the PA State, County, and/or Municipal Health Department at (phone number).

**Highly Pathogenic Avian Influenza Exposure Symptom Questionnaire**

Attachment 3

Date of interview (mm/dd/yy) \_\_\_\_\_ Name of interviewer: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Address (# Street Name): \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Primary Language Spoken \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/cell phone: \_\_\_\_\_

Age (Years): \_\_\_\_\_ DOB (mm/dd/yy): \_\_\_\_\_ Gender: ☐ M ☐ F**Vaccination Information:****Did you receive an influenza vaccination this year?**☐ Yes (approximate date mm/dd/yy \_\_\_\_\_) What type? ☐ Flu shot ☐ FluMist ☐ No**Work Information:**

Occupation: \_\_\_\_\_

Employer : Poultry Company \_\_\_\_\_ Private contractor \_\_\_\_\_ State/Fed Agency \_\_\_\_\_

**Type of work (check all that apply):**

- ☐ Care of live poultry or trucks ☐ Transportation of live poultry ☐ Clean of poultry houses, cages
- ☐ Obtaining blood samples of poultry swabs ☐ Process poultry specimens in a lab ☐ Obtain cloacal or tracheal



Attachment D

- ☐ Slaughter poultry (not depopulation)      ☐ Poultry depopulation      ☐ Composting dead poultry
- ☐ Disinfecting equipment      ☐ Farm owner      ☐ Other farm work
- ☐ Other \_\_\_\_\_

**What is the most recent date you were performing any of the above activities (at any location)?**

**Date (mm/dd/yy)::** \_\_\_\_\_ ☐ Still performing above duties

Pennsylvania Poultry Industry and Pennsylvania Department of Health Joint Working Group on the Response to Highly Pathogenic Avian Influenza (HPAI)

**What is the most recent date you performed any of the above activities at a site where poultry were known to be infected with avian influenza?**

**Date (mm/dd/yy)::** \_\_\_\_\_ ☐ Still performing above duties

**While performing these activities (during the past two weeks), have you used personal protective equipment (PPE)?**

- ☐ Yes, always      ☐ Yes, most of the time      ☐ Yes, sometimes      ☐ Never

**Name: (Last)** \_\_\_\_\_ **(First)** \_\_\_\_\_

**Exposure Date (mm/dd/yy):** \_\_\_\_\_ **Exposure Location** \_\_\_\_\_ **Exposure #** \_\_\_\_\_

**If you used PPE, which articles did you use? (Check all that apply)**

- ☐ Protective clothing (such as disposable clothing)      ☐ Disposable gloves      ☐ Hair bonnet
- ☐ Fit-tested respirator (such as an N95 mask or better)      ☐ Goggles

# Attachment D

☐ Disposable protective foot wear or washable boots

☐ Other \_\_\_\_\_

## Health Assessment:

Since your first possible contact with avian influenza infected birds, have you developed any of the following symptoms?

Symptoms	Day 0 (Today's Date: _____)			Day 7 (Today's Date: _____)			Day 14 (Today's Date: _____)		
	Circle One	Date of Onset	Date Resolved	Circle One	Date of Onset	Date Resolved	Circle One	Date of Onset	Date Resolved
Fever	Yes No			Yes No			Yes No		
Measured Temp $\geq 100^{\circ}\text{F}$	Yes No Temp:			Yes No Temp:			Yes No		
Cough	Yes No			Yes No			Yes No		
Sore Throat	Yes No			Yes No			Yes No		
Runny Nose	Yes No			Yes No			Yes No		
Body Aches *	Yes No			Yes No			Yes No		
Red or Watery Eyes	Yes No			Yes No			Yes No		
Diarrhea	Yes No			Yes No			Yes No		
Headache	Yes No			Yes No			Yes No		
Drowsiness	Yes No			Yes No			Yes No		
Other: _____	Yes No			Yes No			Yes No		

\* symptom by itself does not indicate referral to local health department for follow up

Pennsylvania Poultry Industry and Pennsylvania Department of Health Joint Working Group on the Response to Highly Pathogenic Avian Influenza (HPAI)

Did you seek medical care for your illness? ☐ No ☐ Yes

If yes, name of provider: _____	Address: _____	Phone Number: _____
Were you hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Name of Hospital _____	Dates admitted _____	

**Antiviral Information:**

Have you taken any antiviral medication? (Amantadine/Rimantadine/Oseltamivir)

☐ Yes Name of antiviral: \_\_\_\_\_ First dose: \_\_\_\_\_ Last dose: \_\_\_\_\_ ☐ No

Have any of your family members or other close contacts developed any of the above symptoms? ☐ No ☐ Yes If yes, who?

<u>Name</u>	<u>Age (Yrs.)</u>	<u>Relationship</u>	<u>Contact #</u>
_____			
_____			
_____			

# LETTER HEAD

## Attachment 4

# MEMO

To: Medical Provider  
From: \_\_\_\_\_ PA State, County, and/or Municipal Health Dept.  
Date: \_\_\_\_\_  
Re: \_\_\_\_\_ (patient name)

The person identified above is referred to you for evaluation and follow-up due to their exposure to laboratory confirmed Highly Pathogenic Avian Influenza. The exposure occurred on (date). The duties leading to this exposure included:  
\_\_\_\_\_.

This patient ( ) has ( ) has not been vaccinated with the current season's influenza vaccine.

*CDC Interim Guidance for Protection of Persons Involved in US Avian Influenza Outbreak Disease Prevention and Control and Eradication Activities* ([www.cdc.gov/flu/avian/professional/protect-guid.htm](http://www.cdc.gov/flu/avian/professional/protect-guid.htm)) recommends the following: "Workers receive an influenza antiviral drug daily for the duration of time during which direct contact with infected poultry or contaminated surfaces occurs." "A neuraminidase inhibitor (oseltamavir) is the first choice..."

Please consider this patient for prophylaxis with antiviral therapy.

If you would like a copy of the CDC guidelines, have questions, or need additional information, please contact the PA State, County, and/or Municipal Health Department at (phone number).

## LETTER HEAD

Attachment 5

## MEMO

To: (Medical Provider)  
 From: \_\_\_\_\_ PA State, County, and/or Municipal Health  
 Department  
 Date: \_\_\_\_\_  
 Re: \_\_\_\_\_ (patient name)

The person identified above is referred to you for evaluation and follow-up due to their exposure to laboratory confirmed Highly Pathogenic Avian Influenza (HPAI). An interview with the patient revealed the following information:

- Interview date \_\_\_\_\_
- Exposure date \_\_\_\_\_
- Duties leading to this exposure included: \_\_\_\_\_
- \_\_\_\_\_
- Symptoms began on \_\_\_\_\_
- Symptoms include \_\_\_\_\_
- This patient ( ) has ( ) has not been vaccinated with the current season's influenza vaccine.
- This patient ( ) has ( ) has not receive antiviral prophylaxis during the exposure period.

*CDC Interim Guidance for Protection of Persons Involved in US Avian Influenza Outbreak Disease Prevention and Control and Eradication Activities* ([www.cdc.gov/flu/avian/professional/protect-guid.htm](http://www.cdc.gov/flu/avian/professional/protect-guid.htm)) recommends the following evaluation of ill workers:

- Workers who develop a febrile respiratory illness should have a respiratory sample (e.g., nasopharyngeal swab or aspirate) collected.
- Optimally, an acute- (within 1 week of illness onset) and convalescent-phase (after 3 weeks of illness onset) serum sample should be collected and stored locally in case testing for antibody to the HPAI virus should be needed.

The Health Department can assist you in submitting a nasopharyngeal swab and serology for HPAI testing to the state laboratory. If you would like a copy of the CDC guidelines, have questions, or need additional information, please contact the PA State, County, and/or Municipal Health Department at (phone number).

ATTACHMENT E

DEPARTMENT OF EPIDEMIOLOGY RESPONSE TASKS



### Bureau of Epidemiology Response Tasks

Table 1  
(Response Tasks by Epidemiology Teams)

Task	Teams				
	Out-break Management	Clinical	Case Finding	Exposure Assessment	Data Base Support
I. Confirm cases A. Review and confirm suspect cases B. Submit specimens to lab		X X			
II. Confirm disease event and notification A. Confirmation of disease event B. Agency notification	X X				
III. Activate teams A. Activate and recruit teams B. Train untrained team staff C. Coordinates team and epi response	X X X				
IV. Protection of employee health A. Identify high risk employees B. Educate about risk C. Assure vaccinations D. Assure PPE	X X X X				
V. Case Finding A. Develop working case definition B. Initiate enhanced passive surveillance 1. Educate providers: media alerts and fact sheet dissemination 2. Receive and review reports to identify suspect cases. C. Initiate active surveillance 1. Interview providers 2. Abstract/review records 3. Interview suspected cases	X  X      		X  X      		
VI. Contact Tracing Identify cases to identify contacts		X	X		
VII. Exposure Assessment A. Interview cases: obtain exposure and risk factor information B. Take nasal swabs if possible/appropriate C. Coordinate with sampling team D. Hypothesis testing Data base development Data analysis E. Identify exposed populations	   X X  X X	  X X	  X	X   X   X	      X X
VIII. Surveillance of exposed and contacts A. Contact exposed and refer for PEP B. Contact contacts and refer for PEP	X X	X X	X X		
IX. Prevention and control A. Assure PEP for exposed and contacts B. Assure treatment of cases C. Assure PH prevention and infection control	X X X	X X X			

**Table 2**  
**(Number of Personnel Needed for Each Epi-Team by Size of Outbreak)**

Epi-Section Responsibilities	Number cases in Outbreak		
	<26	26-150	151-499
<b>Clinical Epi-Section</b> (0.5 persons per 50 cases) Case confirmation/ nasal swabs / referral for treatment and PEP	.5	1.5	5
<b>Total Clinical Epi-Section</b>	.5	1.5	5
<b>Case Finding Epi-Section</b>			
a. Alert/educate Public & physicians/exp (0.5 persons per 50 cases)	0.25	1.5	5
b. Active surveillance: record review/interview of physicians at ERs	10	10	10
c. Call exposed <24hrs (1 tracer calls 25 exposed/day x 5 exposed/case)	5	15	100
d. Personal interview exposed: visit 20% of exposed <24 hrs (10 per day)	1	6	20
e. Personal interview of each case <24hrs & identify contacts (1 interviewer/25 cases/day)	1	6	20
f. Call case-contacts <24hrs (1 tracer/25 contacts/day x 5 contacts/case)	5	15	100
g. Personal interview of contacts: visit 20% of contacts <24 hrs (10 per day)	1	6	20
<b>Total Case Finding Epi-Section</b>	23.25	59.5	275
<b>Outbreak Management Epi-Section</b>			
a. Project management (1.0 per 50 cases)	0.5	3	5
Notification and confirmation			
Develop working case definition/recording forms			
Epi-Section supervision/agency coordination			
Develop line listing of cases			
Database coordination			
Hypothesis testing of exposure and risk factors			
Treatment and PEP recommendations and coordination			
b. Identify high risk employees (Guess)	0.5	1.5	5
c. Handling public inquiries (1 person per 50 cases)	0.5	3	10
<b>Total Outbreak Management Epi-Section</b>	1.5	4.5	20
<b>Exposure Assessment Epi-Section</b>			
a. Personal interview of 20 cases for exposure assessment	1	1	1
b. Identification of exposed & develop line listing	0.5	1	4
<b>Total Exposure Assessment Epi-Section</b>	1.5	2	5
<b>Data Base Support Epi-Section</b> (0.5 per 50 cases)	0.5	1.5	5
Maintain line listings of cases, exposed, & contacts			
Maintain clinical, lab, and exposure database			
Provide data tabulations for hypothesis testing			
Technical IT support			
<b>Total Data Base Support Epi-Section</b>	0.5	1.5	5
<b>Total Personnel Needed</b>	<b>31.75</b>	<b>166.5</b>	<b>310</b>

**Table 3**  
(Number of Personnel Needed for Each Epi-Team for a 500 Case Outbreak)

Epi-Section Responsibilities	Number Needed	Phys./ Nurses	Person Interv	Phone Interv	Educ/ Comm	Phone Ans	Epi II	Epi I	Data Coord	Data Entry
<b>Clinical Epi-Section</b> (0.5 persons per 50 cases) Case confirmation/nasal swabs/referral for treatment/PEP	5	5								
<b>Total Clinical Epi-Section</b>	5	5								
<b>Case Finding Epi-Section</b> a. Alert/educ. Public & physicians/exp b. Active surveillance: record review/interview at ERs c. Call exposed <24hrs d. Personal interview 20% exposed <24hrs e. Personal int. of each case <24hrs & identify contacts f. Call case-contacts <24hrs g. Personal interview of 20% contacts <24 hrs	5 10 100 20 20 100 20	9	20 20 20	100 100	5					
<b>Total Case Finding Epi-Section</b>	275	9	40	200	5					
<b>Outbreak Management Epi-Section</b> a. Project management (1.0 per 50 cases) Notification and confirmation Develop working case definition/recording forms Epi-Section supervision/agency coordination Develop line listing of cases Database coordination Hypothesis testing of exposure and risk factors Treatment and PEP recommendations and coordination b. Identify high risk employees (Guess) c. Handling public inquiries (1 person per 50 cases)	5 5 10						2	3		
<b>Total Outbreak Management Epi-Section</b>	20					10	2	8		
<b>Exposure Assessment Epi-Section</b> a. Personal interview of 20 cases for exposure assessment b. Identification of exposed & develop line listing	1 4							1 4		
<b>Total Exposure Assessment Epi-Section</b>	5							5		
<b>Data Base Support Epi-Section</b> (0.5 per 50 cases) Maintain line listings of cases, exposed, & contacts Maintain clinical, lab, and exposure database Provide data tabulations for hypothesis testing Technical IT support	5								3	2
<b>Total Data Base Support Epi-Section</b>	5								3	2
<b>Total Personnel Needed</b>	310	14	40	200	5	10	2	14	3	2

ATTACHMENT F

INFLUENZA TESTING AT THE BUREAU OF LABORATORIES

## Influenza Testing at the Bureau of Laboratories

Test	Method	Application
Directogen	EIA*	Rapid screening for influenza A/B
Subtyping	PCR*	Determines "H" type*
Viral Isolation	Cell culture	Definitive detection of influenza and other respiratory viruses
Viral Culture Confirmation	FA*	Confirmation of cell culture
Influenza confirmation	HA and HAI*	Definitive typing of influenza using WHO antisera

EIA = Enzyme immunoassay  
PCR = Polymerase chain reaction  
"H" type = Specific kind of hemagglutinin on virus  
FA = Fluorescent antibody  
HA = Hemagglutination assay  
HAI = Hemagglutination inhibition assay

ATTACHMENT G  
EMERGENCY MEDICAL SERVICES EMERGENCY RESPONSE PLAN



## **Emergency Medical Service – Emergency Response Plan**

### **Interpandemic Period**

1. The Emergency Medical Service Office (EMSO) will establish a standard outline of necessary components for service infection control guideline program. An infection control program is required for ambulance licensure.
2. Recommendations will be based on CDC guidelines, OSHA standards, PA laws, EMS directives and recommendations from the DOH Epidemiology.
3. The EMSO will maintain ambulance and quick response service (QRS) infection control coordinator database. The EMSO will establish components for initial infection control practices training and yearly update training there after.
4. The EMSO will establish components for initial refresher training courses for those individuals nominated as service infection control coordinators. Such training will provide them with the necessary information to do their job and have the ability to conduct infection control training.
5. Infection control programs will be made available through the Learning Management System and in the traditional classroom setting
6. Training will also be made available on an annual basis at the state EMS conference.

### **Pandemic Period**

1. The EMSO will notify ambulance and QRS services Infection Control coordinators, service physicians, regional council of disease specific infection control precautions and vaccines available.
2. The EMSO will monitor daily/weekly diversion through reports from regional EMS councils
3. The EMSO will establish two-way communication flow.
4. The EMSO will monitor availability of EMS services and practitioners through conference calls with regional EMS councils

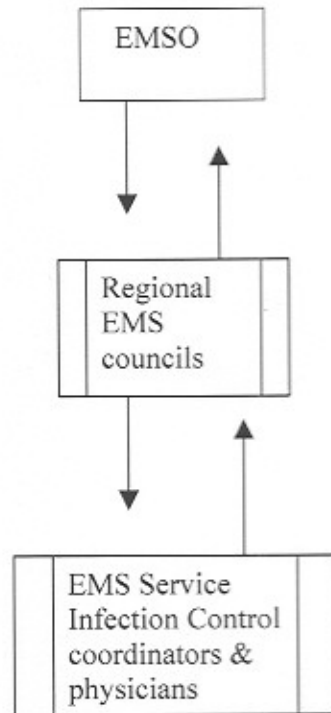
### **Post Pandemic**

1. Continuation of chain of communication between service infection control coordinator, service MD's, regional EMS councils and EMS providers through LMS and emails
2. Increase infection control measures and awareness

### **Post Response**

1. Meet with regional EMS councils, service infection control coordinator and service MDs to discuss lessons learned
2. Conduct CISM or debriefing if needed for EMS providers and support staff
3. Continue training

**Two-way Communications for Phase II - Response**



ATTACHMENT H  
POINTS OF DISPENSING (POD) TEMPLATE PLAN

## FOREWORD

This SNS Points Of Dispensing (POD) template is to be used by the Regional Counter Terrorism Task Forces (RCTTF) to develop specific dispensing site operational plans and standard operating procedures. The template provides the required content area that all RCTTFs should include. The format and terminology can be adjusted or newly developed. The appendices are tools for RCTTFs to use/revise if they are helpful or new forms/tools can be developed.

The template also serves to create an operational consistency between RCTTFs that may be called upon to provide assistance to neighboring RCTTFs as necessary. The greater the similarity between jurisdictions and regions, the easier for personnel to adapt if asked to help.

## SNS DISPENSING SITE PLAN TEMPLATE TABLE OF CONTENTS

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**ALL HAZARDS POINT OF DISPENSING (POD) PLAN TEMPLATE****I. INTRODUCTION**

The dispensing of medications/vaccine is a core function of the Strategic National Stockpile (SNS) plan and preparedness. It is the most complex and challenging of all the functions since large numbers of persons must be provided medication/vaccine in just a few days when an event occurs. The key to survival for most people is to provide antibiotics/vaccine as soon as possible and/or before an individual begins to show any clinical symptoms. This plan describes the dispensing of medications to a large number of people for prophylaxis of asymptomatic individuals as well as treatment of symptomatic persons. This is made possible through venues such as Points Of Dispensing (PODS) and hospitals that are part of the medical system developed in each region. The affected population determines the number of PODs. The CDC recommendation is one POD per 20,000 populace. Persons eligible to receive medications/vaccine will be determined by Public Health officials working within a unified command structure based upon reports from Emergency Medical Services (EMS), hospitals, Infection Control Practitioners (ICPs), law enforcement (LE), and physicians regarding the number of the potentially exposed population.

**II. PURPOSE**

The purpose of this document is to describe the organization and operation of a POD; define responsibilities and responsible parties; provide an operational template for dispensing medications/vaccine locally or regionally; receive medications, vaccines, supplies, equipment from the Receipt, Stage and Store (RSS) warehouse; submit orders to restock materials; maintain tracking and inventory of material; and tracking of recipients and documentation of personal health information care received. This document is intended to provide a basis for standard operating procedure (SOP) development.

**III. ORGANIZATION**

The organization of the command and control structure for PODs will be locally determined and will fit into existing local emergency command structure. The model for such organization is the National Incident Management System (NIMS) and specifically the Incident Management System (IMS). Figure 3-1 is a model that can be adopted/adapted locally and regionally to provide on-site structure for efficient and productive service. See also Appendices A-E for complete organization structure.

Figure 3-1 POD Command Organization



#### IV. ROLES AND RESPONSIBILITIES

- A. **POD Manager:** The POD Manager is responsible for the command and control activities of the POD. This person(s) will manage and control the total operation of the facility. The Manager ensures the POD functions at the highest level of efficiency possible with the given staff and supplies. The POD Manager directly oversees the operations, logistics, planning, and administration by working closely with the section chiefs and coordinators for all shifts. The POD Manager (or designee) will communicate/coordinate with the county EOC.
- B. **Public Information Officer(s) (PIO):** This person(s) will establish and maintain a relationship with all stakeholders to provide information and receive information. The POD PIO will coordinate media activities and information releases with the county EOC and PA DOH PIO. Media communications will be the responsibility of the county or state PIO. Information will be forwarded to the county/state PIOs for possible distribution to appropriate groups or organizations. The PIO will participate in the Joint Information Center (JIC).
- C. **Health and Safety Officer:** This person is responsible for ensuring the POD is free from health and safety hazards before, during and after operations. The Health and Safety Officer will collaborate with the other sections chiefs regarding the resolution of any safety issue.
- D. **Operations Section Lead:** This section takes responsibility for all clinical areas of the POD. This section consists of the following functional areas:
  1. Patient Services: registration, medical screening/triage, emergency care, transportation of internal patients, patient education and exit monitor
  2. Pharmacy Services: dispensing and consultation



3. Special Needs: non-English speaking patients; deaf, blind, illiterate patients, wheelchair/walker/cane patients, and patients requiring mental health services
4. Inventory of supplies, medications, equipment

The Operations Chief will ensure the staff in the respective services fulfill the requirements of the standard operating procedures (SOPs) and are within their scope of practice and training. If staffing adjustments are needed, this Chief will develop the plan/recommendations for the Site Manager to consider and/or implement. This section must coordinate the transport of any patient from triage or sick room to a treatment center.

- E. **Logistics Section Lead:** This section is responsible for all support needs of the POD. This section consists of the following functional areas:

1. Facility maintenance
2. Security
3. Supplies
4. Food Services
5. Equipment Maintenance
6. Housekeeping

This section is tasked with procurement of materiel and therefore, must work closely with the Operations Section Lead and the POD Manager. There may be specific refrigeration and security needs for pharmaceuticals that should meet federal Occupational Safety and Health Administration (OSHA) and PA DOH standards. The nutritional needs of the staff are essential and this must be coordinated with the county EOC, American Red Cross (ARC), and other agencies contracted by the county EOC to provide food/beverages.

- F. **Administration Section Lead:** This section is responsible for ensuring all POD personnel, volunteers, patient and supply records are correctly kept and maintained throughout the event. This section consists of the following functional areas:

1. Event documentation
2. Patient record retention
3. Patient data entry
4. Coordination of personnel/volunteers (time records, credential verification, staff schedules)
5. Transportation of personnel/volunteers to POD from staging site, if necessary
6. Communication with the Section Leads and POD Manager regarding problems, shortages, needs, etc.
7. Documentation, tracking, inventory tools/logs
8. Routine reporting to POD Manager, county/state EOC

This Section Lead will need to work closely with this section's coordinators to insure patient and personnel statuses are current and accurate. Time, procurement and cost

accounting are the primary functional activities of this section. This section will manage all paperwork generated at the POD. This section is responsible for patient registration, treatment or its deferral, disposition of records, and communicating changes in standing orders. Additionally, this section will direct the management of unassigned personnel/staff, such as spontaneous volunteers who may report to the POD, and coordinate with the POD Manager to insure impromptu on-site training to new members is provided as necessary. Consider positioning the POD Manager's office/workstation in close proximity to the Administration Section. Insure internal POD communications conform to the site IMS structure. Must be prepared to handle situations such as: post-exposure prophylaxis capacities based on different event scenarios; multiple vs. individual regimens; adult pick-up for other family members with incomplete identification (ID) information; establishment of triage location at outset; collaborating with county and state EOCs to determine volume of patients per hour; and staffing for continuous operations.

- G. Communications Chief:** Responsible for coordinating the internal and external communication resources such as radios, walkie-talkies, RACES activities if used, land and cell phones, computers, printers, and fax machines. Telecommunications and information technology are crucial because incoming and outgoing information must be efficiently and consistently maintained. Important information, such as: number of radios, frequencies used, and who has what type of equipment must be determined. The Communications Chief will perform an inventory analysis at the end of each shift to account for such materiel. All offices, appropriate workstations, and administrative areas must have, at minimum, phone lines. The Communications section must have dedicated phone lines and computers to receive and transmit requests and information. The Chief and section coordinators must provide technical assistance, as needed, or be able to access such assistance. Additional phone jacks should be made available. Consider use of multi-function wireless communication devices powerful enough to communicate outside of the POD. Consider a staff pool to use as runners if resources are scarce, inadequate, or inoperable.

## **V. FUNCTIONAL UNIT: OPERATIONS**

### **A. Credential Verification of Licensed Personnel**

1. County/regional plans should utilize and develop a pre-event list of interested professionals that would volunteer but are not part of the public health and hospital staff. These Public Health volunteers should be updated every two years. Licensing can be verified using the PA Department of State. Incident badges should be designed and produced pre-event so they are ready for distribution to all professional volunteers. The design of the badges should enable a picture ID to be attached to the backside of the incident ID. No staff should gain entry to the POD without appropriate ID. Any ID process should be coordinated with the county/RCTTF.

The counties plan needs to include:

- (a) A database of essential personnel and immediate family members, with guidelines to regularly update database
  - (b) A protocol to handle essential personnel not listed in the database
  - (c) Pre-determined staging sites to gather personnel and issue ID badges
  - (d) A notification system to alert volunteers and direct them to a staging site or designated clinic site
2. County plans should include a process for identifying volunteers that will be needed for non-skilled functions. A pre-event volunteer list would enable a criminal background check to occur.
  3. If locally required a liability waiver form and decide when individual volunteer staff will sign the form.

#### B. Orientation and Training of Volunteers

1. Pre-event preparation should include community-training opportunities for both professional and non-professional volunteers. Consider use of videos, community presentations, web-based instruction, collaborative partnerships between organizations to provide the training, etc. Regions should work with all stakeholders to develop standardized training modules and tools to insure correct and consistent information. Employers for staff education and in-services can use the same training materials. Contacting a variety of civil, fraternal and cultural organizations to solicit their cooperation may be a way of accessing groups of volunteers. These volunteers will be especially needed to assist with interpreting for the non-English speaking; signing for the hearing impaired; and assisting the visually impaired. Consider language line services to augment interpreter resources.
2. Staff briefing and just-in-time training should occur on-site. Pre-planning will make this process effective and efficient. Suggested training materials may include: educational videos, job action guidelines, agent specific information (i.e., fact sheets), samples of accurately completed forms, written scripts when applicable, and an organizational chart outlining the chain of command and communication flow. The staff should be clear about whom to report to regarding questions. A POD flow chart should be clearly posted for staff to use as a reference tool. Training (pre-event or on-site) must also include use of personal protective equipment (PPE) and relevant infection control measures, standard operating procedures (SOPs), information on the agent and prophylactic measures/standing orders, standard reporting procedures, response to outside requests for information, and patient confidentiality. Universal precautions should be routinely practiced by health care workers/volunteers at the POD. Hand washing or waterless hand sanitizer use is paramount. PPE should be disposable and disposed of appropriately. County plans will include provisions made for having PPE readily available.

### C. Receipt of the Medications and Supplies

1. The POD must have the ability to maintain appropriately controlled temperature settings for medications/pharmaceuticals. The U.S. Pharmacopoeia defines as "the usual and customary working environment of 20° C to 25° C (68-77° F) that allows for brief deviations between 15° C and 30° C (59-86° F) that are experienced in pharmacies, hospitals, and warehouses"<sup>1</sup>. When the POD receives the medications and supplies from the RSS, the material must be formally accepted and stored immediately by the Supply Coordinator.
2. The received pharmaceuticals and supplies must be inventoried by the Supply Coordinator and documented. Any discrepancies (excess/deficiency or wrong medications/supplies) between the order and delivery require the Logistics Section Lead be notified in order to contact the RSS for reconciliation.
3. The delivery invoice is checked, signed off by the Logistics Section Lead, and then copied by the appropriate person in logistics. This is then forwarded to the Administration section, RSS, and county EOC.
4. POD delivery points should be designated and clearly marked.
5. Ensure that the POD has a plan to unload supplies.

### D. Labeling of Prescriptions

1. Describe how medications will be labeled to comply with Commonwealth of Pennsylvania and Food and Drug Administration (FDA) regulations. Minimum information should include, but is not limited to:
  - (a) Lot number
  - (b) Drug name, strength, and quantity
  - (c) Directions for use
  - (d) Name/address of dispensing location
  - (e) Name of prescribing provider
  - (f) Date
  - (g) 24 hour telephone number
  - (h) Prescription number
  - (i) Patient name
  - (j) Initials of dispenser
2. Pre-event: Create a CD-ROM or floppy disks with label information ready for printing. Repeat all labels in appropriate foreign languages. CDC provides a CD-

<sup>1</sup> U.S. Pharmacopoeia, *Practitioner Reporting*. No. 40, Revised 6/94, "Storage Definitions."

ROM with software to print labels in 47 languages. Each Public Health Department and RCTTF should have a copy of this CD-ROM.

When creating a label in a foreign language, the English version of the label will have to be edited; print two labels (one in English, one in the other language) on Avery 5395 name badge labels or an equivalent. It will hold all the required information in English.

- (a) The English label is placed on the front of a bag/container and will contain the FDA required information. Labels in other languages contain instructions for taking the drug and precautions for using it.
  - (b) Foreign labels cannot be edited
  - (c) Unit dose bottles will only require prescribing agency, provider, and 24-hour telephone number for questions.
3. As an alternative to having a printer and computer at each site, the county/RCTTF may wish to establish a contingency contract with a large photocopy firm to store the contents of the CD-ROM, the name/address/phone/health history (NAPH) form, and other event-related forms. During an emergency, the firm could replicate needed labels/forms and deliver them to the POD.

#### E. Patient Health History/Release of Information

1. The CDC software on CD-ROM includes electronic versions of patient information forms in English and 47 other languages, for each drug and threat. The templates are in Adobe Acrobat. The templates do not require special fonts. The dispenser's name, the prescriber's name, and a 24-hour phone number for questions can be inserted.
2. The CD-ROM contains formats for printing dosing instructions and precautions in multiple languages that cannot be edited.
3. The NAPH form needs to contain name, address, phone number, health history, lot number, and prescription number of medications/vaccine, allergies, telephone number or message number, birth date, demographics and relevant questions with regard to the bioagent. Any actual or probable contraindications to receiving prophylaxis or vaccine should be referred to an on-site professional for further assessment and resolution of outcome.
4. The county/RCTTF may consider a contingency contract with a local printer to produce health history forms, fact sheets, and documentation tools for delivery during an emergency (such as a power outage or when computers/printers are not available.) The contractor could be provided a copy of the CDC CD-ROM.
5. An appropriate release of information must be signed for each adult/child who is a recipient of the medications/vaccine.



6. Local PODs will forward data to PA DOH for aggregate databases in accordance with established guidelines.
7. When developing forms, consider carbonless copy format to facilitate tracking.
8. Refer to Appendix H for sample forms

F. Tracking Medications/Vaccine and Recipients

1. Name, address, phone, and health history information must be obtained during registration. Barriers to overcome include: language, blindness, deafness, illiteracy, as well as undocumented individuals who are fearful of providing accurate information. Additionally, a family member picking up medications for other family members may not have all the information needed to accurately prescribe for each member (e.g., a child's weight). Forms, therefore, should be short, simple, and bio-agent specific. Include instructions for completing the NAPH form and make it available to people in line for a large-scale event.
2. The key to tracking drugs, its lot, and its recipient is the drug's unique prescription number. Documenting the prescription number on the patient's NAPH form will allow for the identification of every patient that received a particular drug/lot combination. Additionally, the dispenser must document the date, time, and location of the POD, then sign and date the form.
  - (a) 30 stamping machines for creating unique recipient prescription numbers are included in the 12-hour push package. The machine is hand-held and will stamp a 7-digit number as many times as specified
  - (b) Consider providing a block of prescription numbers to each site.
3. PODs may wish to utilize a tracking and identification system that allows for accurate, unduplicated patient count and also prevents patients from processing more than once (tags, hand stamps, etc.)
4. Local jurisdictions must determine how to aggregate the recipient data either by computer entry or hand tabulation. Key entry while patients are in line will invariably slow the patient flow process significantly. On-site key entry, if used, should occur after the client has exited. Another option is to consider contracting for the key entry from annotated NAPH forms. Again, the signed release of information must allow for this.
5. Each dispensing site should have several copies of the standing orders for the specific bio-agent that includes guidelines for both adult and pediatric regimens
6. Establish procedures for consultation for those patients who have extensive questions for the pharmacist

## 7. Protection of Those Who Cannot Use PODs

- (a) County plans need to address dispensing to staff and in-house populace of nursing homes and other long-term care facilities (including mental health facilities), senior residential centers, inmates of a correctional system (jails, prisons, juvenile detention centers), hospitals, special needs, cloistered communities, homeless, and homebound individuals

## 8. Essential Personnel

- (a) Local or Regional caches of medications/vaccines for essential personnel should be pre-planned by that jurisdiction.
- (b) The county and regional plans should include when and where immediate family members will receive their prophylaxis and how they will be notified.
- (c) If local or region caches exist then a POD should to be activated as quickly as possible to provide medications/vaccine to essential personnel.
- (d) Each county/regional jurisdiction should know the number of people in the following essential personnel groups:
  - (1) Emergency first responders: EMS, HAZMAT, fire, law enforcement, public health response teams
  - (2) Hospital personnel
  - (3) Mortuary Services
  - (4) Other individuals assigned specific tasks within the response
- (e) The total number of essential personnel multiplied by the number of immediate family members (3-4) equals the amount of medication needed before the 12-hour Push Package or VMI arrives
- (f) Priority groups for receiving prophylaxis may include the following:

Priority 1	Priority 2	Priority 3	Priority 4
Essential government-federal, state, local	High risk by age, condition, disability	Secondary government, medical, public service personnel	Others-healthy individuals, transits such as tourists
Essential medical physicians, nurses, EMS, pharmacists	Essential civilians-food service workers, mortuary personnel		
Essential public service-police, fire, public health, utility, hospital personnel, National Guard (NG)			

Note of concern: Family members of personnel in the above groupings. Once groups are listed by priority, must determine how individuals will identify themselves to receive their supplies.



## (g) Important selection criteria at time of the incident:

- (1) Nature of disease: Target certain groups more than others? Which groups are at highest risk for death?
- (2) Geographic location: Is it likely to be contained in one area that then becomes a higher priority?
- (3) Time factors: Can sick people be effectively treated once they show symptoms? Would drugs/supplies be better used for prophylaxis or treatment?
- (4) Can self-isolation or quarantine be effectively implemented to reduce need for drug use? How at risk are family members for getting sick?
- (5) How many people fall into each category? Enough supplies to effectively treat desired groups?
- (6) How fast will supplies be available to conduct further dispensing to various groups?

## G. Staffing

1. The number of personnel needed to operate a POD depends on the size of the POD; the number of patients expected to be treated over selected days; the type of agent; the magnitude of the event; and whether the agent is infectious or non-infectious. Identification of staff with proper training is paramount to POD operations. Staff can be categorized as follows:
  - (a) Core personnel are health professionals with specialized skills and training. This group includes doctors, nurses, and pharmacists, and emergency medical services personnel.
  - (b) Trained volunteers. This group includes the following:
    - (1) Interpreters
    - (2) People who know sign language
    - (3) Generalists that have provided assistance before, such as the American Red Cross, truck drivers, etc.
  - (c) Untrained volunteers, such as civic and fraternal organizations
  - (d) Develop system to enable rapid identification of runners by utilizing colored vests.
2. Assess and initiate waiver process pre-event to overcome legal/regulatory barriers that prevent non-pharmacists from dispensing/distributing prescription drugs during a large-scale emergency
3. Refer to Appendix K for staffing roles and JASs
4. Weill/Cornell Bioterrorism and Epidemic outbreak Response Model (BERM) is a software tool that can assist in determining the number and types of personnel

needed to staff dispensing sites. Additionally, the software assists in calculating patient flow rates. The user is allowed to determine the population size, number of days of POD operations, hours of operation, number of shifts, and downtime to include in the calculations.

5. The Weill-Cornell tool can be downloaded from:  
[www.ahrq.gov/research/biomodel.htm](http://www.ahrq.gov/research/biomodel.htm)
6. The POD should have designated staff parking with appropriate signage to reserve the area

## VI. SITE SELECTION

- A. Selection of dispensing sites should be based on a worst-case scenario. Facilities should be assessed with consideration to providing prophylaxis to the entire population of the local jurisdiction. It is much easier to scale down than to try to expand. Magnitude, type, and location of the incident determine the number of people exposed and therefore, the number and location of the sites needed to protect people within a specific time period. More sites enable easier public access; reduced length of lines, time, and anxiety. The trade off is more security, delivery vehicles, drivers, and core staff members, particularly pharmacists, doctors and nurses, are needed. Therefore, it is better to have larger and fewer sites.
- B. Triage Location
  1. Triage should be located a relatively short distance from the dispensing site.
  2. Triage design should include:
    - (a) Climate controlled waiting area
    - (b) Special needs accommodations
    - (c) Sanitary facilities
    - (d) Privacy for medical counsel
- C. Operating hours at each site should be planned for 24 hours a day until the community receives the first protective regimen. In addition to size and location, consider accessibility to major roads and transportation, and facility capacity to handle large numbers of people under cover and out of the weather. Each site should have, at a minimum, the following characteristics:
  1. Heat and air conditioning to maintain controlled room temperature (see also Section 5.31)
  2. Refrigeration for vaccines, if necessary
  3. Adequate bathrooms, water, and electricity
  4. A loading area for receipt of supplies
  5. Adequate parking for staff and populace

6. Heliport of helicopter landing zone if required
  7. Handicap accessibility
- D. Refer to Appendix K for the POD site criteria checklist when performing an assessment site visit.
- E. Possible facilities to consider for PODs:
1. Public Schools, e.g., high schools
  2. Universities
  3. Community recreation centers
  4. Armories
  5. Government buildings
  6. Polling places
  7. Community colleges
- F. The county/regional SNS plan should include the following information regarding the identified dispensing site(s): facility name, address, contact person with phone and pager numbers to reach the individual, schematic of the building, detailed directions, and location in building where supply delivery will occur. If a helicopter is used to deliver, the longitude and latitude should be included, if possible.

## VII. SITE DESIGN

- A. Efficiency is directly related to the number of community members that can receive medication/vaccine per hour. If the number is greater than the capacity of a POD, the efficiency of the selected site needs to be improved or increase the number of sites. If professional staff such as doctors, nurses, pharmacists are in short supply, have the health care workers supervise volunteers who do the work at the stations, when appropriate. The HCWs become available for management, consultation, supervision, and education. Create redundancy for all the major functions.
- B. Important Processes to Include in County/Regional Plans
1. Design the POD to function at maximum efficiency
  2. Prepare pre-event multi-language signs, handouts, posters, videos that will:
    - (a) Direct the movement of people
    - (b) Keep people moving
    - (c) Let them know what is happening
    - (d) Educate them about the medications
  3. Keep the NAPH forms simple
  4. Minimize the number of stops to get medications

- (a) If a patient is diverted for consultation, weighing, etc., do not have him/her start at the beginning again
- 5. Insure adequate staffing and space for anticipated bottle necks
  - (a) Registration
  - (b) Triage
  - (c) Medical screening/evaluation
  - (d) Special needs such as language interpretation, signing for the hearing impaired, assistance for the illiterate, scales and volunteers to weigh children under age 5
- 6. Insure adequate security by communicating with the county EOC. Crowd control, lines, entrance and exits, and supplies require adequate protection. Avoid underestimating the law enforcement manpower.
- C. Insure that floor plans allow for one entrance and exit to maintain efficient and controllable patient flow
  - 1. Refer to Appendix M for sample floor/patient flow plans
  - 2. Utilize facility schematic to develop pre-event facility specific patient flow plan
  - 3. Use various facility flow plans for table top exercises
  - 4. Develop a diagram of patient flow for each facility identifying all the needed stations and work areas
  - 5. Confidentiality maintained at the medical evaluation/consultation stations

## **VIII. PUBLIC INFORMATION AND RISK COMMUNICATION**

- A. During a large-scale emergency, a swift and effective health communications plan designed to inform and reassure the public will reduce fear and anxiety and earn confidence and cooperation from the community. The state and local all-hazards plans should contain bioterrorism information that educates, directs, and informs. State/local Public Information Officers (PIO) and health educators are crucial in the pre-event planning and development of threat specific messages, information, media releases as well as disease and medication information. Incident specific messages tell people where to go for prophylactic medication if well; where to go if sick; dispensing site locations and hours, required identification documents to bring, etc. Prepared messages and information materials can quickly be modified with incident specific facts and data. A health communications plan should minimally include:

1. Multi-language text of all documents used to inform the public during an emergency. These include TV and radio public service announcements (PSAs), informational materials, forms scripts, and videos that the dispensing site will use to provide medications
2. Storage location of all informational materials, including electronic versions
3. Methods for reproducing and disseminating informational materials during the emergency
4. Specific communication channels, partnerships, and staffing pools that support all of the health communications activities

**B. Health Communications Information Regarding PODs**

1. Agent and the threat to the public health
  - (a) Contagious?
  - (b) Who should be concerned about exposure?
  - (c) Who should seek prophylaxis at dispensing sites and who should seek treatment at treatment centers?
2. Directions to and information about dispensing site locations
  - (a) When will the POD operation start and what hours will the site be open?
  - (b) Where is the nearest POD?
  - (c) What is the best street access?
  - (d) Where should the public park at each POD?
  - (e) What is the best way to get to the POD? Walk, public transportation, drive?
  - (f) What is the dispensing process within the POD?
  - (g) What types of identification are needed?
  - (h) What information must be brought to pick up medications for other family members?
    - (1) For children: weight, age, health information, drug allergies, and current medications.
    - (2) For adults: health information, drug allergies, and current medications
3. Medication information the public will receive at the POD:
  - (a) Reasons for using specific drugs or changing drug regimens
  - (b) Importance of taking all of the medication
  - (c) Danger of over medicating
  - (d) 24-hour information phone number for medication questions
  - (e) Medications are not intended for pets

- C. Incorporate resources/examples as needed from the PA DOH Risk Communication plan

**IX. Infection Control**

- A. Include generic infection control measures to prevent transmission to health care staff and close household contacts
- B. Suggested measures if client presents with symptoms or history of exposure extending beyond the incubation period
  1. Patient use of mask, if applicable
  2. Hand washing with soap and water or as second choice, with alcohol based hand rub. If disposable gloves used, wash hands after removing
  3. Notify transport personnel in order to don PPE, if appropriate, for transfer to treatment facility or home
  4. Separate from other clientele at dispensing site or triage area
  5. Clean or remove items handled by the sick/exposed client if agent appropriate
  6. Notify county EOC of needed transport

**X. Security/Transportation**

- A. Security of dispensing sites, personnel, and supplies will be coordinated through the county EOC
  1. Establish guidelines for regular security sweeps of the POD, including all areas the public is permitted to access
  2. 24 hour emergency management phone number:
  3. Name of emergency management coordinator:
  4. 24/7 PA DOH phone number:
    - (a) 1-877-PA HEALTH
- B. Local law enforcement or Pennsylvania State Police (PSP) will provide security for the POD.
- C. Consider forms of transportation to take patients to POD to decrease traffic flow

**XI. Training and education: Training gives responding participants a basic understanding of the POD operations.**

**A. Pre-event training module**

1. POD schematic for patient flow and work station locations
2. Roles and functions for each work station
  - (a) Include scripts for each role
  - (b) Utilize JASs for teaching and learning
  - (c) Standing Orders
  - (d) Use of forms
3. Communication Skills
  - (a) Guidelines for handling on-site procedural changes that impact other functional groups
  - (b) Document information received via phone
  - (c) Periodic briefing of all staff to clarify misunderstandings, answer questions, and provide new information/updates
4. Screening Protocols
5. POD Supplies and Equipment List
6. POD Operations
  - (a) Documentation forms: NAPH form, meds/vaccine and recipient tracking
  - (b) Screening tools
  - (c) Patient Education materials
  - (d) Referral processes
  - (e) VAERS Reporting
  - (f) Staffing Schedule
  - (g) Organizational structure
  - (h) Signage
  - (i) Taping arrows/lanes/path for clients to follow
  - (j) Numbering stations
  - (k) Procedure for victim status system utilizing color-coded system. Provide quick reference cards to all greeters, registration staff, security, and other relevant personnel.
7. Recruit and train a corps of professionals to staff and manage dispensing operations (nurses, doctors, pharmacists, mental health specialists, etc)
8. Tabletop exercise

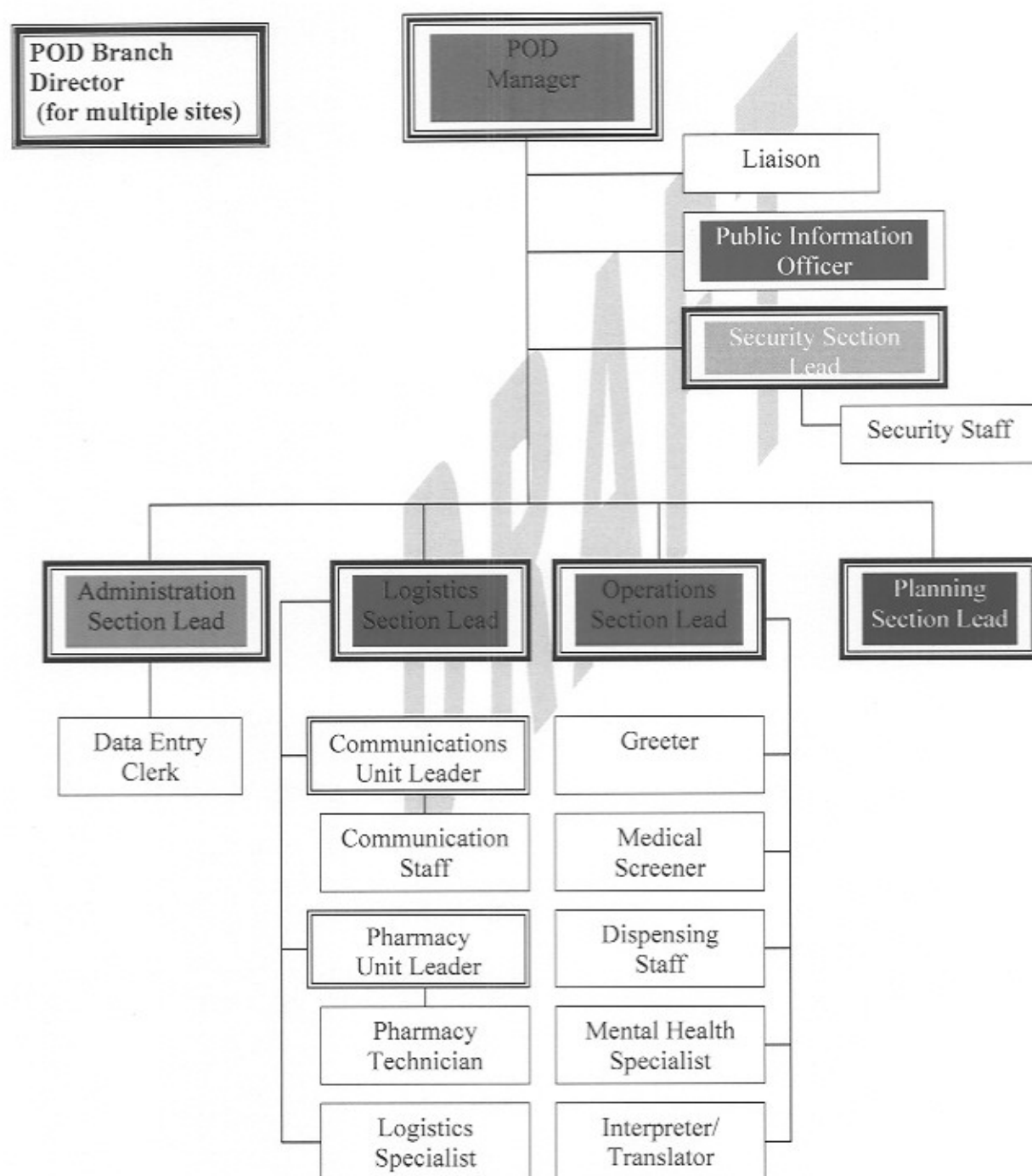


- 9. Functional exercises
- B. NIMS/ICS training for local public health
- C. After Action Review
  - 1. On-site manual with all of the pre-event training information
  - 2. Use of individual JAS to orient each group of personnel
  - 3. Group review of on-site manual
  - 4. Designated on-site individuals to handle all staff questions

## **XII. Recovery**

- A. Inventory all unused meds/vaccine and supplies
  - 1. Specialized cargo containers
  - 2. Refrigeration systems
  - 3. Unused medications that can be verified for proper temperature maintenance
  - 4. Generators (if borrowed)
  - 5. Computer and communication equipment, as applicable
- B. Return to RSS in labeled boxes/containers
- C. Return all unopened boxes to RSS
- D. Clean facility: debris, personal items, medical supplies/equipment, biowaste
- E. Remove equipment brought to site: e.g. tables, chairs, computers, communication equipment, etc.
- F. Notification of site point of contact (POC) when the facility is vacated

**APPENDIX A**  
**PADOH Incident Command Structure**  
 POD ORGANIZATIONAL CHART



## POD Lead Job Action Sheets

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

SNS OPERATIONS  
DISPENSING SITE SECTION  
POD Manager  
Revised: 4-03, 9-03, 12-03

### POD MANAGER

Positioned Assigned To:	
You Report To: _____	(POD Branch Director)
Dispensing Site Location: _____	Telephone: _____
SNS Dispensing Sites Manager: _____	Telephone: _____
SNS Operations Command Center: _____	Telephone: _____

**Mission:** Organize and direct aspects relating to the POD. Carry out directives of the SNS POD Branch Manager or Operations Center. Coordinate and supervise the POD Staff.

**Upon Activation:**

- ☐ Receive briefing from SNS POD Branch Director or Operations Center. Ensure knowledge of mission and plan of operations.
- ☐ Review this position checklist.
- ☐ Review Mass Prophylaxis Planning Guide. (SNS, Pandemic, Smallpox, etc. Plan)
- ☐ Confirm activation of your staff, and assign or greet them as they arrive:
  - Administration Section Lead
  - Logistics Sections Lead
  - Operations Section Lead
  - Planning Section Lead
  - Security Section Lead
  - Public Information Officer
  - Liaison Officer
- ☐ Meet with your staff:
  - Establish chain of command and performance expectations:
    - Your staff is to report **ONLY** to you.
    - They work with other staff as assigned by you, but they **DO NOT** take instructions from or provide information to anyone other than you (or a Safety Officer if regarding a safety issue).
    - Any questions, problems, or incidents should be reported to you, **NOT** to anyone else.

- It is important that they DO NOT MAKE DECISIONS on their own, other than provided for in their Position Checklist. This ensures critical consistency with respect to performance and information at the site.
- Ensure that they are personally prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Prepare a briefing statement, for the Operations Section Lead, to be given to staff members at scheduled briefing(s):
  - Operational overview
  - Stations / patient flow
- ☐ Confirm with Logistics Section Lead that all equipment and supplies are being shipped to the treatment site, and that areas are being set up.
- ☐ Develop on-site staff assignments and work schedule.

#### On-site Operations:

- ☐ Follow the chain-of-command. THIS IS CRITICAL to ensuring consistent behavior and information across sections and shifts:
  - Give instructions ONLY to personnel that report to you, and take instructions ONLY from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do NOT make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Participate in staff briefing(s) as scheduled by the Section Leads.
- ☐ Maintain Unit Log.
- ☐ Work with the Logistics Section Lead to set up briefing, interview, dispensing and pharmacy areas. Make sure areas have all equipment and supplies needed to carry out their functions.
- ☐ Work with the Operations Section Lead to ensure that material presented is consistent with the mass prophylaxis process and other information being distributed.
- ☐ Meet with Security Section Lead to review any and all safety or security issues.
- ☐ Meet with Pharmacy Unit Leader to review pharmaceutical operations and supplies.
- ☐ Brief all station supervisors on procedures for additional supplies, security problems, treatment issues or other problems.
- ☐ Follow the mass prophylaxis process as patients begin to filter through each station. Modify any process as needed.
- ☐ Ensure that proper documentation is maintained for all activities.

#### Deactivation Phase:

- ☐ Ensure that all records and reports are turned in to the SNS POD Branch Director or Operations Center.
- ☐ Conduct exit interviews with your direct staff.
- ☐ Participate in the After Action Report process and generate reports on the activities from this POD.

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
PUBLIC INFORMATION SUBSECTION  
Public Information Officer  
Revised 4-03, 9-03, 12-03

### PUBLIC INFORMATION OFFICER (P.I.O.)

Position Assigned To:	
You Report To: _____	(POD Manager)
Dispensing Site Location: _____	Telephone: _____

**Mission:** Provide information to the news media.

Upon Activation:

- ☐ Receive briefing from POD Manager. Ensure knowledge of full mission request and plan of operations.
- ☐ Review this position checklist.
- ☐ Review Mass Prophylaxis Planning Guide. (SNS, Pandemic, Smallpox, etc. Plan)
- ☐ Prepare a briefing statement along with the POD Manager to be given to staff members at scheduled briefing(s):
  - Mission as assigned by local management
  - Latest event information and environmental conditions
  - Any hazards or threats to staff safety and health
  - Media plan and procedures
  - Identification of the affected local emergency management structure
  - Pertinent or unique cultural or local considerations
  - Information flow and reporting requirements
  - Shift considerations, and transition instructions to oncoming staff
  - Problem solving process and methods for establishing or changing priorities

On-site Operations:

- ☐ Review your position checklist.
- ☐ Receive on-site briefing from POD Manager.
- ☐ Determine overall media policy (coordination with State, local, and Incident Joint Information Center). For example:
  - No comment: refer media to a different contact
  - Explanatory statement; no media admittance
  - Media visits permitted
  - Media permitted to attend briefing station
- ☐ Develop media statement(s) as appropriate. Review with POD Manager.
- ☐ Brief all personnel on media policy.
- ☐ Brief security personnel and greeters on media handling procedures.

- ☐ Coordinate media activities:
  - Make media contacts as necessary.
  - Provide media statements, answer questions.
  - Arrange guided tours for media as necessary.
- ☐ Participate in meetings and briefings to ensure that media considerations are a part of the plan at all times.
- ☐ Document all media contacts.

Deactivation Phase:

- ☐ Submit media contact documentation to the POD Manager.
- ☐ Identify issues and participate in After Action Report process.

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**SECURITY SECTION LEAD**

Positioned Assigned To:	
You Report To: _____	(POD Manager)
Dispensing Site Location: _____	Telephone: _____
Radio Frequency: _____	

**Mission:** Oversee the safety and security of POD staff, supplies, and equipment. Organize and enforce scene/facility protection and traffic security.

Upon Activation:

- ☐ Receive briefing from POD Manager. Ensure knowledge of full mission request and plan of operations.
- ☐ Review this position checklist.
- ☐ Review Mass Prophylaxis Planning Guide. (SNS, Pandemic, Smallpox, etc. Plan)
- ☐ Confirm activation of your staff, and assign or greet them as they arrive:
  - Law Enforcement Officers
  - Security Officers / volunteers
  - Traffic Control Volunteers
- ☐ Meet with your Security staff:
  - Establish chain of command and performance expectations:
    - Your staff is to report ONLY to you.
    - They work with other staff as assigned by you, but they DO NOT take instructions from or provide information to anyone other than you (or a Safety Officer if regarding a safety issue).
    - Any questions, problems, or incidents should be reported to you, NOT to anyone else.
    - It is important that they DO NOT MAKE DECISIONS on their own, other than provided for in their Position Checklist. This ensures critical consistency with respect to performance and information at the site.
  - Ensure that they are personally prepared, self-sufficient and adequately equipped to perform their assignments.

On-site Operations:

- ☐ Follow the chain-of-command. THIS IS CRITICAL to ensuring consistent behavior and information across sections and shifts:



- Give instructions ONLY to personnel that report to you, and take instructions ONLY from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do NOT make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Maintain Unit Log.
  - ☐ Ensure that a resource accountability system (personnel and equipment) is established and maintained.
  - ☐ Arrange for security of equipment and supplies as they arrive at the site.
  - ☐ Supervise the set-up of Crowd Control system (cones, barrier tape/ropes, etc.)
  - ☐ Participate in meetings and briefings to ensure that security considerations are a part of the plan at all times.
  - ☐ Post security staff as needed.
- At a minimum:
- Entrance: admit authorized personnel and patients only – be alert for individuals who have been to the POD before as they may be trying to acquire additional medications. Report this immediately to the POD Manager.
  - Exit: ensure no unauthorized entry
  - Roving patrol: maintain calm and order preventing disruption or civil disobedience.
- ☐ Ensure security is provided for all personnel, equipment, supplies (including medications), vehicles and buildings.
  - ☐ Meet with local law enforcement and coordinate issues/efforts.
  - ☐ Coordinate staff badges/passes as necessary.
  - ☐ Identify and advise the POD Manager as to any security issues.
  - ☐ Offer operational assistance and recommendations regarding evidence collection, processing, and security to local law enforcement.
  - ☐ Notify the POD Manager of any accidents or injuries.

Deactivation Phase:

- ☐ Ensure all records and reports are turned in to the POD Manager.
- ☐ Conduct exit interviews with your staff.
- ☐ Identify issues for the After Action Report process.

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
SECURITY SUBSECTION  
Security Staff  
Revised 4-03, 9-03, 12-03

## SECURITY STAFF

Positioned Assigned To:	
You Report To: _____	(Security Section Lead)
Telephone: _____	Radio Frequency _____

**Mission:** Provide for the safety and security of POD Staff and the general population while at the POD Site. Assist with vehicular and pedestrian traffic control.

**Upon Activation:**

- ☐ Receive briefing from Security Section Lead. Ensure knowledge of full mission request and plan of operations.
- ☐ Receive briefing on the Mass Prophylaxis Planning Guide (SNS, Pandemic, Smallpox, etc. Plan)

**On-site Operations:**

- ☐ Receive on-site briefing from Security Section Lead.

**Responsibilities:**

- ☐ Participate in the set-up of crowd control system (cones, barrier tape/ropes, etc.).
- ☐ Check all lines and stations on a routine basis for any potential problems with security and/or safety.
- Report findings to the Security Section Lead.
- ☐ Serve on entry/exit duty as assigned.
- ☐ Assists the Security Section Lead with the acquisition of any access passes/badge required by the local jurisdiction and the delivery to all staff members.
- ☐ Establish a protective perimeter for the POD.
- ☐ Offer assistance and/or advice regarding evidence processing and custody to the agency of the jurisdiction charged with that responsibility.
- ☐ Review sanitation issues as they arise and report concerns to the Security Section Lead.
- ☐ Ensure that evacuation signals and routes are labeled appropriately.
- ☐ Investigate accidents and write accident reports. Submit to Security Section Lead.
- ☐ Render assistance of a general nature as assigned.

**Deactivation Phase:**

- ☐ Turn over all records and reports to Security Section Lead.
- ☐ Provide operational assistance in packing up equipment/supplies to all areas.
- ☐ Identify issues for the after action report.

## POD Operations Job Action Sheets

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
OPERATIONS SUBSECTION  
Operations Section Chief  
Revised: 4-03, 9-03, 12-03

### OPERATIONS SECTION CHIEF

Positioned Assigned To:	
You Report To: _____	(Dispensing Site Supervisor)
Dispensing Site Location: _____	Telephone: _____

**Mission:** Responsible for the supervision of staff involving the efficiency, effectiveness, coordination and operational aspects of the Dispensing Site.

**Upon Activation:**

- ☐ Receive briefing from Dispensing Site Supervisor. Ensure knowledge of mission and plan of operations.
- ☐ Review this position checklist.
- ☐ Review Mass Prophylaxis Planning Guide.(SNS, Pandemic, Smallpox, etc. Plan)
- ☐ Confirm activation of your staff, and assign or greet them as they arrive:
  - Greeter
  - Medical Screener
  - Dispensing staff
  - Mental Health Specialist
  - Translator
- ☐ Meet with your staff:
  - Establish chain of command and performance expectations:
    - Your staff is to report ONLY to you.
    - They work with other staff as assigned by you, but they DO NOT take instructions from or provide information to anyone other than you (or a Safety Officer if regarding a safety issue).
    - Any questions, problems, or incidents should be reported to you, NOT to anyone else.
    - It is important that they DO NOT MAKE DECISIONS on their own, other than provided for in their Position Checklist. This ensures critical consistency with respect to performance and information at the site.
  - Ensure that they are personally prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Prepare a briefing statement for the Dispensing Site Supervisor and other staff at scheduled briefing(s):

- Operational overview
- Stations / patient flow
- ☐ Confirm with Logistics Section Chief that all equipment and supplies are being shipped to the dispensing site, and that areas are being set up.
- ☐ Develop on-site staff assignments and work schedule.

#### On-site Operations:

- ☐ Follow the chain-of-command. THIS IS CRITICAL to ensuring consistent behavior and information across sections and shifts:
  - Give instructions ONLY to personnel that report to you, and take instructions ONLY from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do NOT make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Participate in staff briefing(s) as scheduled by the Dispensing Site Supervisor.
- ☐ Maintain Unit Log.
- ☐ Work with the Logistics Section Chief to set up briefing, interview, clinical and pharmacy areas. Make sure staff has all equipment and supplies needed to carry out their functions.
- ☐ Meet with briefing area staff and ensure that material presented is consistent with mass prophylaxis process and other information being distributed.
- ☐ If needed: assign and brief all station supervisors ( Greeter, Medical Screener, Dispensing Staff, Mental Health Specialist, Interpreter/Translator) on procedures for additional supplies, security problems, treatment issues or other problems.
  - Note: may consider station supervisors for large-scale dispensing operation.
- ☐ Follow the process as patients begin to filter through each station. Modify any process as needed.
- ☐ Ensure that proper documentation is maintained for all activities.

#### Deactivation Phase:

- ☐ Ensure that all records and reports are turned in to the Dispensing Site Supervisor.
- ☐ Conduct exit interviews with your direct reports.
- ☐ Participate in the After Action Report process.

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
OPERATIONS SUBSECTION

Greeter

Revised: 4-03, 9-03, 12-03

## GREETER

Positioned Assigned To:

You Report To: \_\_\_\_\_ (Operations Section Lead)

Dispensing Site Location: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Mission:** Assure that all persons entering the POD are welcomed and initially screened for obvious signs of illness or injury.

### On-site Operations:

- ☐ Review this position checklist.
- ☐ Attend overall staff briefing from the POD Manager and receive assignment-specific briefing from the Operations Section Lead (your supervisor).
- ☐ Assist with set-up of Check-In area, and other areas as requested.
- ☐ Greet patients as they arrive/assemble, and briefly answer their initial questions. Let patients know that all of their technical questions will be answered in the briefings and/or the clinical interview phase.

### Deactivation Phase:

- ☐ Assist with the break-down and re-packing as requested.
- ☐ Identify issues for the After Action Report process.

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
OPERATIONS SUBSECTION  
Medical Screener  
Revised: 4-03, 9-03, 12-03

## MEDICAL SCREENER

Positioned Assigned To:	
You Report To: _____	(Operations Section Lead)
Dispensing Site Location: _____	Telephone: _____

**Mission:** Responsible for reviewing medical history forms to ensure that the correct medication is dispensed.

### On-site Operations:

- ☐ Review this position checklist.
- ☐ Attend overall staff briefing by the POD Manager and receive assignment-specific briefing from the Operations Section Lead (your supervisor).
- ☐ Ensure that interview site is physically set up and ready for operations
- ☐ Ensure that all necessary flowcharts and forms are available including:
  - Treatment Protocol Flowchart
  - Flowchart for Optimal Preventative Therapy
  - Standing orders for antibiotic prophylaxis (RN, RPh, and PA)
  - Alternative Antibiotic List
  - Anti-Seizure Medication Matrix Worksheets
  - Drug Interaction Matrix Worksheets
  - Notification to Patient's Primary Care Provider
  - Prescriptions for Antibiotics
- ☐ Ensure that all patients receive appropriate prescription for antibiotics as per treatment protocol.
- ☐ Ensure that all patients are referred for medical consultation or follow-up as per protocol.

### Deactivation Phase:

- ☐ Assist with the break-down and re-packing of the Interview Area.
- ☐ Ensure the collection of all paperwork and turn in to administration.
- ☐ Identify issues for the After Action Report process.

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**DISPENSING STAFF**

Positioned Assigned To:	
You Report To: _____	(Operations Section Chief)
Dispensing Site Location: _____	Telephone: _____

**Mission:** Initiate and dispense medication to the general population.

**On-site Operations:**

- ☐ Review this position checklist.
- ☐ Attend staff briefing by the POD Manager and receive assignment-specific briefing from the Operations Section Lead (your supervisor).
- ☐ Set up dispensing site workstations.
- ☐ Check and set up all supplies for dispensing.
- ☐ Ensure that all forms are completed properly and retaining all forms.
- ☐ Ensure availability of and distribute drug interactions forms with each prescription.
- ☐ Apply an ink stamp to the right hand of each person that receives medication, and do not issue medication to someone who already has a hand stamp. (if locally available)
- ☐ Ensure that each patient is dispensed the correct drug and strength.

**Deactivation Phase:**

- ☐ Break down and repack all equipment/supplies.
- ☐ Ensure that all paperwork is complete for turn in to administration.
- ☐ Identify issues for the After Action Report process.

Job Action Sheet

OPERATIONS SUBSECTION

Mental Health Specialist

Revised: 4-03, 9-03, 12-03

**MENTAL HEALTH SPECIALIST**

Positioned Assigned To:	
You Report To: _____	(Operations Section Lead)
Dispensing Site Location: _____	Telephone: _____

**Mission:** Assure the provision of psychological, spiritual and emotional support to the POD staff and general population in need of additional services while at the POD. Initiate and organize the Critical Stress Debriefing process as needed.

**On-site Operations:**

- ☐ Review your position checklist.
- ☐ Attend overall staff briefing, and receive assignment-specific briefing from the Operations Section Lead (your supervisor).
- ☐ Prepare the Mental Health Interview Area.
- ☐ Ensure that all patients transiting your area have had their needs met and are as comfortable as possible with the situation.
- ☐ Provide on-site counseling.
- ☐ Identify and refer any patient needing a mental health referral and/or follow-up.

**Deactivation Phase:**

- ☐ Assist with the break-down and re-packing of the Mental Health Interview Area.
- ☐ Ensure the collection of all paperwork and turn in to administration.
- ☐ Identify issues for the After Action Report process.

PA DOH SNS INCIDENT COMMAND SYSTEM

Job Action Sheet

DISPENSING SITE SECTION

OPERATIONS SUBSECTION

Interpreter / Translator

Revised: 4-03, 9-03, 12-03

**INTERPRETER / TRANSLATOR**

Positioned Assigned To:

You Report To: \_\_\_\_\_ (Operations Section Lead)

Dispensing Site Location: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Mission:** Assist the POD staff in communicating with the general population who may experience difficulty understanding the screening questions and directions being given due to a language, or other, communication barrier.

On-site Operations:

- ☐ Review this position checklist.
- ☐ Attend overall staff briefing, and receive assignment-specific briefing from the Operations Section Lead (your supervisor).
- ☐ Work with Greeters, Medical Screeners, and other POD staff to identify and assist with patients who may present with language, or other, communication barriers requiring interpretation / translation.
- ☐ Assist with intake forms completion and provide translation as necessary at each clinical site.

Deactivation Phase:

- ☐ Assist with break down of stations and repacking of all equipment/supplies.
- ☐ Identify issues for the After Action Report process.

**LOGISTICS Job Action Sheets**

PA DOH SNS INCIDENT SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
LOGISTICS SUBSECTION  
Logistics Section Chief  
Revised: 4-03, 9-03, 12-03

**LOGISTICS SECTION CHIEF**

Positioned Assigned To:

You Report To: \_\_\_\_\_ (Dispensing Site Supervisor)

Dispensing Site Location: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Mission:** Organize and direct those operations associated with maintenance of the physical environment, and adequate levels of food, shelter and supplies to support the medical objectives.

**Upon Activation:**

- ☐ Receive briefing from Dispensing Site Supervisor. Ensure knowledge of full mission request and plan of operations.
- ☐ Review this position checklist.
- ☐ Review Mass Prophylaxis Planning Guide. (SNS, Pandemic, Smallpox, etc. Plan)
- ☐ Confirm activation of your staff, and assign or greet them as they arrive:
  - Communications Unit Leader
  - Logistics Specialists
  - Pharmacy Unit Leader
- ☐ Meet with your staff:
  - Establish chain of command and performance expectations:
    - Your staff is to report ONLY to you.
    - They work with other staff as assigned by you, but they DO NOT take instructions from or provide information to anyone other than you (or a Safety Officer if regarding a safety issue).
    - Any questions, problems, or incidents should be reported to you, NOT to anyone else.
    - It is important that they DO NOT MAKE DECISIONS on their own, other than provided for in their Position Checklist. This ensures critical consistency with respect to performance and information at the site.
  - Ensure that they are personally prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Prepare a briefing statement, to be given to staff members at scheduled briefing(s):
  - Facility overview, including locations of stations, restrooms, break rooms, emergency exits, etc.
  - Communications protocol

- Role of logistics in this operation: services you provide, problems you solve, etc.
- ☐ Ensure shipment of equipment/supplies and arrange for transport to treatment site.
- ☐ Ensure that ground transportation is ordered and available for all staff when team reaches destination.
- ☐ Utilize established communications protocols.

#### On-site Operations:

- ☐ Follow the chain-of-command. **THIS IS CRITICAL** to ensuring consistent behavior and information across sections and shifts:
  - Give instructions **ONLY** to personnel that report to you, and take instructions **ONLY** from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do **NOT** make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Participate in staff briefing(s) as scheduled by the Dispensing Site Supervisor.
- ☐ Maintain Unit Log.
- ☐ Arrange for a location and set up of communications equipment (phones and radios) and utilize established communications protocols.
- ☐ Work with staff in each area to set up physical work stations.
- ☐ Arrange for procurement of additional equipment/supplies as needed and as authorized by Dispensing Site Supervisor.
- ☐ Work with Operations Section Chief to make sure that the ordering, inventory, and re-supply of the pharmaceutical cache meets standards.
- ☐ Make arrangements for food and beverages for all staff members. Provide plenty of fluids at each work location.
- ☐ Anticipate staff needs and request additional staff as needed.
- ☐ Arrange for transportation of staff members as necessary.
- ☐ Provide logistical support as needed by each station.
- ☐ Participate in the Demobilization Planning process.

#### Deactivation Phase:

- ☐ Ensure that all records and reports are turned in to the Dispensing Site Supervisor.
- ☐ Conduct exit interviews with your direct reports.
- ☐ Supervise the break down and repacking of all equipment/supplies at each station.
- ☐ Arrange to have all equipment/supplies returned to place of origin and state of readiness.
- ☐ Ensure facility is cleaned and returned to former operating condition.
- ☐ Participate in the After Action Report process.

**COMMUNICATIONS UNIT LEADER**

Positioned Assigned To:

You Report To: \_\_\_\_\_ (Logistics Section Lead)  
 Dispensing Site Location: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Communications Command Center: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Mission:** Organize and coordinate communications; act as custodian of all logged or documented communications.

Upon Activation:

- ☐ Work with the Logistics Section Lead to create an operational site Communications Plan.
- ☐ Work with the Logistics Section Lead to ensure that all communications equipment (radios, telephones, computers, batteries, chargers, electrical cords, etc.) are either included in equipment cache sent to the Dispensing Sites or are obtained through other sources as needed.

On-site Operations:

- ☐ Follow the chain-of-command. THIS IS CRITICAL to ensuring consistent behavior and information across sections and shifts:
  - Give instructions ONLY to personnel that report to you, and take instructions ONLY from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do NOT make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Review this position checklist.
- ☐ Attend overall staff briefing by the POD Manager and receive assignment-specific briefing from the Logistics Section Lead (your supervisor).
- ☐ Meet with your support staff:
  - Establish chain of command and performance expectations:
    - Your staff is to report ONLY to you.
    - They work with other staff as assigned by you, but they DO NOT take instructions from or provide information to anyone other than you (or a Safety Officer if regarding a safety issue).
    - Any questions, problems, or incidents should be reported to you, NOT to anyone else.

- It is important that they DO NOT MAKE DECISIONS on their own, other than provided for in their Position Checklist. This ensures critical consistency with respect to performance and information at the site.
  - Ensure that they are personally prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Set up, test, maintain, and arrange for repair of all telecommunications equipment.
  - ☐ Set up a space in Logistics area to house communications support equipment (back-up radios and phones, batteries, etc.)
  - ☐ Obtain information for a directory of significant contact phone/fax/pager numbers/e-mail addresses.
  - ☐ Establish contact with lead agency and other cooperating agencies.
  - ☐ As needed, obtain on-site operational radio frequencies.
  - ☐ Establish and manage a message system.
  - ☐ Issue radio and/or phone equipment to personnel according to orders from Logistics Section Lead. Maintain records of equipment issued.
  - ☐ Maintain a Unit Log.

Deactivation Phase:

- ☐ Remove all communications equipment and pack it appropriately for transport.
- ☐ Account for all communications equipment issued to staff.
- ☐ Identify and tag all equipment needing repair and/or replacement.
- ☐ Ensure all records and reports are turned over to Logistics Section Lead.
- ☐ Identify issues for After Action Report process.



**COMMUNICATIONS STAFF**

Positioned Assigned To:	
You Report To: _____ (Communications Unit Leader)	
Dispensing Site Location: _____	Telephone: _____
Communications Command Center: _____	Telephone: _____

**Mission:** Assist with the organization and coordination of communications.

Upon Activation:

- ☐ Work with the Communications Unit Leader to assist in the creation of an operational site Communications Plan.
- ☐ Work with the Communications Unit Leader to ensure that all communications equipment (radios, telephones, computers, batteries, chargers, electrical cords, etc.) are either included in equipment cache sent to the Dispensing Sites or are obtained through other sources as needed.

On-site Operations:

- ☐ Follow the chain-of-command. THIS IS CRITICAL to ensuring consistent behavior and information across sections and shifts:
  - Take instructions ONLY from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do NOT make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Review this position checklist.
- ☐ Attend staff briefing by the Communications Unit Leader and receive assignment-specific briefing.
- ☐ Ensure you are personally prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Set up, test, maintain, and arrange for repair of all telecommunications equipment.
- ☐ Set up a space in Logistics area to house communications support equipment (back-up radios and phones, batteries, etc.)
- ☐ Obtain information for a directory of significant contact phone/fax/pager numbers/e-mail addresses.
- ☐ Establish contact with lead agency and other cooperating agencies.
- ☐ As needed, obtain on-site operational radio frequencies.
- ☐ Issue radio and/or phone equipment to personnel according to orders from Logistics Section Chief. Maintain records of equipment issued.
- ☐ Maintain a Unit Log.

Deactivation Phase:

- ☐ Remove all communications equipment and pack it appropriately for transport.
- ☐ Account for all communications equipment issued to staff.
- ☐ Identify and tag all equipment needing repair and/or replacement.
- ☐ Identify issues for After Action Report process.

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**PHARMACY UNIT LEADER**

Positioned Assigned To:	
You Report To: _____	(Logistics Section Lead)
Dispensing Site Location: _____	Telephone: _____

**Mission:** Ensure the availability of emergency, incident specific, pharmaceutical and pharmacy services. Supervise Pharmacy Technicians. This position may also involve the dispensing of medications to the general population.

**On-site Operations:**

- ☐ Follow the chain-of-command. THIS IS CRITICAL to ensuring consistent behavior and information across sections and shifts:
  - Give instructions ONLY to personnel that report to you, and take instructions ONLY from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do NOT make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Review this position checklist.
- ☐ Attend overall staff briefing, and receive assignment-specific briefing from the Logistics Section Lead (your supervisor).
- ☐ Confirm and determine numbers and types of pharmacy staff available by specialty. Assign or greet them as they arrive:
  - Pharmacists
  - Pharmacy Technicians
- ☐ Meet with your staff:
  - Brief all pharmacy staff on set up and operations.
  - Establish chain of command and performance expectations:
    - Your staff is to report ONLY to you.
    - They work with other staff as assigned by you, but they DO NOT take instructions from or provide information to anyone other than you (or a Safety Officer if regarding a safety issue).
    - Any questions, problems, or incidents should be reported to you, NOT to anyone else.

- It is important that they DO NOT MAKE DECISIONS on their own, other than provided for in their Position Checklist. This ensures critical consistency with respect to performance and information at the site.

- ☐ Ensure that all workstations and equipment is set up and operational.
- ☐ Ensure that all pharmaceutical and other supplies are available.
- ☐ Ensure that drug information sheets are available.
- ☐ Assign pharmacist(s) to provide counseling where needed.
- ☐ Ensure drug utilization reviews are conducted as necessary.
- ☐ Monitor patient flow through the process, and recommend movement of staff to the Logistics Section Lead where necessary to reduce or eliminate bottlenecks in the process (i.e. recommend movement of staff to-and-from pharmacy, evaluation, and interview areas)

Deactivation Phase:

- ☐ Supervise the break down and repacking of all pharmaceutical equipment/supplies.
- ☐ Ensure the collection of all paperwork and turn in to administration.
- ☐ Identify issues for the After Action Report process.

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
LOGISTICS SUBSECTION  
Pharmacist / Pharmacy Technician  
Revised: 4-03, 9-03, 12-03

## PHARMACIST / PHARMACY TECHNICIAN

Positioned Assigned To:

You Report To: \_\_\_\_\_ (Pharmacy Unit Leader)

Dispensing Site Location: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Mission:** Assist the Pharmacy Unit Leader with medication preparation, including compounding pediatric doses (Pharmacist), and restocking of dispensing areas.

### On-site Operations:

- ☐ Review this position checklist.
- ☐ Attend overall staff briefing, and receive assignment-specific briefing from the Pharmacy Unit Leader (your supervisor).
- ☐ Set up workstations and ensure availability of pharmaceutical labeling supplies.
- ☐ Prepare stock of prescriptions as required.

### Deactivation Phase:

- ☐ Participate in the break down and repackaging of all equipment/supplies.
- ☐ Ensure that all paperwork is complete for turn in to administration.
- ☐ Identify issues for the After Action Report process.

**LOGISTICS STAFF**

Positioned Assigned To:	
You Report To: _____	(Logistics Section Chief)
Dispensing Site Location: _____	Telephone: _____

**Mission:** Assist with the organization and direction of those operations associated with maintenance of the physical environment, and adequate levels of food, shelter and supplies to support the medical objectives.

Upon Activation:

- ☐ Receive briefing from Logistics Section Chief. Ensure knowledge of full mission request and plan of operations.
- ☐ Review this position checklist.
- ☐ Review Mass Prophylaxis Planning Guide. (SNS, Pandemic, Smallpox, etc. Plan)
- ☐ Ensure you follow the chain of command and that:
  - You report ONLY to your supervisor.
  - You work with other staff as assigned, but DO NOT take instructions from or provide information to anyone other than your supervisor.
  - Any questions, problems, or incidents should be reported to your supervisor, NOT to anyone else.
  - It is important that you DO NOT MAKE DECISIONS on your own, other than provided for in their Position Checklist. This ensures critical consistency with respect to performance and information at the site.
  - Ensure that you are personally prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Ensure you have received a briefing on the following:
  - Facility overview, including locations of stations, restrooms, break rooms, emergency exits, etc.
  - Communications protocol
  - Role of logistics in this operation: services you provide, problems you solve, etc.
- ☐ Ensure shipment of equipment/supplies and arrange for transport to treatment site.
- ☐ Ensure that ground transportation is ordered and available for all staff when team reaches destination.
- ☐ Utilize established communications protocols.

On-site Operations:

- ☐ Follow the chain-of-command. THIS IS CRITICAL to ensuring consistent behavior and information across sections and shifts:
  - Take instructions ONLY from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do NOT make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Participate in staff briefing(s) as scheduled by the Logistics Section Chief.
- ☐ Maintain Unit Log.
- ☐ Arrange for a location and set up of communications equipment (phones and radios) and utilize established communications protocols.
- ☐ Work with staff in each area to set up physical work stations.
- ☐ Arrange for procurement of additional equipment/supplies as needed and as authorized by Logistics Section Chief.
- ☐ Work with Operations Section to make sure that the ordering, inventory, and re-supply of the pharmaceutical cache meets standards.
- ☐ Make arrangements for food and beverages for all staff members. Provide plenty of fluids at each work location.
- ☐ Anticipate staff needs and request additional staff as needed.
- ☐ Arrange for transportation of staff members as necessary.
- ☐ Provide logistical support as needed by each station.
- ☐ Participate in the Demobilization Planning process.

Deactivation Phase:

- ☐ Ensure that all records and reports are turned in to the Logistics Section Chief.
- ☐ Assist with the break down and repacking of all equipment/supplies at each station.
- ☐ Arrange to have all equipment/supplies returned to place of origin and state of readiness.
- ☐ Ensure facility is cleaned and returned to former operating condition.
- ☐ Participate in the After Action Report process.



**ADMINISTRATION/FINANCE Job Action Sheets**

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
ADMINISTRATION SUBSECTION  
Administration Section Chief  
Revised: 4-03, 9-03, 12-03

**ADMINISTRATION SECTION CHIEF**

Positioned Assigned To:

You Report To: \_\_\_\_\_ (Dispensing Site Supervisor)

Dispensing Site Location: \_\_\_\_\_ Telephone: \_\_\_\_\_

Administration Command Center: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Mission:** Monitor the utilization of financial and administrative assets. Oversee the acquisition of supplies and services necessary to carry out the Dispensing Site mission. Supervise the documentation of expenditures relevant to the emergency incident.

**Upon Activation:**

- ☐ Receive briefing from Dispensing Site Supervisor. Ensure knowledge of full mission request and plan of operations.
- ☐ Review this position checklist.
- ☐ Review Mass Prophylaxis Planning Guide. (SNS, Pandemic, Smallpox, etc. Plan)
- ☐ Confirm activation of your support staff, and assign or greet them as they arrive:
  - Data Entry staff
- ☐ Meet with your support staff:
  - Establish chain of command and performance expectations:
    - Your staff is to report ONLY to you.
    - They work with other staff as assigned by you, but they DO NOT take instructions from or provide information to anyone other than you (or a Safety Officer if regarding a safety issue).
    - Any questions, problems, or incidents should be reported to you, NOT to anyone else.
    - It is important that they DO NOT MAKE DECISIONS on their own, other than provided for in their Position Checklist. This ensures critical consistency with respect to performance and information at the site.
  - Ensure that they are personally prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Establish Point of Arrival and Briefing for new incoming staff members.
- ☐ Prepare a briefing statement, to be given to your staff members at scheduled briefing(s):
  - Information flow and reporting requirements
  - Documentation requirements

- ☐ Assist the Dispensing Site Supervisor, and direct command staff (Logistics Section Chief, Operations Section Chief, Planning Section Chief, Security Section Chief, Liaison, and, Public Information Officer) in the preparation their staff briefing notes.

On-site Operations:

- ☐ Follow the chain-of-command. THIS IS CRITICAL to ensuring consistent behavior and information across sections and shifts:
  - Give instructions ONLY to personnel that report to you, and take instructions ONLY from your supervisor.
  - Coordinate with your peers (anyone who reports to your supervisor) to accomplish your assigned tasks.
  - Do NOT make decisions that impact others outside your area, or that use information that is not in writing or provided by your supervisor.
  - Report to your supervisor when you encounter problems that you cannot resolve or questions that you cannot answer.
- ☐ Conduct staff briefings as scheduled.
- ☐ Maintain Unit Log.
- ☐ Work with Operations Section Chief to set up greeting, check-in, waiting, out-processing and data input areas. Make sure staff has all equipment and supplies needed to carry out their functions.
- ☐ Monitor the documentation process and flow. Make modifications as needed.

Deactivation Phase:

- ☐ Ensure that all records and reports are turned in to the Dispensing Site Supervisor.
- ☐ Conduct exit interviews with your staff.
- ☐ Participate in the After Action Report process.

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
ADMINISTRATION SUBSECTION  
Data Entry Clerk  
Revised: 4-03, 9-03, 12-03

## DATA ENTRY CLERK

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## PLANNING Job Action Sheets

PA DOH SNS INCIDENT COMMAND SYSTEM  
Job Action Sheet

DISPENSING SITE SECTION  
PLANNING SUBSECTION  
Planning Section Chief  
Revised: 4-03, 9-03, 12-03

### PLANNING SECTION CHIEF

Positioned Assigned To:	
You Report To: _____	(Dispensing Site Supervisor)
Dispensing Site Location: _____	Telephone: _____

**Mission:** Assure that all planning done within the Point of Dispensing meets operational objectives and that plans are being followed.

On-site Operations:

- ☐ Review plans for the operations of the Point of Dispensing.
- ☐ Attend overall staff briefing from the Dispensing Site Supervisor and receive assignment-specific briefing.
- ☐ Liaison with the Dispensing Site Supervisor on planning and corrections needing made to plans for the most efficient operation of the Point of Dispensing.
- ☐ Perform the duties also of the Safety Officer ensuring the safe operation of the Point of Dispensing.
- ☐ Assist in other areas of the Point of Dispensing as appropriate.

Deactivation Phase:

- ☐ Assist with the break-down and re-packing as requested.

Identify issues for the After Action Report process.

**Appendix B**  
**Point of Dispensing (POD) Template**  
**Smallpox or Other Treatable/Preventable Communicable Disease**  
**Based on Weill/Cornell Bioterrorism and Epidemic Outbreak Model Staffing Calculations (20,000 patients per POD)**

**Introduction:** The purpose of this document is to provide guidance for emergency planners in determining the critical human resources required to effectively and efficiently dispense life saving vaccine/medication to the citizens of their jurisdiction. This document does not address the physical plant design for the location of stations in the POD, as each designated POD will have different characteristics. The guiding principle is to keep the patients moving toward the exit without crossovers or doubling back.

**Station and Core Staffing Recommendations for a 96 Hour Campaign:**

<u>Station</u>	<u>Staffing/shift (96 hours)</u>
Greeters/Screeners	5
Form Distributors	3
Triage	20
Medical Evaluators	8
Testing	3
Vaccinators/Drug dispensers	22
Forms Collection	18
Briefing Station	6
Crisis Counseling	17
Total Core Staff	102

**Support Staffing Recommendations for a 96 Hour Campaign:**

<u>Support Staff</u>	<u>Per Shift 96 hours</u>
Security	25
Station Managers	4
Data Entry	5
IT	2
Resupply	4
EMS (transport crew)	1
POD Manager	1
Custodial	2
Total Support Staff	44

**NOTE:** These recommendations are the minimum staffing, with no breaks or down time for staff during a 12 hour shift.

**Point of Dispensing (POD) Template**  
**Anthrax or Other Treatable Non-communicable Disease**  
**Based on Weill/Cornell Bioterrorism and Epidemic Outbreak Model Staffing Calculations (20,000 patients per POD)**

**Introduction:** The purpose of this document is to provide guidance for emergency planners in determining the critical human resources required to effectively and efficiently dispense life saving medication to the citizens of their jurisdiction. This document does not address the physical plant design for the location of stations in the POD, as each designated POD will have different characteristics. The guiding principle is to keep the patients moving toward the exit without crossovers or doubling back.

**Station and Core Staffing Recommendations for 48 Hour and 96 Hour Campaigns:**

<u>Station</u>	<u>Staffing/shift (48 hours)</u>	<u>Staffing/shift (96 hours)</u>
Greeters/Screeners	2	1
Form Distributors	3	2
Triage	8	4
Medical Evaluators	5	3
Drug Dispensers	9	5
Forms Collection	10	5
Briefing Station (optional)	5	3
Crisis Counseling (optional)	<u>2</u>	<u>1</u>
Total Core Staff	<b>37 (7 optional)</b>	<b>20 (4 optional)</b>

**Support Staffing Recommendations for 48 Hour and 96 Hour Campaigns:**

<u>Support Staff</u>	<u>Per Shift 48 hours</u>	<u>Per Shift 96 hours</u>
Security	7	4
Station Managers	3	3
Data Entry	5	3
IT	2	1
Resupply	3	2
EMS (transport crew)	1	1
POD Manager	1	1
Custodial	<u>2</u>	<u>2</u>
Total Support Staff	<b>24</b>	<b>17</b>

**NOTE:** These recommendations are the minimum staffing, with no breaks or down time for staff during a 12 hour shift.

## APPENDIX C

**PENNSYLVANIA DEPARTMENT OF HEALTH  
POINT OF DISPENSING FACILITY SURVEY AND SECURITY CHECKLIST**

Facility Name:		
Address:		Zip Code:
Main Telephone:	Type of Facility: <input type="checkbox"/> High School <input type="checkbox"/> Middle School <input type="checkbox"/> Elementary School <input type="checkbox"/> Recreation Center <input type="checkbox"/> Other (specify) _____	
Directions to the Facility via Car from Closest Major Intersection:		
Directions to the Facility via Public Transportation:		
<b>EMERGENCY CONTACT INFORMATION</b>		
Primary Contact (first & last name)	Other Contact (first & last name)	Other Contact (first & last name)
Title:	Title:	Title:
Business Phone:	Business Phone:	Business Phone:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Pager:	Pager:	Pager:
Fax:	Fax:	Fax:
E-mail Address:	E-mail Address:	E-mail Address:




FACILITY QUESTIONS		
Number of Staff (not including nurses):	Number of Nurses:	Number of Students:
Number of School Police Officers:	Number of External Building Entrances:	External Building Entrance Handicap Accessible: Yes ___ No ___
Number of Off-Street Parking Spaces for cars:	Auditorium: ___ Yes ___ No	Athletic Fields: ___ Yes ___ No
More than one entrance to the parking lot: ___ Yes ___ No	If yes, how many seats: _____	Loading Dock: ___ Yes ___ No
Dedicated area of buses to park: ___ Yes ___ No	Stage in Auditorium: ___ Yes ___ No	Number of Large Tables:
If yes, how many buses can park at one time:	If yes, square footage of stage:	Number of chairs: (not attached to desks)
PA System: ___ Yes ___ No	Security System: ___ Yes ___ No	Surveillance Cameras: ___ Yes ___ No
Gym: ___ Yes ___ No	Number of Refrigerators: ___ Small (home kitchen) ___ Large (industrial)	
If yes, as large as HS Basketball Court: ___ Yes ___ No Gym Square Footage:  Number of entrances to gym:  Do gym doors lock? ___ Yes ___ No	Can any of the Refrigerators be moved? Explain.  Do the refrigerators have temperature gauges on them? ___ Yes ___ No	
2 secure rooms (close to gym) for material storage and staff break room: ___ Yes ___ No	Telephone outlet in gym? ___ Yes ___ No If no, nearest phone outlet to the gym:	Internet Access in gym: ___ Yes ___ No If no, nearest internet access to gym:
Air Conditioning in entire facility: ___ Yes ___ No If no, anywhere in facility? Explain.	Generator for power ___ Yes ___ No If yes, power for what?  How is generator powered?	Emergency Lighting: ___ Yes ___ No If yes, where is the emergency lighting:

**FACILITY DIAGRAM**

Sketch Entrance and Exit Points, Crowd Flow, Gym Access, Auditorium Access, Arrival Point for Stockpile/Supplies, Location of Loading Dock, Off-Street Car and Bus Parking

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COMMENTS/SPECIAL CONSIDERATIONS		
		
<b>Number of Required Security Personnel</b>  <b>Inside Facility:</b>  <b>Perimeter</b>	<b>Digital Photos:</b> <input type="checkbox"/> Front/Sides/Rear of Facility <input type="checkbox"/> Off-Street Parking <input type="checkbox"/> Gym <input type="checkbox"/> Auditorium <input type="checkbox"/> Athletic Fields <input type="checkbox"/> Other (explain)	
<b>Name and address of closest medical facility/hospital:</b>	<b>Languages (other than English) spoken in community near facility:</b>	
<b>Name of Person Completing Survey:</b>		<b>Date:</b>

ATTACHMENT I

EMERGENCY MEDICAL SERVICES INFECTION CONTROL GUIDELINES

## **EMS Infection Control Guidelines Program Outline**

1. Guideline Statement:
  - policy statement
  - Infection Control Coordinator Position Description
2. Employee/Member Responsibilities
3. Overview of Prevention and Precautions
  - proper hand-washing
  - use of appropriate PPE
  - sharps
  - recommended immunizations
4. Occupational Risks/Exposure
  - definition of occupational risk and occupational exposure
  - develop level of exposure in service language and actions to be taken for each level
  - documentation requirements (provide sample copy of documents in this section such as incident exposure record, infection control coordinator analysis and corrective action report, provider medical exam form, provider exposure follow up report, employer notification of physical exam results, occupational health assessment)
  - notification requirements
  - verification requirements
  - exposure guidelines
  - exposure determination
  - post exposure guideline
  - treatment for post exposure
  - post exposure follow up guideline
  - reporting requirements
  - confidentiality guidelines

5. Principles of the Infectious Process (elements necessary for disease transmission)  
Describe the following:
  - body substance isolation (BSI)
  - modes of transmission
  - infectious disease
  - communicable disease
  - bloodborne pathogens
  - occupational exposure
  - parenteral
  - O.P.I.M (Other Potentially infectious materials)
  - universal precautions
  - contaminated
  - decontamination
  - regulated waste
  - engineering controls
  - incubation period
  - window phase
6. Disease Information (provide information on different diseases)
  - Hepatitis A, B, C (include consent/declination immunization forms)
  - Meningitis
  - Chickenpox
  - Measles (rubella)
  - Measles (rubeola/red measles)
  - HIV/AIDS
  - Tuberculosis (include consent/declination forms for annual PPD testing)
  - Tetanus
  - Syphilis
7. Latex Allergy guideline
8. Bio-Terrorism information and guidelines
  - definition of bio-terrorism
  - list and give description of agents used by terrorist, symptoms that may occur, prevention/appropriate PPE, treatment for agents and decontamination guidelines for surfaces/ambulances
  - Response to Biological and Chemical Incident/Possible Terrorist Incident
    - Purpose
    - Scope
    - Chain of command
    - Staffing requirements
    - Response/scene role
    - Communications
    - Medical evaluations
    - EMS command responsibilities
    - Health & Medical Coordinator responsibilities
    - Emergency, Non-emergency transport and special response guidelines
  - Surge service response (if applicable)

9. Respiratory protection
  - Selection
  - Use
  - Maintenance & Inspections
  - Cleaning
  - Fit test
10. Personal Protective Equipment
  - Gloves
  - Mask
  - Eye
  - Gowns
11. Handwashing recommendations
  - Artificial nails guidelines
12. Sharps
  - Address recapping/resheathing and proper disposal of
13. Cleaning & Disinfection
  - Types of (dispose, cleaning, disinfection, high level disinfectant, dauder) and processes for types of equipment, vehicles and facilities
  - Equipment – equipment categories disposable, non-disposable, etc
  - BVM, AED, stretchers, turn out gear, personal clothing.
  - Cleaning of blood splattered areas/spills process for
  - Cleaning vehicle schedule and log
  - Cleaning facility schedule and log
14. Biohazard Waste Disposal guideline
15. Scene Management
16. Medical Surveillance (Assure that all evaluations, procedures, vaccinations, and post exposure management are provided to the member/employee at a reasonable time and place, according to standard recommendations for medical practice)
  - Personal Immunization records
17. Work restrictions/Reportable diseases
18. Record keeping
19. Training
20. OSHA terminology
21. Ryan White Act
22. PA House Bills & Codes





**RC-2004-015**

**DATE:** April 30, 2004

**CORRECTED COPY**

**SUBJECT:** Emergency Response Employees (EREs)

**TO:** Regional EMS Directors

**THRU:** Margaret E. Trimble, Director  
EMS Office

**FROM:** Robert H. Gaumer  
Licensure, Accreditation and Certification  
Coordinator  
Emergency Medical Services Office  
(717) 787-8740

The Department of Health (Department) has instituted a new process enabling an employer of emergency response employees (EREs) to nominate and secure Department of Health approval of the person the employer chooses to serve as its designated officer of EREs (Designated Officer). This process may be used as an alternative to the paper nomination and approval process the Department published at 24 Pa.B. 4523, (September 3, 1994).

Under a Federal statute, the Ryan White Care Act, every employer of emergency response personnel is required to appoint a Designated Officer and secure approval of that person as a Designated Officer from the chief public health office of the state. EREs are firefighters, law enforcement officers, EMS personnel and other persons (including employees of volunteer organizations, without regard to whether such employees receive nominal compensation) who, in the course of their occupational duties, respond to an emergency involving an illness or injury. An employer of EREs is an organization that, in the course of professional duties, responds to emergencies involving illness or injury. In Pennsylvania, to qualify as a Designated Officer a person must be nominated as such by an employer of EREs and then accepted by the Department.

A Designated Officer acts as a liaison between the employer's employees who have been or believe they have been exposed to a potentially life-threatening infectious disease specified by the United States Department of Health and Human Services (HHS), through a person who is transported to a medical facility, and the medical facility that receives that person. For additional information regarding the potentially life-threatening infectious diseases specified by HHS, guidelines describing the circumstances in which EREs may be exposed to such diseases,

Page 2

guidelines for medical facilities to determine whether such exposure occurred and the responsibilities of a Designated Officer, please review the notice published by HHS at 59 Fed. Reg. 13418-13428, March 21, 1994.

The Department has created a new website where an employer can nominate an individual within the organization. The web address is <https://app1.health.state.pa.us/emso-eresystem/>. No password or ID is required to access the site and to complete the process.

*Employers/organizations who previously submitted the paper nomination form do not have to re-register unless a change has occurred to the previously nominated individual.*

The Bureau of Epidemiology within the Department will continue to maintain the database developed for the EREs. Each nomination will receive an e-mail response upon its submission. Therefore, an e-mail address is required to complete the process.

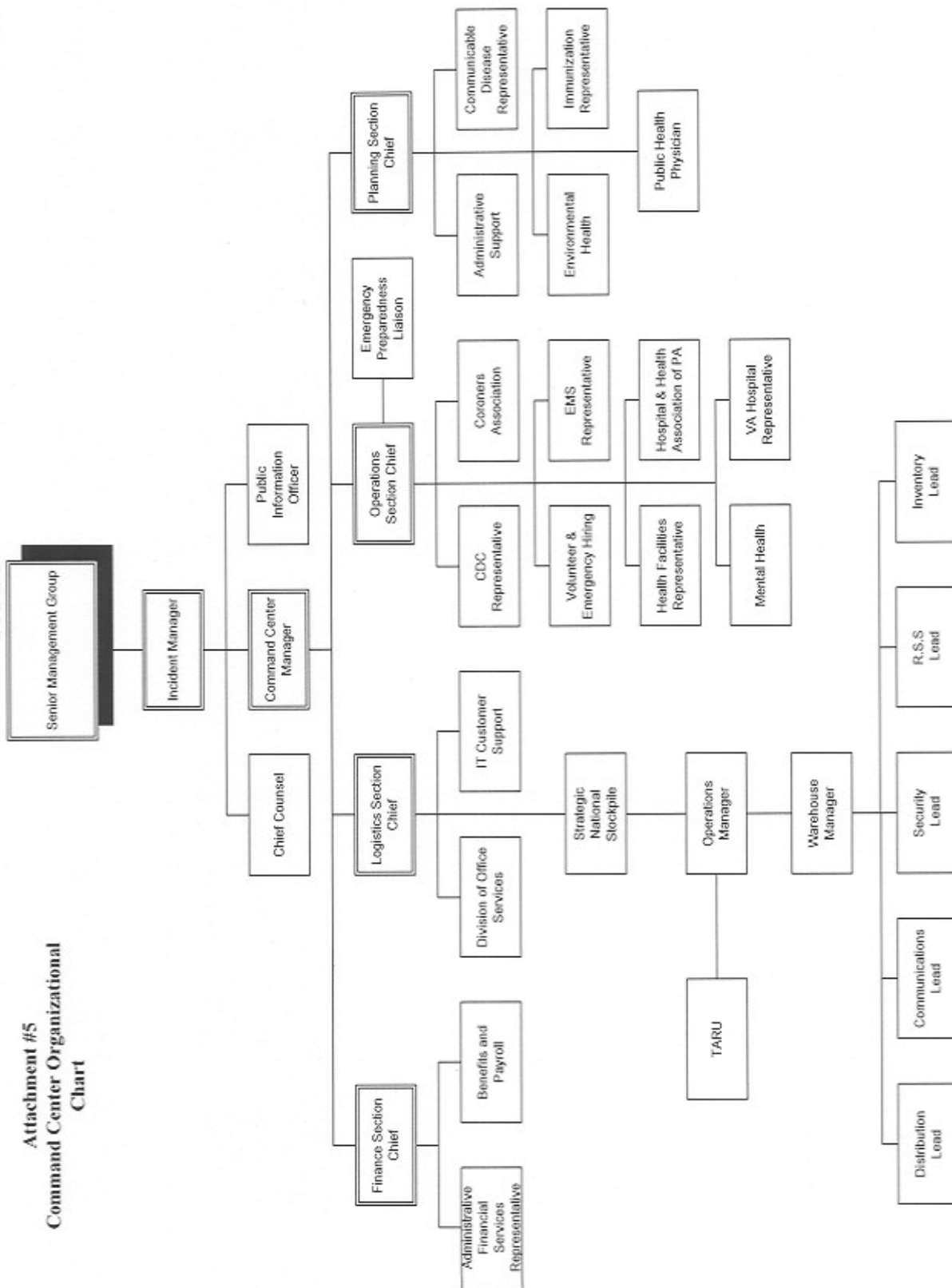
Any questions regarding this procedure should be directed to Mr. Robert H. Gaumer at 717-787-8740 or email to [rgaumer@state.pa.us](mailto:rgaumer@state.pa.us).

ATTACHMENT J

COMMAND CENTER ORGANIZATIONAL CHART

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# Attachment #5 Command Center Organizational Chart



ATTACHMENT K

NOTICE TO ASSIST PENNSYLVANIA HOSPITALS TO ACCOMMODATE  
INCREASED INPATIENT DEMANDS RELATED TO INFLUENZA

**Notice To Assist Pennsylvania Hospitals To Accommodate Increased Inpatient Demands Related To Influenza**

The attached notice provides information on the use of Medicare exempt units and unlicensed beds for inpatient care in response to possible need for inpatient beds as a result of influenza. Included in the notice are requirements for notification of the Department and the conditions under which such bed use may be considered.

In implementing use of beds in exempt units and/or the use of unlicensed beds, hospitals must continue to take the actions necessary to protect patient health and safety, including infection control and privacy.

The DAAC field staff will review and recommend approval for use of Medicare exempt unit beds based on the conditions stated in this notice.

All use of unlicensed beds for inpatient care must be reported through the PAPSRS under infrastructure no more than 24 hours after such beds are put into service.

**Notice To Assist Pennsylvania Hospitals To Accommodate Increased Inpatient Demands Related To Influenza**

In light of the severe shortage of flu vaccine and the potential for larger than usual demand for services, the Department wants to share information well in advance of the peak flu season on the steps the Department of Health is prepared to take to assist general hospitals to accommodate increased inpatient demands related to influenza.

1. While most hospitals have already done this, we encourage all hospitals to review their historical records to determine the peak hospital bed need during prior flu seasons. All hospitals should prepare to meet or exceed the peak from prior years.
2. Hospitals should utilize all licensed beds, however, the department acknowledges that some hospitals may have compelling reasons for not being able to promptly bring un-staffed licensed beds on line in a timely manner. To that end, field staff will assess the practicality of rapidly opening, equipping and fully staffing such unused licensed beds to alleviate a temporary surge in demand, versus providing appropriate medical care to influenza patients in another existing but currently underutilized exempt service unit. In making this determination, field staff may rely on the attestation of the hospital's Chief Executive Officer or the Administrator on Call that all set up and staffed medical surgical beds are utilized.
3. Hospitals must assess the medical necessity of both inpatient and outpatient elective surgeries. Hospitals should where practical postpone inpatient and outpatient elective procedures such as purely elective cosmetic surgery. Field staff will take into consideration that some types of elective surgery may be necessary to prevent unscheduled visits to the emergency department or inpatient admissions, thus cancellation of all elective surgeries is not to be considered a requirement when a facility is seeking a capacity exemption.
4. If the hospital believes that even with the above steps, additional medical-surgical beds will be needed, the hospital may request the use of beds in its "exempt" psychiatric unit or rehabilitation unit for medical-surgical patients. CMS has the authority to approve the temporary use of beds in these exempt units if the Secretary of Health (or his designate) declares a "health emergency" and recommends such temporary use to CMS. The Department will use the fact that the hospital is utilizing all currently available medical surgical beds and is postponing elective surgical procedures that can be safely deferred as the basis for declaring an emergency. Hospitals should contact the field office to get approval for these requests.
5. If the above steps are not sufficient, the hospital may be forced to add non-licensed beds to hallways, administrative offices and other non-patient care areas. If the hospital finds itself in that position, the situation must be reported through the PSA electronic system, under infrastructure failure. In reviewing these PSA reports, field staff will focus



on two areas: 1) were these non-licensed beds adequately staffed and 2) did the hospital follow the steps in its Emergency Preparedness plan.

Because of the possible need for quick reviews and approvals the field office staff have been delegated the authority to make prompt and timely case-by-case decisions, as long as they are consistent with this directive.

If you have additional questions, please contact your field office.

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ATTACHMENT L

PRIORITY VACCINATION DISTRIBUTION

## PRIORITY VACCINATION DISTRIBUTION

### VACCINE PRIORITIZATION

Given a limited supply of vaccine, prioritization will occur to determine which groups to target first for vaccination. To some extent, these decisions will depend upon the nature of the current pandemic – who is getting sick, who is spreading the disease, and who is dying. Other priorities will be to maintain essential public services and the health care infrastructure. Not all of these goals can be met with a limited vaccine supply.

The following potential target groups might be chosen for the following goals (in no particular order):

1. Protecting the public health/health care infrastructure (so there will be personnel available to care for victims of influenza, investigate the outbreak, and staff vaccination clinics):
  - a. Health-care workers in emergency departments and critical care units in acute care facilities.
  - b. Emergency medical services personnel.
  - c. Public health personnel involved in the distribution of vaccine and antiviral agents.
  - d. Health-care workers in long term care facilities
  - e. Laboratory workers handling the virus and disease outbreak investigations.
  - f. Families of these workers (if they become ill, the workers might stay home to take care of them).
2. Maintaining essential public services:
  - a. Persons responsible for community safety and security, e.g., police, firefighters, military personnel, National Guard, "first responders" not included in first priority group.
  - b. PEMA, SEOC, local EMA and regional EMS council staff.
  - c. Other highly skilled persons who provide essential community services whose absence would either pose a significant hazard to public safety (e.g., nuclear power plant workers) or severely disrupt the pandemic response effort (e.g., persons who operate

regional telecommunications or electric utility grids). [NOTE: Members of this target group are likely to vary widely from jurisdiction to jurisdiction, depending on local circumstances.]

- d. Families of essential personnel (if they become ill, the essential workers might stay home to take care of them).
3. Minimizing deaths from influenza:
- a. Persons traditionally considered to be at increased risk of severe influenza illness and mortality, as currently defined by the ACIP:
    - 1) Persons of any age with high-risk medical conditions
    - 2) Pregnant women.
    - 3) Persons in nursing homes and other long-term care facilities.
    - 4) Persons  $\geq 65$  years of age without high-risk medical conditions.
    - 5) Infants age 6-12 mo (if supported by epidemiological and clinical data).
  - b. Household contacts of persons with high-risk medical conditions (and of infants  $< 6$  months of age)
4. Minimizing the number of additional cases of influenza:
- Pre-school-age (especially day-care-center attendees) and school age children [the population least likely to have severe illness, but most likely to be the source of infection for the majority of cases].

ATTACHMENT M

PRIORITY ANTIVIRAL DISTRIBUTION

## **PRIORITY ANTIVIRAL DISTRIBUTION**

### **ANTIVIRAL AGENTS**

Amantidine, rimantidine, oseltamivir and zanamivir can be used to treat influenza. If given within two days of onset of symptoms, they can reduce the duration of uncomplicated influenza illness by 1-2 days, potentially reducing the spread of disease in the community. However, these drugs have NOT been shown to prevent complications of influenza, or to reduce mortality rates. Treatment should be of as short duration as possible, typically 3-5 days in order to prevent the development of drug resistant influenza viruses.

Although the antiviral medications amantidine, rimantidine and oseltamivir have been approved for influenza prophylaxis, and zanamivir is probably also effective as a prophylactic agent (but has not been FDA approved for this use), the supply of these drugs is severely limited. To be maximally effective for prophylaxis, the drugs must be taken each day for the duration of influenza activity in the community (which could be many months during a pandemic).

Due to their costs, limited availability and side effects, prophylactic use is primarily limited to outbreak control in closed institutions such as nursing homes and dormitories because of the need to provide prophylaxis to the entire community at the same time. If this is not done, the influenza viruses circulating in the community will develop resistance to these antiviral drugs (particularly amantidine and rimantidine), rendering the drugs useless in the future.

If these drugs are being used both for treatment and prevention of influenza, it is necessary to keep the two types of patients separated, to reduce the development of drug resistant viruses.

If antiviral drugs are used for prophylaxis early in a pandemic, the entire supply will be quickly exhausted and drug resistant viruses are likely to develop and spread within the community.

#### **Recommendations for prophylaxis and use of antivirals**

1. Treatment of persons hospitalized for influenza
2. Treatment of ill health care and emergency services workers
3. Treatment of ill high-risk persons in the community
4. Prophylaxis of health care workers
5. Control outbreaks in high-risk residents of institutions (nursing homes and other long-term care facilities)
6. Prophylaxis of essential service workers
7. Prophylaxis of high-risk persons hospitalized for illnesses other than influenza
8. Prophylaxis of high-risk persons in the community

Hospitals should include regional planning for the mobilization and identification of a cache of antiviral pharmaceuticals in support of their critical infrastructure.

**PRIORITIZATION FOR USE AND  
PROCEDURE TO ACCESS ANTIVIRALS**

**Procedure for institutions/providers requesting antiviral therapy during influenza outbreaks prior to activating the SNS**

1. Ensure a confirmed case of influenza exists at the institution via BOL and CDC.
2. Exhaust all other methods of obtaining a supply of antivirals from local pharmacies, distribution centers, hospitals, etc. in the geographic area.
3. Restrict all visitors to the institution upon notification of a confirmed case of influenza.
4. Ask infection control staff to submit a roster of employees who have been vaccinated with either TIV or LAIV.
5. Consult with BOE, Infectious Diseases on a case-by-case basis to determine the duration of the antiviral chemoprophylaxis or treatment needed.
6. Confirm with Secretary of Health the need to activate the SNS if a large quantity of antivirals is requested. The State or Territory Health Department should call the CDC to make a request for antiviral medications. A logistics plan is being drafted and will be available to all state and territorial health departments in the near future.
7. Allocate antivirals according to CDC guidelines under the supervision of the SNS Coordinator and BCHS.
8. Maintain and forward list and quantity delivered to each institution for reimbursement procedures to the Budget Office.



ATTACHMENT N

COMMUNICATIONS CHAIN OF COMMAND

## Office of Communications Chain of Command

Pennsylvania's Main Point of Contact for Communications is:

Press Secretary, Department of Health\*\*  
Room 808  
Health and Welfare Building  
Harrisburg, PA 17108

Pennsylvania's Second Point of Contact for Communications,  
if the Press Secretary is unavailable, is: Information Specialist Designate

Pennsylvania's Third Point of Contact for Communications,  
if the Press Secretary is unavailable, is: Information Specialist Designate

Pennsylvania's Fourth Point of Contact for Communications,  
if the Press Secretary is unavailable, is: Information Specialist Designate

Pennsylvania's Fifth Point of Contact for Communications,  
if the Press Secretary is unavailable, is: Information Specialist Designate

Pennsylvania's Sixth Point of Contact for Communications,  
if the Press Secretary is unavailable, is: Information Specialist Designate

Pennsylvania's Seventh Point of Contact for Communications,  
if the Press Secretary is unavailable, is: Information Specialist Designate

*\*\* Note: The Department of Health's Press Secretary will defer to the Governor's Press Secretary if necessary and required.*

## **Public Information Officer Support Staff Contact Information**

### **Community Health Districts**

**Northcentral**  
Public Health Educator  
Telephone: 570-327-3400

**Northeast**  
Public Health Educator  
Telephone: 570-826-2062

**Northwest**  
Public Health Educator  
Telephone: 724-662-6068

**Southcentral**  
Public Health Educator  
Telephone: 717-787-8092

**Southeast**  
Public Health Educator  
Telephone: 610-378-4352

**Southwest**  
Public Health Educator  
Telephone: 412-565-5101

**Office of Public Health Preparedness**  
Public Health Educator  
Telephone: 717-346-0640

## **Public Information Officer Support Staff Contact Information**

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**Allegheny County**

Public Information Officer  
Telephone: 412-578-8026

**Allentown**

Public Information Officer  
Telephone: 610-437-7760

**Bethlehem**

Public Information Officer  
Telephone: 610-865-7087

**Bucks County**

Public Information Officer  
Telephone: 215-345-3318

**Chester County**

Public Information Officer  
Telephone: 610-344-6225

**Erie County**

Public Information Officer  
Telephone: 814-451-6700

**Montgomery County**

Public Information Officer  
Telephone: 610-278-5117

**Philadelphia County**

Public Information Officer  
Telephone: 215-685-5670

**Wilkes-Barre**

Public Information Officer  
Telephone: 570-208-4268

**York**

Public Information Officer  
Telephone: 717-849-2252

ATTACHMENT O

COMMUNICATION STRATEGIES