# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>i</td>
</tr>
<tr>
<td>List of Attachments</td>
<td>ii</td>
</tr>
<tr>
<td>Abbreviations Used in This Document</td>
<td>iii</td>
</tr>
<tr>
<td>I. Purpose</td>
<td>1</td>
</tr>
<tr>
<td>II. Authority and Responsibilities</td>
<td>1</td>
</tr>
<tr>
<td>III. Situation and Assumptions</td>
<td>2</td>
</tr>
<tr>
<td>IV. Concept of Operations</td>
<td>4</td>
</tr>
<tr>
<td>Command Management</td>
<td></td>
</tr>
<tr>
<td>Roles and Responsibilities</td>
<td></td>
</tr>
<tr>
<td>V. Influenza Pandemic Response Actions</td>
<td>6</td>
</tr>
<tr>
<td>Interpandemic Period</td>
<td></td>
</tr>
<tr>
<td>Pandemic Alert Period</td>
<td></td>
</tr>
<tr>
<td>Pandemic Period</td>
<td></td>
</tr>
<tr>
<td>Post-Pandemic Period</td>
<td></td>
</tr>
<tr>
<td>VI. Pandemic Influenza Surveillance</td>
<td>7</td>
</tr>
<tr>
<td>VII. Laboratory Diagnostics</td>
<td>17</td>
</tr>
<tr>
<td>VIII. Emergency Response</td>
<td>21</td>
</tr>
<tr>
<td>Health care Planning</td>
<td></td>
</tr>
<tr>
<td>IX. Community Disease Control and Prevention</td>
<td>27</td>
</tr>
<tr>
<td>Isolation and Quarantine/Community Containment</td>
<td></td>
</tr>
<tr>
<td>Travel Management</td>
<td></td>
</tr>
<tr>
<td>X. Distribution of Vaccines and Antivirals</td>
<td>35</td>
</tr>
<tr>
<td>Clinical Guidelines</td>
<td></td>
</tr>
<tr>
<td>XI. Public Health Communications</td>
<td>41</td>
</tr>
<tr>
<td>XII. Workforce Support</td>
<td>46</td>
</tr>
</tbody>
</table>
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

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCHS</td>
<td>Bureau of Community Health Systems</td>
</tr>
<tr>
<td>BOE</td>
<td>Bureau of Epidemiology</td>
</tr>
<tr>
<td>BOL</td>
<td>Bureau of Laboratories</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CENIC</td>
<td>Commonwealth Emergency Network Information Center</td>
</tr>
<tr>
<td>CISM</td>
<td>Critical Incident Stress Management</td>
</tr>
<tr>
<td>CMHD</td>
<td>County and Municipal Health Departments</td>
</tr>
<tr>
<td>CPPR</td>
<td>Counterterrorism Planning Preparedness and Response Act</td>
</tr>
<tr>
<td>DAAC/DNCF</td>
<td>Division of Acute and Ambulatory Care/Division of Nursing Care Facilities</td>
</tr>
<tr>
<td>DCORT</td>
<td>Disaster Crisis Outreach and Referral Teams</td>
</tr>
<tr>
<td>Department</td>
<td>Pennsylvania Department of Health</td>
</tr>
<tr>
<td>DPCL</td>
<td>Disease Prevention and Control Law</td>
</tr>
<tr>
<td>DPW</td>
<td>Department of Public Welfare</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>EpiX</td>
<td>Epidemic Information Exchange</td>
</tr>
<tr>
<td>EPRP</td>
<td>Emergency Preparedness and Response Plan</td>
</tr>
<tr>
<td>FEOC</td>
<td>Forward Emergency Operations Center</td>
</tr>
<tr>
<td>HRSA</td>
<td>Health Resources Services Administration</td>
</tr>
<tr>
<td>ICP</td>
<td>Infection Control Practitioner</td>
</tr>
<tr>
<td>ICS</td>
<td>Incident Command System</td>
</tr>
</tbody>
</table>
### Abbreviations Used in This Document (cont’d)

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

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require Outpatient Care</td>
<td>50 million</td>
<td>1.6 million</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>2 million</td>
<td>37,800</td>
</tr>
<tr>
<td>Deaths</td>
<td>500,000</td>
<td>9,100</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Interpandemic Period</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Pandemic Alert Period</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Phase 5: Larger cluster(s), but human-to-human spread still localized; virus increasingly better adapted to humans, but not yet fully transmissible.</td>
</tr>
<tr>
<td>Pandemic Period and Next wave(s)</td>
<td>Phase 6: Increased and sustained transmission in general population.</td>
</tr>
<tr>
<td>Post-Pandemic Period</td>
<td>Return to interpandemic period and evaluation/assessment.</td>
</tr>
</tbody>
</table>

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 Bureaus 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 biocontainment 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 Proection 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.
   d. Identify demographic characteristics and prioritize disease investigation.
   e. 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.
   f. Provide 24/7 consultations for epidemiological investigation of disease outbreaks to the areas most affected or in danger of large numbers of mortality.
   g. Current systems of ILI surveillance and lab testing will likely be overwhelmed.
   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.
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:
      i. Virologic surveillance.
      ii. Disease-based surveillance.
      iii. Outbreak investigations.
      iv. Case investigations of pediatric deaths associated with influenza.
      v. 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:

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
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)
q. 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 IFRP 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.
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.
ATTACHMENT A

DEPARTMENT OF HEALTH'S ORGANIZATIONAL CHART
ATTACHMENT B

STATUTORY AUTHORITY
## STATUTORY AUTHORITY

<table>
<thead>
<tr>
<th>Statute</th>
<th>Regulations</th>
<th>Agency</th>
<th>Authority</th>
</tr>
</thead>
</table>
| Section 2106 of the Administrative Code of 1929 (71 P.S. §536) | DOH | (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.  
(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.  
(c) To administer and enforce the laws of this Commonwealth with regard to vaccination and other means of preventing the spread of communicable diseases. | |
| Section 2102 of the Administrative Code of 1929 (71 P.S. §532) | DOH | (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.  
(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.  
(g) To promulgate its rules and regulations. | |
| 71 P.S. §1402 | DOH | 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.  
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.  
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]. | |
| 71 P.S. § 1403(a) | DOH and local health departments | **Duty to protect health of the people.**

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.

***

| 35 P.S. §521.3. **Responsibility for disease prevention and control.**

(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.

(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.

(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.

| 35 P.S. §521.4. **Reports**

(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.

(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.
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.

* * *

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 please 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)

<table>
<thead>
<tr>
<th>Governor</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) <strong>Responsibility to meet disasters.</strong> – The Governor is responsible for meeting the dangers to this Commonwealth and people presented by disasters.</td>
</tr>
<tr>
<td>(b) <strong>Executive orders, proclamations and regulations.</strong> – Under this part, the Governor may issue, amend and rescind executive orders, proclamations and regulations which shall have the force and effect of law.</td>
</tr>
<tr>
<td>(c) <strong>Declaration of disaster emergency.</strong> – 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. . . .</td>
</tr>
<tr>
<td>(d) <strong>Activation of disaster response.</strong> – 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.</td>
</tr>
<tr>
<td>(e) <strong>Commander in chief of the military forces.</strong> – 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.</td>
</tr>
</tbody>
</table>
(f) **Additional powers.** – In addition to any other powers conferred upon the Governor by law, the Governor may:

(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.

(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.

(3) Transfer the direction, personnel or functions of Commonwealth agencies or units thereof for the purpose of performing or facilitating emergency services.

(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.

(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.

(6) Prescribe routes, modes of transportation and destinations in connection with evacuation.

(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.

* * *

---

**DRAFT**
<table>
<thead>
<tr>
<th>Section</th>
<th>Law</th>
<th>Powers and duties</th>
</tr>
</thead>
</table>
| 35 Pa. C.S.A. §7313 | Pennsylvania Emergency Management Agency (PEMA) | The agency shall have the following powers and duties: (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 . . . 
* * * (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. 
* * * (13) To administer grant programs to political subdivisions for disaster management. 
(14) To accept and coordinate assistance provided by federal agencies in major disasters or emergencies. . . |

<table>
<thead>
<tr>
<th>Section</th>
<th>Law</th>
<th>Article V. Licenses and Permits</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 Pa. C.S.A. §7601</td>
<td>Emergency Management Assistance Compact</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Law</th>
<th>Medical good Samaritan civil immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 Pa. C.S.A. §8331</td>
<td>Immunity</td>
<td>(a) General rule.—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.</td>
</tr>
<tr>
<td>42 Pa. C.S.A. §832.4</td>
<td>Immunity</td>
<td>Volunteer-in-public-service negligence standard</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>(b) Definition. — 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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>42 Pa. C.S.A. §8332</th>
<th>Immunity</th>
<th>Nonmedical good Samaritan civil immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) General rule. — 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Exceptions. —</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) This section shall not relieve a driver of an ambulance or other emergency or rescue vehicle from</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(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.

42 P.S. §8334

<table>
<thead>
<tr>
<th>DOH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Civil immunity in mass immunization projects</strong></td>
</tr>
<tr>
<td><strong>(a) General rule.</strong> — 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.</td>
</tr>
<tr>
<td><strong>(b) Exception</strong> — This section shall not exempt any drug manufacturer from liability for any drug or vaccine used in such project.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Governor, in consultation with DOH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 301 of the Counterterrorism Planning, Preparedness and Response Act (CPPRA) (35 P.S. § 2140.301)</strong></td>
</tr>
<tr>
<td><strong>(a) Temporary isolation or quarantine.</strong> — 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.</td>
</tr>
<tr>
<td><strong>(b) Judicial review.</strong> —</td>
</tr>
<tr>
<td>(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.</td>
</tr>
</tbody>
</table>
| (2) The court shall hold a hearing on the petition not more than 72 hours after the filing of the petition to
(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.

(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.

(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).

(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.

(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.

(c) Relation to other laws.—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.

| Section 302 of the CPPRA (35 P.S. §2140.302) | Immunity | 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. |
ATTACHMENT C

PANDEMIC ALERT & PANDEMIC PERIOD FLOW CHART
PANDEMIC ALERT AND PANDEMIC PERIOD FLOW CHART

Possible novel flu strain reported or detected by surveillance

Detecting agency (LDH, IDE or BOL) notifies other relevant agencies by telephone, e-mail and fax during regular working hours or the on-call person evenings and weekends and Holidays.

LHD arranges definitive samples and urgent transport to BOL
LHD arranges temporary isolation of patient pending result, LHD notifies BCHS
IDE/ LDH begins initial epidemiology to determine the potential extent and methods of disease transmission

SPECIMENS TESTED AT BOL – BOL INFORMS IDE, LHD OF RESULTS

NEGATIVE

Epidemiology suggestive of circulating influenza strain or other disease

POSITIVE H3

Unusual mortality or severity or other indicators of a novel virus

NOVEL VIRUS

BOL informs results to IDE, LHD, BCHS, Sec. of Health

IDE informs CDC, DOH Command Center
Specimen sent to CDC for further identification

IDE, CDC, LHD, BCHS discuss strategies and make recommendations to Secretary based upon activity in other locations, possibility of containment, and known mechanisms of transmission. Secretary may mobilize entire HD or request additional resources from Governor

Pandemic Alert

1) Post exposure chemoprophylaxis for all household contacts and high risk hospital contacts
2) Monitor the health of all contacts
3) Limit the activities of contacts and monitor contacts of contacts
4) Serology and lab testing of contacts
5) Search for source including bird and animal.
6) Active surveillance to find

Pandemic

1) Fully activated the Epidemiology Response Plan.
2) Define a case definition specific to the jurisdictions and situations where cases are available and work with individual hospitals to report those cases.
3) Recommend levels of infection control measures needed for Version 1.0
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

Questions and comments may be directed to:

Enzo R. Campagnolo, DVM, MPH
Division of Infectious Disease Epidemiology
Pennsylvania Department of Health
(717) 787-3350
c-ecampagn@state.pa.us

Christian R. Herr
PennAg Poultry Council
PennAg Industries Association
(717) 651-5920
cherr@pennag.com

We wish to acknowledge and gratefully thank the Delmarva Poultry Industries – Health Departments Joint Task Force for this document and for their guidance.

Pennsylvania Poultry Industry and Pennsylvania Department of Health Joint Working Group on the Response to Highly Pathogenic Avian Influenza (HPAI)
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 (orpornitics). 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 Oseltamivir (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 14th 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:


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


Training Checklist for Workers Exposed 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.
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 courtty 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: ____________________________________

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

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

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:
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 ___________________________________________

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
□ 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?

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Day 0 (Today’s Date: _____)</th>
<th>Day 7 (Today’s Date: _____)</th>
<th>Day 14 (Today’s Date: _____)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Circle One Date of Onset Date Resolved</td>
<td>Circle One Date of Onset Date Resolved</td>
<td>Circle One Date of Onset Date Resolved</td>
</tr>
<tr>
<td>Fever</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Measured Temp &gt; 100F</td>
<td>Yes No Temp*:</td>
<td>Yes No Temp*:</td>
<td>Yes No</td>
</tr>
<tr>
<td>Cough</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Runny Nose</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Body Aches *</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Red or Watery Eyes</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Headache</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Other:</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

* 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? □ No  □ 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?

<table>
<thead>
<tr>
<th>Name</th>
<th>Age (Yrs.)</th>
<th>Relationship</th>
<th>Contact #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

To: Medical Provider
From: PA State, County, and/or Municipal Health Dept.
Date: (patient name)
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-quiv.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 (oseltamivir) 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).
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) 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).

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

DEPARTMENT OF EPIDEMIOLOGY RESPONSE TASKS
### Bureau of Epidemiology Response Tasks

#### Table 1
(Response Tasks by Epidemiology Teams)

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

<table>
<thead>
<tr>
<th>Epi-Section Responsibilities</th>
<th>Number of Cases in Outbreak</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;26</td>
</tr>
<tr>
<td><strong>Clinical Epi-Section</strong></td>
<td></td>
</tr>
<tr>
<td>0.5 persons per 50 cases</td>
<td>5</td>
</tr>
<tr>
<td>Case confirmation/ nasal swabs/ referral for treatment and PEP</td>
<td></td>
</tr>
<tr>
<td><strong>Total Clinical Epi-Section</strong></td>
<td>5</td>
</tr>
<tr>
<td>Case Finding Epi-Section</td>
<td></td>
</tr>
<tr>
<td>Alert/educate Public&amp; physicians/exp (0.5 persons per 50 cases)</td>
<td>0.25</td>
</tr>
<tr>
<td>Active surveillance: record review/interview of physicians at ERs</td>
<td>10</td>
</tr>
<tr>
<td>Call exposed &lt;24hrs (1 tracer calls 25 exposed/day x 5 exposed/case)</td>
<td>5</td>
</tr>
<tr>
<td>Personal interview exposed: visit 20% of exposed &lt;24 hrs (10 per day)</td>
<td>1</td>
</tr>
<tr>
<td>Personal interview of each case &lt;24hrs &amp; identify contacts (1 interviewer/25 cases/day)</td>
<td>1</td>
</tr>
<tr>
<td>Call case-contacts &lt;24hrs (1 tracer/25 contacts/day x 5 contacts/case)</td>
<td>5</td>
</tr>
<tr>
<td>Personal interview of contacts: visit 20% of contacts &lt;24 hrs (10 per day)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Case Finding Epi-Section</strong></td>
<td>23.25</td>
</tr>
<tr>
<td>Outbreak Management Epi-Section</td>
<td></td>
</tr>
<tr>
<td>Project management (1.0 per 50 cases)</td>
<td>0.5</td>
</tr>
<tr>
<td>Notification and confirmation</td>
<td></td>
</tr>
<tr>
<td>Develop working case definition/recording forms</td>
<td></td>
</tr>
<tr>
<td>Epi-Section supervision/agency coordination</td>
<td></td>
</tr>
<tr>
<td>Develop line listing of cases</td>
<td></td>
</tr>
<tr>
<td>Database coordination</td>
<td></td>
</tr>
<tr>
<td>Hypothesis testing of exposure and risk factors</td>
<td></td>
</tr>
<tr>
<td>Treatment and PEP recommendations and coordination</td>
<td></td>
</tr>
<tr>
<td>Identify high risk employees (Guess)</td>
<td>0.5</td>
</tr>
<tr>
<td>Handling public inquiries (1 person per 50 cases)</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total Outbreak Management Epi-Section</strong></td>
<td>1.5</td>
</tr>
<tr>
<td>Exposure Assessment Epi-Section</td>
<td></td>
</tr>
<tr>
<td>Personal interview of 20 cases for exposure assessment</td>
<td>1</td>
</tr>
<tr>
<td>Identification of exposed &amp; develop line listing</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total Exposure Assessment Epi-Section</strong></td>
<td>1.5</td>
</tr>
<tr>
<td>Database Support Epi-Section (0.5 per 50 cases)</td>
<td></td>
</tr>
<tr>
<td>Maintain line listings of cases, exposed, &amp; contacts</td>
<td>0.5</td>
</tr>
<tr>
<td>Maintain clinical, lab, and exposure database</td>
<td></td>
</tr>
<tr>
<td>Provide data tabulations for hypothesis testing</td>
<td></td>
</tr>
<tr>
<td>Technical IT support</td>
<td></td>
</tr>
<tr>
<td><strong>Total Database Support Epi-Section</strong></td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total Personnel Needed</strong></td>
<td>31.75</td>
</tr>
</tbody>
</table>
Table 3
(Number of Personnel Needed for Each Epi-Team for a 500 Case Outbreak)

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

INFLUENZA TESTING AT THE BUREAU OF LABORATORIES
## Influenza Testing at the Bureau of Laboratories

<table>
<thead>
<tr>
<th>Test</th>
<th>Method</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directogen</td>
<td>EIA*</td>
<td>Rapid screening for influenza A/B</td>
</tr>
<tr>
<td>Subtyping</td>
<td>PCR*</td>
<td>Determines “H” type*</td>
</tr>
<tr>
<td>Viral Isolation</td>
<td>Cell culture</td>
<td>Definitive detection of influenza and other respiratory viruses</td>
</tr>
<tr>
<td>Viral Culture Confirmation</td>
<td>FA*</td>
<td>Confirmation of cell culture</td>
</tr>
<tr>
<td>Influenza confirmation</td>
<td>HA and HAI*</td>
<td>Definitive typing of influenza using WHO antisera</td>
</tr>
</tbody>
</table>

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.

Version 1.0
Two-way Communications for Phase II - Response

EMSO

Regional EMS councils

EMS Service Infection Control coordinators & physicians
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

<table>
<thead>
<tr>
<th>DISPENSING SITE TEMPLATE</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Purpose</td>
<td>4</td>
</tr>
<tr>
<td>Organization</td>
<td>4</td>
</tr>
<tr>
<td>Roles and Responsibilities</td>
<td>5</td>
</tr>
<tr>
<td>Functional Unit Operations</td>
<td>7</td>
</tr>
<tr>
<td>Site Selection</td>
<td>14</td>
</tr>
<tr>
<td>Site Design</td>
<td>15</td>
</tr>
<tr>
<td>Public Information and Risk Communication</td>
<td>16</td>
</tr>
<tr>
<td>Infection Control</td>
<td>17</td>
</tr>
<tr>
<td>Security/Transportation</td>
<td>17</td>
</tr>
<tr>
<td>Training and Education</td>
<td>18</td>
</tr>
<tr>
<td>Recovery</td>
<td>19</td>
</tr>
</tbody>
</table>

#### APPENDICES

- Appendix A: POD Organizational Chart and Job Action Sheets
- Appendix B: Model Staffing Calculations
- Appendix C: Point of Dispensing Facility Survey and Security Checklist
- Appendix D: Sample Patient History Form
- Appendix E: Anthrax Information
- Appendix F: Botulism Information
- Appendix G: Plague Information
- Appendix H: Tularemia Information
- Appendix I: Pennsylvania’s Smallpox Vaccination Plan (Redacted)
- Appendix J: Directions for Preparing Oral Suspensions of Amoxicillin, Cipro and Doxy
- Appendix K: Point of Dispensing Site List with Contact Information
- Appendix L: Sample Dispensing Site Floor Plan
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.
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”1. 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-

---

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:

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

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

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 JAsSs 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 Branch Director
(for multiple sites)

POD Manager

Liaison

Public Information Officer

Security Section Lead

Security Staff

Administration Section Lead

Data Entry Clerk

Logistics Section Lead

Communications Unit Leader

Communication Staff

Pharmacy Unit Leader

Pharmacy Technician

Logistics Specialist

Operations Section Lead

Greeter

Medical Screener

Dispensing Staff

Mental Health Specialist

Interpreter/Translator

Planning Section Lead
POD Lead Job Action Sheets

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.
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.
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.
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.
☐ Assist 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

**OPERATIONS SECTION CHIEF**

<table>
<thead>
<tr>
<th>Positioned Assigned To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Report To: ____________________ (Dispensing Site Supervisor)</td>
</tr>
<tr>
<td>Dispensing Site Location: _______________ Telephone: _______________</td>
</tr>
</tbody>
</table>

**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.
  o 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.
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.
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.
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.
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.
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

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.
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.
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:

46
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

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

48 Version 1.0
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.
DATA ENTRY CLERK
PLANNING Job Action Sheets

PA DOH SNS INCIDENT COMMAND SYSTEM
Job Action Sheet

PLANNING SECTION CHIEF

<table>
<thead>
<tr>
<th>Positioned Assigned To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Report To: ______________________________ (Dispensing Site Supervisor)</td>
</tr>
<tr>
<td>Dispensing Site Location: ___________________ Telephone: __________________</td>
</tr>
</tbody>
</table>

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:

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

Support Staffing Recommendations for a 96 Hour Campaign:

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

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:**

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

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

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

**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

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Main Telephone:</td>
<td>Type of Facility:</td>
</tr>
<tr>
<td></td>
<td>High School</td>
</tr>
<tr>
<td></td>
<td>Middle School</td>
</tr>
<tr>
<td></td>
<td>Elementary School</td>
</tr>
<tr>
<td></td>
<td>Recreation Center</td>
</tr>
<tr>
<td></td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

Directions to the Facility via Car from Closest Major Intersection:

Directions to the Facility via Public Transportation:

## EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Primary Contact (first &amp; last name)</th>
<th>Other Contact (first &amp; last name)</th>
<th>Other Contact (first &amp; last name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Title:</td>
<td>Title:</td>
</tr>
<tr>
<td>Business Phone:</td>
<td>Business Phone:</td>
<td>Business Phone:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Home Phone:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>Pager:</td>
<td>Pager:</td>
<td>Pager:</td>
</tr>
<tr>
<td>Fax:</td>
<td>Fax:</td>
<td>Fax:</td>
</tr>
<tr>
<td>E-mail Address:</td>
<td>E-mail Address:</td>
<td>E-mail Address:</td>
</tr>
<tr>
<td>FACILITY QUESTIONS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of Staff (not including nurses):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of Nurses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of Students:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of School Police Officers:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of External Building Entrances:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>External Building Entrance Handicap Accessible:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of Off-Street Parking Spaces for cars:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Auditorium:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of External Building Entrances:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>More than one entrance to the parking lot:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Stage in Auditorium:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dedicated area of buses to park:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If yes, how many buses can park at one time:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If yes, square footage of stage:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PA System:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Security System:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Surveillance Cameras:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gym:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of Refrigerators:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Small (home kitchen)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Large (industrial)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Can any of the Refrigerators be moved? Explain.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of entrances to gym:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do gym doors lock?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If yes, as large as HS Basketball Court:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gym Square Footage:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of entrances to gym:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do gym doors lock?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2 secure rooms (close to gym) for material storage and staff break room:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Telephone outlet in gym?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If no, nearest phone outlet to the gym:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Internet Access in gym?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If no, nearest internet access to gym:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Air Conditioning in entire facility:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If no, anywhere in facility? Explain.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generator for power</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If yes, power for what?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Lighting:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td><strong>How is generator powered?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### FACILITY DIAGRAM

<p>| 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 |</p>
<table>
<thead>
<tr>
<th>Number of Required Security Personnel</th>
<th>Digital Photos:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inside Facility:</td>
<td>arena/Front/Sides/Rear of Facility</td>
</tr>
<tr>
<td>Perimeter</td>
<td>Off-Street Parking</td>
</tr>
<tr>
<td></td>
<td>Gym</td>
</tr>
<tr>
<td></td>
<td>Auditorium</td>
</tr>
<tr>
<td></td>
<td>Athletic Fields</td>
</tr>
<tr>
<td></td>
<td>Other (explain)</td>
</tr>
</tbody>
</table>

| Name and address of closest medical facility/hospital: | Languages (other than English) spoken in community near facility: |

| Name of Person Completing Survey: | Date: |
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, daunder) 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 t&
    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
DATE: April 30, 2004

SUBJECT: Emergency Response Employees (EREs)

TO: Regional EMS Directors

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

THRU: Margaret E. Trimble, Director
EMS Office

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,
Emergency Response Employees (EREs)  
April 30, 2004  
RC-2004-015  
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.
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 of exposure
   - 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, daunder) 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
DATE: April 30, 2004

SUBJECT: Emergency Response Employees (EREs)

TO: Regional EMS Directors

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

THRU: Margaret E. Trimble, Director
EMS Office

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,
Emergency Response Employees (EREs)                           April 30, 2004
RC-2004-015
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.

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.
ATTACHMENT J

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 unstaffed 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.
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 ≥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

County/Municipal Health Departments

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
### Communication Strategies for Pandemic

Spokesperson: Office of Communications or Designate

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Communication Channel</th>
<th>Key Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner Agencies</td>
<td>• HAN</td>
<td>• Relevant information on the pandemic response and current status of the pandemic (surveillance information)</td>
</tr>
<tr>
<td></td>
<td>• Fax</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Direct mail</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Email</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Direct discussion (meetings)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Conference call</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Website (Health Unit)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Direct Health Unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Telephone line</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• LMS</td>
<td></td>
</tr>
<tr>
<td>Health Care Providers, Physicians and Pharmacists</td>
<td>• HAN</td>
<td>• Relevant information on the status of the pandemic (surveillance information)</td>
</tr>
<tr>
<td></td>
<td>• Fax</td>
<td>• Notice of all public communications</td>
</tr>
<tr>
<td></td>
<td>• Direct mail</td>
<td>• Priorities and rationales</td>
</tr>
<tr>
<td></td>
<td>• Email</td>
<td>• Recommended Control measures</td>
</tr>
<tr>
<td></td>
<td>• Direct discussions (meetings)</td>
<td>• Recommended monitoring of adverse events and mechanisms for reporting</td>
</tr>
<tr>
<td></td>
<td>• Conference call</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Presentations, rounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Website (Health Unit)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Communiqués</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Direct Health Unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Telephone line</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• LMS</td>
<td></td>
</tr>
<tr>
<td>General Public</td>
<td>• Media releases, alerts</td>
<td>• Relevant information on the status of the pandemic (surveillance information)</td>
</tr>
<tr>
<td></td>
<td>• Press conferences</td>
<td>• Information on protective measures</td>
</tr>
<tr>
<td></td>
<td>• 1-877-PA-HEALTH extended staff hours</td>
<td>• Announcements regarding public health measures being taken (school closures, travel restrictions, etc.)</td>
</tr>
<tr>
<td></td>
<td>• 1-877-PA-HEALTH recorded message</td>
<td>• Information regarding vaccines and antiviral medication</td>
</tr>
<tr>
<td></td>
<td>• Special hotline</td>
<td>• Schedules and instructions for public clinics</td>
</tr>
<tr>
<td></td>
<td>• Website (Health Unit, other)</td>
<td>• Announcements regarding changes in provision of health care/emergency services.</td>
</tr>
<tr>
<td></td>
<td>• Fax or e-mail to community organizations</td>
<td>• Information regarding adverse events</td>
</tr>
<tr>
<td></td>
<td>• Public presentations, community forums</td>
<td>• Actions to cope with the effects of a pandemic.</td>
</tr>
</tbody>
</table>
EXAMPLE OF A MEDIA RELEASE (1st case)

FOR IMMEDIATE RELEASE

COMMONWEALTH OF PENNSYLVANIA
Department of Health
Commonwealth News Bureau
Room 308, Main Capitol Building
Harrisburg, PA 17120

CONTACT: Name
(###) ###-####

HEALTH DEPARTMENT CONFIRMS FIRST HUMAN CASE OF AVIAN INFLUENZA IN PENNSYLVANIA
Public should seek immediate treatment for flu-like symptoms

HARRISBURG - The first lab-confirmed human case of avian influenza in Pennsylvania was found today in a ###-year-old resident of County, according to the state Department of Health. The department is currently investigating to determine the source of transmission and identify any sources of public risk.

Members of the public are advised to contact a physician immediately if experiencing flu-like symptoms, such as: aches, fever, or chills. Individuals should also take the following preventive measures to prevent contracting or transmitting the flu virus:

- Wash hands thoroughly after using the bathroom, before eating, and after coughing, sneezing or blowing your nose.
- Use a tissue to cover your nose and mouth when coughing or sneezing.
- Regularly clean surfaces and objects that are frequently touched or handled.

Avian influenza is a virus that occurs naturally among birds worldwide. It is very contagious among birds and can cause severe illness or death in infected birds. Human infection with avian influenza viruses began in 1997. Symptoms in humans can range from typical flu-like symptoms such as fever, cough, sore throat and muscle aches, to eye infections, pneumonia, severe respiratory diseases and other severe health complications.

###

2

Version 1.0
EXAMPLE OF A DISTRICT OFFICE MEDIA RELEASE (1st case)

FOR IMMEDIATE RELEASE

COMMONWEALTH OF PENNSYLVANIA
Department of Health
District Office

Address 1
Address 2

CONTACT: Name
(###) ###-####

HEALTH DEPARTMENT CONFIRMS FIRST HUMAN CASE OF AVIAN INFLUENZA IN BERKS COUNTY
Public should seek immediate treatment for flu-like symptoms

HARRISBURG - The first human case of avian influenza in Berks County was confirmed today in a ###-year-old resident, according to the Pennsylvania Department of Health, which is currently investigating to determine the source of transmission and identify any sources of public risk. This is the # human case of avian flu detected in the Pennsylvania. The first human case was detected on (date) in a resident of _____ County.

The public is advised to contact a physician immediately if experiencing flu-like symptoms such as aches, fever or chills. Individuals should also take the following preventive measures to prevent contracting or transmitting the flu virus:

• Wash hands thoroughly after using the bathroom, before eating, and after coughing, sneezing or blowing your nose.
• Use a tissue to cover your nose and mouth when coughing or sneezing.
• Regularly clean surfaces and objects that are frequently touched or handled.

Avian influenza is a virus that occurs naturally among birds worldwide. It is very contagious among birds and can cause severe illness or death in infected birds. Human infection with avian influenza viruses began in 1997. Symptoms in humans can range from typical flu-like symptoms such as fever, cough, sore throat and muscle aches, to eye infections, pneumonia, severe respiratory diseases and other severe health complications.
EXAMPLE OF A MEDIA RELEASE (1st death)

FOR IMMEDIATE RELEASE

Date

COMMONWEALTH OF PENNSYLVANIA
Department of Health
Commonwealth News Bureau
Room 308, Main Capitol Building
Harrisburg, PA 17120

CONTACT: Name
(###) ###-####

HEALTH DEPARTMENT CONFIRMS FIRST HUMAN DEATH DUE TO AVIAN INFLUENZA IN PENNSYLVANIA
A total of ### human cases of avian influenza reported in Pennsylvania.

HARRISBURG - The first human death due to avian influenza in Pennsylvania was confirmed today in a ###-year-old ___ County resident, according to state Department of Health. The state public health laboratory has confirmed a total of ### human cases of avian influenza in Pennsylvania since (date).

“The Department of Health is monitoring the outbreak of avian flu in Pennsylvania very closely and is working with health care providers across the state to ensure patients receive antiviral medication and supportive therapy,” said state Health Secretary Dr. Calvin B. Johnson.

“Our primary goal is to identify human cases of avian flu early so we can contain the outbreak and prevent more Pennsylvanians from being infected with the virus.”

The public is advised to contact a physician immediately if experiencing flu-like symptoms such as aches, fever or chills. Individuals who believe they may be experiencing symptoms are urged not to report to emergency rooms in order to prevent transmission of the virus in the hospital setting. Emergency departments are being advised to divert patients presenting symptoms of avian flu to the patient’s primary care physician or a separate treatment center to receive antiviral medication.
“If you are experiencing flu-like symptoms, it is critical that you contact your primary care physician right away so you can begin taking antiviral medications as soon as possible,” Dr. Johnson said. “However, the best defense against spreading or becoming infected with avian influenza virus is for everyone to take simple preventive measures to improve hygiene and reduce transmission.”

Individuals should take the following preventive measures to prevent contracting or transmitting the avian flu virus.

- Wash hands thoroughly after using the bathroom, before eating, and after coughing, sneezing or blowing your nose.
- Use a tissue to cover your nose and mouth when coughing or sneezing.
- Regularly clean surfaces and objects that are frequently touched or handled.
- Stay home from work or school and avoid all non-essential visits to public places if you are sick.
- Employers and schools should encourage the appropriate use of sick leave for anyone who is ill.

Symptoms in humans can range from typical flu-like symptoms such as fever, cough, sore throat and muscle aches, to eye infections, pneumonia, severe respiratory diseases and other severe health complications.
EXAMPLE OF A MEDIA RELEASE (Antiviral distribution)

FOR IMMEDIATE RELEASE

COMMONWEALTH OF PENNSYLVANIA

Department of Health
Commonwealth News Bureau
Room 308, Main Capitol Building
Harrisburg, PA 17120

CONTACT: Name
(###) ###-####

HEALTH DEPARTMENT OPENS ANTIVIRAL DISTRIBUTION CLINICS STATEWIDE

Anyone experiencing flu-like symptoms is urged to seek antiviral medication.

HARRISBURG- Public clinics for the distribution of antiviral medications are opening across the state to address the growing number of human cases of avian influenza, according to state Health Secretary Dr. Calvin B. Johnson.

Anyone experiencing flu-like symptoms is encouraged to seek antiviral medication from either their primary care physician or the nearest Department of Health clinic as soon as symptoms appear.

“It is critical that antiviral medication is started within two days of experiencing flu-like symptoms for it to be most effective,” Dr. Johnson said. “The Department of Health’s local distribution clinics will make it faster and easier for individuals to receive the antiviral medication they need.”

A list of all health department antiviral distribution clinics statewide is available on the Department of Health website, www.health.state.pa.us, or by calling 1-877-PA-HEALTH. In order to improve the efficiency of medication distribution at the clinic and reduce wait time, individuals should be prepared to supply the following information:

- Photo ID
- Allergies
- Current medications

6

Version 1.0
• Health conditions
• Height and weight of children if they are receiving the medication

“In addition to seeking antiviral medication for yourself if you are sick, I urge all Pennsylvanians to help any family, friends, neighbors or coworkers who may need assistance getting to a clinic or seeking medical treatment,” said Dr. Johnson. “During this outbreak, we must take a more active role in protecting the health of ourselves, our families and those around us who are more vulnerable.”

Individuals who believe they may be experiencing symptoms of avian flu are urged not to report to emergency rooms in order to prevent transmission of the virus in the hospital setting. Emergency departments are being advised to divert patients presenting symptoms of avian flu to the patient’s primary care physician or the nearest health department clinic.

Individuals should take the following preventive measures to prevent contracting or transmitting the avian flu virus:

• Wash hands thoroughly after using the bathroom, before eating, and after coughing, sneezing or blowing your nose.
• Use a tissue to cover your nose and mouth when coughing or sneezing.
• Regularly clean surfaces and objects that are frequently touched or handled.
• Stay home from work or school and avoid all non-essential visits to public places if you are sick.
• Employers and schools should encourage the appropriate use of sick leave for anyone who is ill.

###
EXAMPLE OF A DISTINCT OFFICE MEDIA RELEASE (Antiviral distribution)

FOR IMMEDIATE RELEASE
Date

COMMONWEALTH OF PENNSYLVANIA
Department of Health
District Office
Address 1
Address 2

CONTACT: Name
(###) ###-####

HEALTH DEPARTMENT OPENS ANTIVIRAL DISTRIBUTION CLINICS IN SOUTHEAST PENNSYLVANIA

Anyone experiencing flu-like symptoms is urged to seek antiviral medication.

HARRISBURG: The Department of Health is opening public clinics for the distribution of antiviral medication to address the growing number of human cases of avian influenza in Pennsylvania.

Anyone experiencing flu-like symptoms is encouraged to seek antiviral medication from either their primary care physician or the nearest Department of Health clinic as soon as symptoms appear.

A complete list of health department distribution clinics in southeast Pennsylvania by county is included below. Individuals are encouraged to report to the nearest clinic to receive medication and to help family, friends, neighbors and others who may need assistance.

ANTIVIRAL MEDICATION DISTRIBUTION SITES:

_____ COUNTY
- Site name
  Address1
  Address2
  Date and time

_____ COUNTY
- Site name
  Address1
In order to improve the efficiency of antiviral distribution at the clinic and reduce wait time, individuals should be prepared to supply the following information:

- Photo ID
- Allergies
- Current medications
- Health conditions
- Height and weight of children if they are receiving the medication

A complete list of Department of Health antiviral distribution clinics statewide is available at [www.health.state.pa.us](http://www.health.state.pa.us).
EXAMPLE OF A MEDIA RELEASE (Limited vaccine distribution)

FOR IMMEDIATE RELEASE
Date

COMMONWEALTH OF PENNSYLVANIA
Department of Health
Commonwealth News Bureau
Room 308, Main Capitol Building
Harrisburg, PA 17120

CONTACT: Name
(###) ###-####

HEALTH DEPARTMENT WILL OFFER AVIAN INFLUENZA VACCINE TO HIGH-RISK GROUPS

Anyone experiencing flu-like symptoms is urged to seek antiviral medication.

HARRISBURG: The Department of Health will begin offering avian influenza vaccine to individuals considered to be at high risk for serious complications from avian flu. Only individuals that meet the criteria for one of the following high-risk groups will be eligible to receive the vaccine:

- Medical workers and public health workers involved in direct patient care
- Persons 65 years and older with one or more influenza high-risk conditions
- Persons 6 months to 64 years with two or more influenza high-risk conditions
- Persons 6 months or older with a history of hospitalization for pneumonia, influenza or other influenza high-risk condition in the past year
- Pregnant women
- Household contacts of severely immunocompromised persons who cannot be vaccinated
- Household contacts of children less than 6 months old
- Public health emergency response workers
- Key government leaders

The high-risk groups are based on criteria recommended by the U.S. Department of Health and Human Services to reduce severe health complications among those individuals at the highest risk for hospitalization and death and individuals essential to maintaining health care and other essential public services.
Individuals that are not part of the high-risk priority groups are urged to seek antiviral medication at the first sign of flu-like symptoms. A list of all health department antiviral distribution clinics statewide is available on the Department of Health website at www.health.state.pa.us or by calling 1-877-PA-HEALTH.

All individuals should take the following measures to prevent contracting or transmitting the avian flu virus.

- Wash hands thoroughly after using the bathroom, before eating, and after coughing, sneezing or blowing your nose.
- Use a tissue to cover your nose and mouth when coughing or sneezing.
- Regularly clean surfaces and objects that are frequently touched or handled.
- Stay home from work or school and avoid all non-essential visits to public places if you are sick.
- Employers and schools should encourage the appropriate use of sick leave for anyone who is ill.
FOR IMMEDIATE RELEASE

COMMONWEALTH OF PENNSYLVANIA
Departments of Health and Public Welfare
Commonwealth News Bureau
Room 308, Main Capitol Building
Harrisburg, PA 17120

CONTACT: Name
(###) ###-####

*** MEDIA ADVISORY ***
For Planning Purposes Only

HEALTH DEPARTMENT TO PROVIDE BRIEFING ON
AVIAN INFLuenza OUTBREAK IN PENNSYLVANIA

HARRISBURG: On (date) at (time), state Health Secretary Dr. Calvin B. Johnson will
hold a press briefing in the Capitol Media Center in Harrisburg on the avian influenza
outbreak in Pennsylvania.

Secretary Johnson will provide current Pennsylvania avian influenza case information,
discuss Department of Health actions and provide instructions for the public to help
prevent infection and transmission.

EVENT:
Secretary of Health Dr. Calvin B. Johnson
Press Briefing on Avian Influenza Outbreak

DATE: TBD
TIME: TBD
LOCATION: Capitol Media Center
Harrisburg

###
Commonwealth Emergency News and Information Center Planning Manual

I. Purpose

This document is meant to be a supplement to Annex D of the State Emergency Operations Plan. It describes the purpose, function and operation of the Commonwealth Emergency News and Information Center. (CENIC)

II. CENIC Purpose

A. CENIC serves as the Commonwealth’s communications office during an emergency. It is activated at the discretion of the PEMA Press Secretary, in consultation with the PEMA Director.

B. Just as each emergency requires a unique response, communications is unique to the situation. CENIC is not required to be activated when there is a full activation of the State Emergency Operations Center. Conversely, a full activation of the operations center is not required to activate CENIC.

III. CENIC Function

The PEMA Press Secretary, in consultation with the Governor’s Office Representative, manages CENIC. The PEMA Press Secretary provides direction as to information that should be released to the public during an emergency. The PEMA Press Secretary also designates personnel from other state agencies that will come to the State Emergency Operations Center to staff CENIC.

IV. CENIC Operation

A. Location

CENIC is located in the vicinity of State Emergency Operations Center. It is part of the operation during the state’s response to an emergency.

B. Staffing

1. Primary agencies that will be called upon to staff CENIC include:

   Governor’s Press Office
   Lt. Governor’s Press Office
   Department of Environmental Protection
   Department of Health

   Department of Transportation
   State Police
   Department of Military and Veterans Affairs
2. Secondary agencies that will be called upon to staff CENIC include:

   a. Office of Administration
   b. Department of Aging
   c. Department of Agriculture
   d. Department of Banking
   e. Department of Community and Economic Development
   f. Department of Conservation and Natural Resources
   g. Department of Corrections
   h. Department of Education
   i. Department of General Services
   j. Department of Labor and Industry
   k. Department of Revenue
   l. Department of Welfare

3. Depending on the nature of the emergency, the PEMA Press Secretary has the discretion to activate the necessary state agency press staff. In addition, Commonwealth Media Services will be put on standby to provide video and production support at the discretion of the PEMA Press Secretary.

V. Media Releases

   A. The PEMA Press Secretary and PEMA Director will approve media releases distributed by CENIC. In the case that there is a Governor’s Office representative in the State Emergency Operations Center, this representative also will sign off on any media releases.

   B. Once approved, releases will be sent to the Editor of the Commonwealth News Bureau or designee for distribution via PR Newswire. The Governor’s Director of Communications must approve any change to this process.

VI. Media Inquires

   The PEMA Press Secretary will be the primary spokesperson for CENIC. It will be the PEMA Press Secretary’s discretion to assign media inquires to other agencies as necessary. In a SIGNIFICANT event, it is obvious that the Governor’s Office Representative would perform this public function.

VII. Staffing Assessment

   The PEMA Press Secretary, in consultation with the PEMA Director and the Governor’s Office Representative, will assess CENIC Activation on a 24-hour basis.
IX. CENIC Equipment

Computers and printers
Incoming/Outgoing fax machine
Cable television access
Outside phone lines
News conference room located inside PEMA headquarters
Satellite uplink trucks
Bulletin board/white board
Office supplies
Google Search

(state name) pandemic influenza plan

→ also search (state name) dept of health website re: pandemic plan

yes - discuss
yes - ID
yes - reopen
no - process
no - communication
yes - continuity but very briefly

PA FAQs - Pandemic Planning Preparation for Schools
Pilot funds
Maggie meeting w/ the Dean re: Artificial Intelligence & Legal Research
- ontological way of searching
<table>
<thead>
<tr>
<th>Yes/No</th>
<th>Parameter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Does the state plan discuss school closure as a disease mitigation strategy?</td>
</tr>
<tr>
<td>Yes</td>
<td>Does the state plan identify who may order school closure?</td>
</tr>
<tr>
<td>No</td>
<td>Does the state plan describe how school closure will be effectuated (i.e., the process)?</td>
</tr>
<tr>
<td>No</td>
<td>Does the state plan address communication issues (i.e., coordination among state/local agencies, dissemination of information to parents, teachers, other stakeholders)?</td>
</tr>
<tr>
<td>Yes</td>
<td>Does the state plan address continuity of education issues?</td>
</tr>
<tr>
<td>Yes</td>
<td>Does the state plan address the reopening of schools?</td>
</tr>
</tbody>
</table>

Google search completed? ✓

State DOH search completed? ✓

Notes:
Score based on the Pandemic Planning Preparation for Schools FAQs
<table>
<thead>
<tr>
<th>PLAN REFERENCE</th>
<th>PAGE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a plan to close and reopen schools, businesses and other public places/events.</td>
<td>5</td>
</tr>
<tr>
<td>Communicate with schools, businesses and other venues for potential closures</td>
<td>5</td>
</tr>
<tr>
<td>Monitor school absenteeism due to [flu] with the Division of School Health, PA DOE and local health jurisdictions.</td>
<td>12</td>
</tr>
<tr>
<td>Recommend, in conjunction with PEMA, that the Governor limit egress and ingress into the disaster emergency area.</td>
<td>33</td>
</tr>
<tr>
<td>Recommend, in conjunction with PEMA, that the Governor restrict travel within the disaster emergency area.</td>
<td>33</td>
</tr>
<tr>
<td>Suspend public gatherings.</td>
<td>33</td>
</tr>
<tr>
<td>Monitor fever in public places.</td>
<td>33</td>
</tr>
<tr>
<td>Cancel public events.</td>
<td>33</td>
</tr>
<tr>
<td>Close public buildings and public spaces.</td>
<td>33</td>
</tr>
</tbody>
</table>

Score of 6/10
- Discusses school closure
- Discusses communication (rather tenuously)
  - too vague (no description)

→ 3 w/ FAQs information
A Tool-Kit for Community Preparedness: A Practical Approach to Pandemic Influenza Planning
# Table of Contents

## Introduction 3

## Step 1: Understanding how a flu pandemic differs from other emergencies 4

## Step 2: Organizing and leading a Community Work Group 9

## Step 3: Develop an incident management system 12

## Step 4: Decide how, what, when, where, and to whom to communicate 21

## Step 5: Determine how to coordinate local resources 23

## Step 6: Protect essential community infrastructure 24

## Step 7: Identify and support vulnerable populations 26

## Step 8: Understand everyone’s role 28

## Step 9: Test and evaluate your plan 29

## Information Resources 30

## Attachments

1. Planning Assumptions
   - Sample Incident Specific Annex (Plan Template)
2. Sample COOP Plan Template
3. Sample County Checklist
4. CDC Community Checklists
   - Trigger points for activation of various stages of response
   - State Emergency Operations Center Seating Chart
   - Department of Health Command Center Seating Chart
   - County Emergency Management 24-hour contacts
5. Health resources available through DOH District Offices
   - Communications matrix
6. Sample public messages before, during, and after a pandemic
7. Messaging to Employees
   - Sample Community Work Group organization, mission, and deliverables – Executive Order
8. Resource Request Flowchart
Introduction

This toolkit has been designed for your use in planning a community response to a pandemic influenza emergency. As with all incident specific planning, emergency managers should use the community All Hazards Emergency Operations Plan as a base plan and build onto the existing plan where appropriate. This toolkit includes a didactic module with accompanying illustrative PowerPoint and a series of attachments for your use. A number of weblinks and phone numbers have been provided for your use during planning as well. The PowerPoint can be utilized as is, or modified for your use in training or educating community members and leaders.

The Pennsylvania Emergency Management Agency and the Department of Health have a number of subject matter experts available to you in your planning process. Please feel free to use the numbers and web links provided in this document.
A Community Tool-Kit for Preparedness Planning
A Practical Approach to Pandemic Influenza

Step 1: Understanding how a flu pandemic differs from other emergencies.

a. Basics of pandemic influenza

What is a Pandemic?

A pandemic is a global outbreak of disease that occurs when a virus appears or “emerges” in human population, causes serious illness, and then spreads easily from person to person worldwide. Pandemics are e different from seasonal outbreaks or “epidemics” of influenza. Seasonal outbreaks are caused by subtypes of influenza a viruses viruses that already circulate among people, whereas pandemic outbreaks are caused by new subtypes, by subtypes that have never circulated among people, or by subtypes that have not circulated among people for a long time. Past pandemics have led to high levels of illness, death, social disruption, and economic loss.

Appearance (Emergence) of Pandemic Influenza Viruses

There are many different subtypes of Influenza or “flu” viruses. The subtypes differ based upon certain proteins on the surface of the virus (the hemagglutinin or “HA” protein and the neuraminidase or the “NA” protein).

Pandemic viruses emerge as a result of a process called “antigenic shift”, which causes an abrupt or sudden, major change in influenza A viruses. These changes are caused by y new combinations of the HA and/or NA proteins on the surface of the virus. Changes results in a new influenza A virus subtype. The appearance of a new influenza A virus s subtype is the first step toward a pandemic; however, to cause a pandemic, the new virus subtype also must have the capacity to spread easily from person to person. Once a new pandemic influenza virus emerges and spreads, it usually becomes established among people and moves around or “circulates” for many years as seasonal epidemics of influenza.
b. Differences between pandemic and seasonal influenza

<table>
<thead>
<tr>
<th>SEASONAL FLU</th>
<th>PANDEMIC FLU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outbreaks follow predictable seasonal patterns; occurs annually, usually in winter, in temperate climates.</td>
<td>Occurs rarely (three times in 20th century – last in 1968)</td>
</tr>
<tr>
<td>Usually some immunity built up from previous exposure.</td>
<td>No previous exposure; little or no pre-existing immunity.</td>
</tr>
<tr>
<td>Outbreaks usually last only 5-6 months.</td>
<td>Outbreaks may occur in waves over a long period of time, even years.</td>
</tr>
<tr>
<td>Healthy adults usually not at risk for serious complications (the very young, the elderly and those with certain underlying health conditions at increased risk for serious complications).</td>
<td>Healthy people may be at increased risk for serious complications.</td>
</tr>
<tr>
<td>Health systems can usually meet public and patient needs.</td>
<td>Health systems may be overwhelmed.</td>
</tr>
<tr>
<td>Vaccine developed based on known virus strains and available for annual flu season.</td>
<td>Vaccine probably would not be available in early stages of a pandemic.</td>
</tr>
<tr>
<td>Adequate supplies of antivirals are usually available.</td>
<td>Effective antivirals may be limited supply.</td>
</tr>
<tr>
<td>Average U.S. deaths approximately 36,000/yr.</td>
<td>Number of deaths could be quite high (e.g., U.S. 1918 death toll approximately 500,000).</td>
</tr>
<tr>
<td>Symptoms: fever, cough, runny nose, muscle pain. Deaths often caused by complications, such as pneumonia.</td>
<td>Symptoms may be more severe and complications more frequent.</td>
</tr>
<tr>
<td>Generally causes modest impact on society (e.g., some school closing, encouragement of people who are sick to stay home).</td>
<td>May cause major impact on society (e.g. widespread restrictions on travel, closing of schools and businesses, cancellation of large public gatherings).</td>
</tr>
<tr>
<td>Manageable impact on domestic and</td>
<td>Potential for severe impact on domestic</td>
</tr>
</tbody>
</table>
Differences between typical emergency response and pandemic response

Add a table to illustrate how response to a pandemic influenza emergency might differ from other types of responses, e.g., flood, large accidents, etc. EXAMPLE – use your expertise to build the actual table

<table>
<thead>
<tr>
<th>Typical Response</th>
<th>Pandemic Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term, one-time response</td>
<td>Long-term, multiple wave response</td>
</tr>
<tr>
<td>Usually have “full complement” of staff</td>
<td>May have up to 40% of staff out sick</td>
</tr>
<tr>
<td>Relatively short lived event</td>
<td>May last several weeks or months</td>
</tr>
<tr>
<td>Affects a specific area</td>
<td>Widespread across large geographic area</td>
</tr>
<tr>
<td>Personnel and volunteers readily available</td>
<td>May need to quarantine population in cycles</td>
</tr>
<tr>
<td>Resources quickly renewable</td>
<td>Severe demand and impact on resources</td>
</tr>
</tbody>
</table>

Influenza Pandemic Response | Typical Response

12 – 18 months duration | Short duration 1 day to 4-5 weeks
Severe impact on resources | Resources quickly renewable
Severely limited human resources | Personnel and volunteers readily available
Infrastructure may be diminished | Infrastructure largely intact

a. Monitoring the spread of avian flu

A pandemic is global in nature, but response to a pandemic will be local. Local officials cannot rely on other states, counties or communities for assistance because all areas will be equally affected.

Although there is no immediate threat of an influenza pandemic reaching Pennsylvania, state and local officials are taking an aggressive approach to preparing for local outbreaks in birds and humans.

For instance, the Pennsylvania Department of Agriculture leads the nation in its ability to monitor poultry flocks for avian influenza and contain outbreaks. The Pennsylvania Department of Health has extensive experience responding to many types of disease outbreaks, and uses an award-winning disease surveillance system to immediately spot outbreaks and monitor their spread. Local officials, hospitals and community organizations continue to work on plans for handling the impact of a pandemic on local services.

b. Stages of a pandemic:
The World Health Organization (WHO) has developed a system for communicating stages of a pandemic. This system describes pandemic periods related to the progression of novel virus with the potential to cause a pandemic. The periods and phases are described below.

Interpandemic period

Phase 1: No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk to human infection or disease is considered to 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.

Pandemic alert period:

Phase 3: Human infection (s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.

Phase 4: Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.

Phase 5: Large cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk).

Pandemic period:

Phase 6: Pandemic: increased and sustained transmission in general population.

Post-pandemic period:

Return to the Interpandemic period (Phase 1)

c. How a pandemic might unfold

Influenza pandemics are recurring events.

An influenza pandemic is a rare but recurrent event. Three pandemics occurred in the previous century: “Spanish influenza” in 1918, “Asia influenza” in 1957, and the “Hong Kong influenza” in 1968. The 1918 pandemic killed an estimated 40-50 million people worldwide. That pandemic, which was exceptional, is considered one of the deadliest disease events in human history. Subsequent pandemics were much milder, with an estimated 2 million deaths in 1957 and 1 million deaths in 1968. A pandemic occurs when a new influenza virus emerges and starts spreading as easily as normal influenza – by coughing and sneezing. Because the virus is new, the human immune system will have no pre-existing immunity.
This makes it likely that people who contact pandemic influenza will experience more serious disease than that caused by normal influenza.

The world may be on the brink of another pandemic. A little alarmist?

Health experts have been monitoring a new extremely severe influenza virus – the H5N1 strain – for almost eight years. The H5N1 strain first infected humans in Hong Kong in 1997, causing 18 cases, including six deaths. Since mid – 2003, this virus has caused the largest and most severe outbreaks in poultry on record. In December 2003, infections in people exposed to sick birds were identified. Since then, over 125600 human cases have been laboratory confirmed in four ten Asian countries (as of October 16, 2006, www.pandemicflu.gov) (Cambodia, Indonesia, Thailand, and Viet Nam), and 151 more than half of these people patients have died. Most cases have occurred in previously healthy children and young adults. Fortunately, the virus does has not jumped easily from birds to humans or spread readily and sustainably among humans. Should H5N1 evolve to a moreform as contagious form, as normal influenza, a pandemic could begin.

All countries around the world will be affected.

Once a fully contagious virus emerges, its global spread is considered inevitable. Countries might, through measures such as border closures and travel restrictions, delay arrival of virus, but cannot stop it. The pandemics of the previous century encircled the globe in 6 to 9 months, even when most international travel was accomplished by ship. Given the speed and volume of international air travel today, the virus could spread more rapidly, possibly reaching all continents in less than 3 months.

Widespread illness will occur.

Because most people will have no immunity to the pandemic virus, infection and illness rates are expected to be higher than during seasonal epidemics of normal influenza. Current projections for the next pandemic estimate that a substantial percentage of the world’s population will require some form of medical care. Few countries have the staff, facilities, equipment, and hospital beds needed to cope with large numbers of people who suddenly fall ill.

d. Planning assumptions for an influenza pandemic

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.

A pandemic is defined as a disease affecting or attacking the population of an extensive region, country or continent. Influenza pandemic is most likely to occur 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 6-12 weeks, nationwide, and in Pennsylvania is as shown below:

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require Outpatient Care</td>
<td>50 million</td>
<td>1.6 million</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>2 million</td>
<td>37,800</td>
</tr>
<tr>
<td>Deaths</td>
<td>500,000</td>
<td>9,100</td>
</tr>
</tbody>
</table>

An influenza pandemic may have several 6-12 week “waves”, therefore the numbers above do not reflect the total impact to Pennsylvania for the entire influenza pandemic, rather just one 6-12 week wave.

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 novel virus is identified and begins to spread among humans before a specific vaccine would likely be available for distribution.

The Department of Health 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 local, regional, and state and local resources.

e. Summary:

The history of pandemic influenza throughout the world has shown it can travel very quickly around the globe and infect large populations. The best defense is knowledge of the pandemic disease along with preparedness and response activities to reduce mortality and morbidity. History has shown us, that no part of the world will be exempt from the impact of pandemic and transmission today will be faster with increase in rapid worldwide transportation networks, many which were not in place during the 1918 pandemic.
Step 2: Organizing and Leading a Community Work Group

Planning for a pandemic response must be a community-wide effort

Help and resources may not be available from state or federal agencies, which will themselves be stretched thin.

Communities must know in advance how they will respond locally to an event which poses the threat of a large scale disruption of services at the same time that an increasing number of persons will need and expect help.

Why a community wide work group?

1) During a wide spread event, a well planned and coordinated response will make the difference between success and failure.
2) It’s important that every organization in the community have a clear understanding of who’s in charge during a pandemic influenza emergency, and their own organization’s role during that time.
3) An understanding of roles leads to improved communications during an event
   A well thought out and exercised plan will permit more efficient response during an actual emergency.
4)
   a.During a pandemic emergency, the maintenance of essential services might be compromised, necessitating continuity of business planning

5)

b. Deciding who should be at the table.

The basic composition of a county-wide pandemic influenza planning committee will vary for each county, depending on the size of the county, the types of organizations located there, local civic leadership, and other factors. For this reason, there is no single “best list” of individuals and organizations who should participate in a particular county. However, planners who are developing a local pandemic influenza planning committee, may want to consider the following types of organizations and local resources. It is imperative that there be consistent and clear communication among all the stakeholders. The stakeholders include the following:

1. Elected Officials
2. Emergency Management Directors
3. School, College and University leaders
4. Faith Based Community leaders
5. News Media
6. Volunteer Organization leaders (Red Cross, Salvation Army, and other Charities)
7. Civic and fraternal organization leaders
8. Hospital, Nursing Home and Home Health Administrators
9. Medical Professionals – Doctors, Dentists and Community Health Centers
10. Major Employers
11. Poultry Farmers and Growers
12. Extension Agents
13. State Health Center Staff or C/MHDCounty/Local Health Department staff
14. Local Emergency Services/Public Safety

In general, for maximum efficiency, the committee should be between 15 and 25 persons. If additional representation is needed, specific purpose task forces can be developed – for example, an employers work group or a school administrators work group.

A SAMPLE letter of invitation is included in the appendix of this Tool Kit, along with a SAMPLE Agenda and Mission Statement.

c. Deciding who should lead the group.

Leadership should be chosen from the above group working in cooperation. The group leader should have the authority to make decisions and commit resources on behalf of the government. The leadership should communicate across all these broad and diverse groups. It is important that the leadership be inclusive of all and be geographically, culturally, and ethnically diverse. At the same time, it is important to identify persons who will staff the committee, e.g. handle the logistics of arranging committee meetings and task force meetings (sites, notices) and serve as recorders, and ultimately prepare the plan document for review and editing.

d. Identifying the mission and goals of group.

This work group should meet on a regularly scheduled basis with an agenda. This will allow the group to develop a clear mission, goals and objectives. In developing the mission, goals and objectives care should be taken to account for regional cultural and, ethnic considerations and unique strengths, weaknesses, opportunities and threats to effective and efficient pandemic planning preparedness and response.

e. Developing planning assumptions.

Some assumptions can be made by looking a recent natural disasters and how the community responded to the need to pull together in a crisis. Past historical data about hospital admissions, EMS call volume and employee absenteeism will provide potential insight. The DOH Pandemic Plan and the Federal Pandemic Plan include planning assumptions and basic planning assumptions are provided as an attachment to the document. Various programs, such as, Flu Aid, can be used to assist in estimating the local impact of an influenza pandemic.
g. Developing task forces or work groups.

Many potential participants already work in collaboration on a daily basis, so it is important to not reinvent the wheel. As an example the Chamber of Commerce would be a great source to coordinate with large employers and to assist in tracking employee absenteeism. Many of the emergency responders and health leadership meet regularly with their respective Regional Counter-Terrorism Task Force (RCTTF) and would be a great opportunity to collaborate and create synergy.

h. Managing for results.

Systems must be put in place to test and validate plans, procedures, methods and strategies. There must be outcomes that are clear, measurable and attainable. This requires that everyday operations be reviewed for the impact of substantial personnel absenteeism. Human resources will be stretched to the limit with a need to focus on critical tasks and efficient use of these limited resources. Goals and Objectives should be SMART – eg. Specific, Measurable, Achievable, Relevant, and Timely in order to track progress. for the committee to track of its progress in meeting its stated goals and objectives.

i. Community planning checklists.

See Community Planning Checklist (attached)

k. Flexibility.

All levels of government and the business community will have to have “Continuity of Operations Plans” to be agile and flexible to change and adapt with the environment. Contingency plans must be in place for every essential function of the community duty and responsibility to ensure continued effective and efficient public services.

m. Summary.

It is abundantly clear that the pandemic influenza potential will create some of the greatest challenges for government, business and society as a whole, which can only be mitigated by good planning and preparedness with collaboration with the widest group possible of stakeholders. For this reason, a “systems” approach to planning for a pandemic is essential. Participants should visualize that the response system to a pandemic will be far broader than other more typical responses, and that the involvement of “non-traditional” community partners is essential for successful planning.
Step 3: Develop an incident management system systematized incident management process

It is often said that communication is the first casualty of a disaster. All participants in pandemic response planning have a responsibility to know and understand:

1) 1) the role their agency will be asked to assume during an emergency;
2) 2) who (or which organization) will assume the local administrative lead during an emergency and what the chain of command will be; and
3) and, 3) the organization of local emergency response efforts.

To assist in this effort, a specific response organizationsystem, called National Incident Management System (NIMS)NIMS/ICS ha has been developed as the organizational template for federal, state, and local response organizations.

a. NIMS/Incident Command System (ICS) Basics

NIMS is the first-ever standardized approach to incident management and response. Developed by the US Department of Homeland Security and released in March 2004, it establishes a uniform set of processes and procedures that emergency responders at all levels of government will use to conduct response operations.

Developed by the Secretary of Homeland Security at the request of the President, through the issuance of Homeland Security Presidential Directive 5, the National Incident Management System (NIMS) integrates effective practices in emergency response into a comprehensive national framework for incident management.

NIMS will enable responders at all levels to work together more effectively and efficiently to manage domestic incidents no matter what the cause, size or complexity, including catastrophic acts of terrorism and disasters.

Federal agencies also are required to use the NIMS framework in domestic incident management and in support of state and local incident response and recovery activities.

The benefits of the NIMS system will be significant:

• Standardized organizational structures, processes and procedures

• Standards for planning, training and exercising

• Personnel qualification standards

• Equipment acquisition and certification standards

• Interoperable communications processes, procedures and systems

• Information management systems with a commonly accepted architecture

13
• Supporting technologies – voice and data communications systems, information systems, data display systems, specialized technologies; and

• Publication management processes and activities.

Importance of NIMS/ICS to a well-managed, coordinated response.

NIMS provides a consistent, flexible and adjustable national framework within which government and private entities at all levels can work together to manage domestic incidents, regardless of their cause, size, location or complexity. This flexibility applies across all phases of incident management: prevention, preparedness, response, recovery and mitigation.

NIMS provides a set of standardized organizational structures – including the ICS, Multi-Agency Coordination Systems and public information systems – as well as requirements for processes, procedures and systems to improve interoperability among jurisdictions and disciplines in various areas.

Homeland Security recognizes that the overwhelming majority of emergency incidents are handled on a daily basis by a single jurisdiction at the local level. However, the challenges we face as a nation are far greater than the capabilities of any one community or state, but no greater than the sum of all of us working together.

There will be instances in which successful domestic incident management operations depend on the involvement of emergency responders from multiple jurisdictions, as well as personnel and equipment from other states and the federal government. These instances require effective and efficient coordination across a broad spectrum of organizations and activities.

The success of the operations will depend on the ability to mobilize and effectively utilize multiple outside resources. These resources must come together in an organizational framework that is understood by everyone and must utilize a common plan, as specified through a process of incident action planning. This will only be possible if we unite, plan, exercise and respond using a common National Incident Management System.

b. Assuring that community organizations about understand ICS.

NIMS compliance should be considered and undertaken as a community-wide effort. The benefit of NIMS is most evident at the local level, when a community as a whole prepares for and provides an integrated response to an incident. Incident response organizations (to include local public health, public works, emergency management, fire, emergency medical services, law enforcement, hazardous materials, private sector entities, non-governmental organizations, medical organizations, utilities, and others) must work together to comply with NIMS components, policies, and procedures. Implementation of the NIMS in every tribal and local jurisdiction establishes a baseline capability that once established nationwide, can be used as a foundation upon which more advanced homeland security capabilities can be built.
Small and/or rural jurisdictions will benefit from a regional approach. In many instances smaller communities may not have the resources to implement all elements of NIMS on their own. However, by working together with other localities in their regions, these jurisdictions will be able to pool their resources to implement NIMS.

When NIMS is fully implemented, your local community or jurisdiction will be able to:

- Ensure common and proven incident management doctrine, practices, and principles are used to plan for, protect against, respond to, and recover from emergency incidents and preplanned events;
- Maintain a response operation capable of expanding to meet an escalating situation and the ability to integrate resources and equipment from intrastate and interstate mutual aid agreements, state-provided assistance, and federal government response;
- Order and track response assets using common resource typing and definitions, and draw on mutual aid agreements for additional assistance;
- Establish staging and allocation plans for the re-distribution of equipment, supplies, and aid coming into the area from other localities, states, or the federal government through mutual aid agreements;
- Conduct situational assessments and establish the appropriate ICS organizational structure to effectively manage the incident; and
- Establish communication processes, procedures and protocols that will ensure effective interoperable communications among emergency responders, 9-1-1 centers, and multi-agency coordination systems (Emergency Operations Centers).

It is important to recognize that NIMS implementation will not end in Fiscal YearY 2006. The NIMS is a dynamic system, and the doctrine as well as the implementation requirements will continue to evolve as our prevention, preparedness, response, and recovery capabilities improve and our homeland security landscape changes. Further, new personnel will continue to need NIMS training, and NIMS processes will still have to be exercised in future years.

c. Adopting ICS NIMS for your own organization.

The National Incident Management System (NIMS) was issued by the Department of Homeland Security on March 1, 2004, to provide a comprehensive and consistent national approach to all-hazard incident management at all jurisdictional levels and across all functional emergency management disciplines.

The support of elected and appointed officials in the NIMS implementation process nationwide is critical to the nation’s success in preventing, preparing for, responding to and recovering from emergencies and disasters.

Who should lead this effort? Locally elected and appointed officials.
The benefit of NIMS is most evident at the local level, when a community as a whole prepares for and provides an integrated response to an incident. Chief elected and appointed officials need to be involved in all aspects of NIMS implementation to include the following:

- Adopt NIMS at the community level for all government departments and agencies and
- Encourage NIMS adoption and use by associations, utilities, non-government organizations and the private sector.
- NIMS should be adopted through executive order, proclamation, resolution, or legislation as the jurisdiction’s official all-hazards, incident response system.

The NIMS requires the use of the Incident Command System (ICS), the multi-agency coordination systems and a public information system. All these command and management systems require the direct involvement of chief elected and appointed officials in a community during emergencies/disasters. NIMS requires all emergency plans and SOPs procedures to incorporate NIMS components, principles and policies, to include emergency planning, training, response, exercises, equipment, evaluation, and corrective actions. Chief elected and appointed officials in a community need to be directly involved in these NIMS preparedness elements, especially the elements dealing with exercising community emergency management policies, plans, procedures and resources.

Jurisdictions will be required to meet the FY 2006 NIMS implementation requirements as a condition of receiving federal preparedness funding assistance in FY 2007. However, it is important to recognize that the NIMS is a dynamic system, and the doctrine as well as the implementation requirements will continue to evolve as our emergency management capabilities nationwide change based on the hazards and threats of the nation. Contact the Pennsylvania Emergency Management Agency (PEMA) for an up to date listing of required NIMS training by position.

Local chief elected and appointed officials are urged to complete the IS-700 NIMS: An Introduction, training course, which is available online from the Emergency Management Institute at http://training.fema.gov/emiweb/IS/crslist.asp or through the State Learning Management System, http://www.pahealthinfo.net

An important planning note for developing an Incident Command Structure for response to a pandemic influenza emergency is that workforce depletion is expected. When identifying and training personnel to function in a response to this type of emergency, it is recommended to train at least 5 people for each position.

d. Pennsylvania’s Incident Command System (ICS).

Pennsylvania has adopted NIMS and uses ICS to manage incidents. All emergencies, including a pandemic start as local emergencies handled by the local emergency management system. As the incident grows and exceeds the local capabilities, the local emergency management system requests assistance from the County emergency management system to access additional resources. When the county becomes overwhelmed or needs additional resources, they can reach out to the State Emergency Operations Center to report on unmet needs. At the State level, various State Agencies are coordinated through the State Emergency Operations Center (EOC) at PEMA headquarters in Harrisburg EOC and resources and information can be channeled back through the command system to
the local areas. A seating chart and contact information for the State EOC and PEMA are located at the end of this toolkit.

e. Where to find out more about ICS.

Information on ICS and NIMS is available through your county emergency management agency, or online at www.fema.gov, www.nimsonline.com, www.pema.state.pa.us, www.osfc.state.pa.us. Free online training is available through the State Learning Management System at http://www.pahealthinfo.net. The Department recommends that all participants on the local pandemic influenza planning committee should start by taking the online courses offered by the Federal Emergency Management Agency, Emergency Management Institute, specifically Independent Study (IS) course 100: Introduction to ICS and IS-700 NIMS: An Introduction.: NIMS 100 and ICS 700


If the demand for resources overwhelms the local emergency management agency, the local EMA requests assistance from the county, if the county is overwhelmed, the request goes to the State Emergency Operations Center (EOC). If the State is overwhelmed and needs additional resources, the Emergency Management Assistance Compact (EMAC) can be used at the State level to get mutual aid from other states. The EMAC request must originate through the State EOC and follow predetermined parameters for aid.

EMAC can be used for two purposes:
1. To request resources from outside the area
2. To respond to requests from outside the local jurisdiction to other areas

Requesting resources: [identify the steps and the process used to request resources with the caveat that in a pandemic, outside resources should not be relied on. Local responders do not request resources through EMAC. The normal chain of command is followed, Local responders channel requests to the County. The County channels requests to the State EOC, the State EOC either locates resources regionally within the State, through FEMA or the Federal Government, or through and EMAC request. The requesting State is responsible for all costs of resources requested through EMAC.]

Responding to requests: If a local response organization is going to provide resources to another state through an EMAC request, the local agency needs to provide:
- Cost estimates based on salaries & benefits
- Costs for travel
- Costs for equipment usage (based on FEMA cost codes)
- Costs for subsistence
- Must sign Memorandum of Agreement (MOA)OA with PEMA prior to deployment

[identify the steps and the process used to respond to requests for resources and the implications – using examples from Katrina]
EMAC is not considered a viable option when planning for a pandemic emergency, because all states will be potentially affected and resources nationwide will be scarce. EMAC is presented here for information and awareness only.

Additional information on EMAC can be found at www.emacweb.org.


CDC’s Strategic National Stockpile (SNS) has large quantities of medicine and medical supplies to protect the American public if there is a public health emergency (terrorist attack, flu outbreak, earthquake, etc.) severe enough to cause local supplies to run out. There are two components to the SNS, one is the 12-hour push package system, where the CDC has “strategically” located containers of medication and supplies around the United States, the second component is Vendor Managed Inventory, where the CDC has entered into agreements with vendors to drop ship required medications and pharmaceuticals directly to a location in a State.

Once Federal and local State authorities agree that the SNS is needed, medicines pharmaceuticals and supplies in the 12-hour push packages can will be delivered to any state in the U.S. within 12 hours. Each state has plans to receive and distribute SNS medicine and medical supplies to local communities as quickly as possible.

- The medicine in the SNS is FREE for everyone, recipients, however the requesting State may incur a cost.
- The SNS has stockpiled enough medicine to protect people in several large cities at the same time.
- Federal, state and local community planners are working together to ensure that the SNS medicines will be delivered to the affected area to protect you and your family if there is a terrorist attack.

What triggers an SNS decision?

1. Factors for requesting the SNS may include, but are not limited to:
   Overt release of a CBRNE agent.
   (a) Overt release of a Chemical, Biological, Radiological, Nuclear, or Explosive (CBRNE) agent
   (b) A claim of release issued by intelligence or law enforcement.
   (c) A mass casualty event that overwhelms local, county and/or regional resources requiring State level assistance. The Commonwealth does not maintain a statewide pharmaceutical cache.
   (d) Clinical or epidemiological indications, that are medically unexplainable that include, but are not limited to:
      (1) Higher than normal morbidity and mortality from a common disease or syndrome.
      (2) Higher than normal number of ill persons with similar disease or syndrome.
      (3) Single case from an uncommon agent such as Smallpox.
      (4) Disease with unusual geographic or seasonal distribution such as influenza pandemic.
      (5) Deaths or illness among animals that precedes or accompanies human death.

2. State and Local resources have been exhausted to control the event in which critical medical
supplies are needed within Pennsylvania.

Who in PA can request SNS assistance?

The Governor must officially direct the Pennsylvania Emergency Management Agency (PEMA) State EOC Emergency Operations Center (EOC) to request the SNS from the CDC. The PEMA EMA State EOC is operational 24-hours per day and can be contacted at (717) 651-2001. The Governor’s request will be based on recommendations from the Secretary of Health.

Can communities request SNS assistance? If so, what is the procedure?

Yes, but not directly from CDC. Local agencies experiencing depletion of medical supplies should notify the County Emergency Management Agency (EMA). If the County EMA is unable to fulfill the required resources, the County EMA will work with mutual aid counties within the Regional Counter Terrorism Task Force for resources. If those counties within the Regional Counter Terrorism Task Force are unable to fill the need for the required resources, the request is made to the Pennsylvania Emergency Management Agency (PEMA) who will assign the resource request to the DOH EPLOappropriate Emergency Preparedness Liaison Officer (EPLO), which in this case would be the Department of Health EPLO.

How will the medications and supplies be delivered to the community?

The delivery of SNS materiel to the community is done through several steps. First, in the pre-event planning phase, the Department of Health SNS Coordinator is developing a SNS distribution plan. This plan calls for the creation of two different entities; a Receipt, Secure, and Store (RSS) facility, and Points of Distribution (PODs). RSS sites are the initial drop point from the CDC to the State. At this facility, large pallets of equipment are broken down into smaller more manageable sizes, then moved to PODs and other end users. PODs are locations in the community where citizens will receive their medications.

How can communities identify PODS in their locales and understand how these will be opened and staffed?

POD locations are will not be not being publicly released publicly for the following reasons:

1. Security concerns
   All PODs may not be opened due to the nature of the event and prior publication of sites may be confusing to residents. We may not open all PODs, therefore we don’t want people believing they will be required to go to one individual POD and then when they get there, the POD is not opened.

2. 

3. PODs may change due to occurrences at that POD that would no longer make it a suitable dispensing site.
When a POD needs to be opened, public information announcements over TV, Radio and a DOH website will be activated to inform residents of where the PODs are POD locations, where they should go, what they should bring, and when the POD will open.

Can communities rely on SNS?

Yes. CDC has taken the position that in the event of an emergency, they will be able to respond. The Strategic National Stockpile has been successfully deployed on a number of occasions such as 9/11, 2001 Anthrax attacks and during Hurricanes Katrina and Rita in 2005.

What parts of SNS placement are communities responsible for, if anything?

State, regional, county and local planners are responsible for ensuring a plan is in place to receive and dispense Strategic National Stockpile assets within their jurisdiction. The Department of Health will be in contact with your specific community regarding individual responsibilities, but in general every individual POD requires over 100 people to staff and support the operation. Recruiting and training volunteers at the local level will be critical.

County and local communities are asked to identify and staff a POD to ensure approximately 20,000 people are able to access critical medical supplies within that POD.

Pandemic Influenza Specific Response Actions: We need more information for communities on SNS than this. What triggers an SNS decision? Who in PA can request SNS assistance? Can communities request SNS assistance? If so, what is the procedure? How can communities identify PODs in their locales and understand how these will be opened and staffed? Can communities rely on SNS? What parts of SNS placement are communities responsible for, if anything? They’re going to want specific information about what happens in their county, not general information.

h. Understanding Isolation/Quarantine.

In the event of a pandemic, isolation or quarantine restrictions may be implemented need to be declared to help contain the spread of the disease.

Quarantine is for people who have been exposed to a communicable disease, but are not ill. Quarantine is the restriction of movement of people to contain a possible outbreak. Quarantine could occur anywhere and could be voluntary or mandatory. Is restriction of movement or separation of well person(s) presumed to have been exposed to a contagious disease.

Isolation is for people who are ill. Isolation keeps a person who is ill separated from persons who are not ill to prevent the spread of disease. – Isolation may occur in homes, hospitals, or designated healthcare facilities. restriction of movement or separation of ill, infected person(s) with contagious disease.

Public health officials can take action to control communicable disease or the spread of disease such as:

- Impose quarantine/isolation
- Impose travel restrictions
- Conduct investigations and contact tracing
- Require inoculations or medical examinations
Common Questions/Misconceptions with Isolation and Quarantine Weak.

1. 1. Who can declare a quarantine?

The County Board of Health, the Secretary of Health, or the Governor can declare quarantine.

2. How is the duration of a quarantine set?

Persons can be quarantined until they are no longer infectious. In the event the person refuses to comply, a petition can be filed with the court with a subsequent hearing and shall have a hearing. The court can require testing and compliance with the quarantine until the petitioner is no longer contagious.

3. When will a quarantine order be removed?

When there is no longer risk of infection either determined by the authority, or at the order of the Court.

43. In counties without a C/MHDHealth Department, who can they turn to to request a quarantine order?

The Secretary of Health or the Governor can issue a quarantine order.

54. Local elected officials **do not** have authority to impose quarantine or isolation orders.

   – The order must come from a Board of Health, Secretary of Health, or the Governor. In the absence of a local health authority, following ICS a county can request assistance with a quarantine order by contact the PEMA State EOC.

65. Will quarantine orders be general or specific to a particular location?

Quarantine orders will be determined based on the specifics of the incident and the possible contamination exposure that may develop.

i. Understanding a Governor’s Declaration of Emergency.

In the event of an outbreak that significantly affects the Commonwealth or overwhelms a county, the Governor can announce a Declaration of Emergency that allows State agencies to operate under emergency provisions. A Governor’s Declaration also opens up emergency funding for dealing with the emergency, and may set the stage for application for a Federal Disaster Declaration which allows for Federal assistance to mitigate the emergency.

Common Questions Regarding a Governor’s Declaration Needs detail:
1. What are the parts of a governor’s declaration order? The declaration will detail the event, what areas of the state that are affected, what State resources are to be made available, and any special direction to State Agencies.

2. What can you expect to see in a governor’s declaration order? The areas affected, and the resources to be made available.

3. What are the governor’s emergency powers? The Governor can make additional funding available, make state resources available for local assistance, institute emergency purchasing procedures, issue quarantine or isolation orders, or suspend additional regulations to mitigate the emergency.

4. Is there a process for communities to request certain specific things to be included in a governor’s executive order? As with all unmet needs, all requests need to go through the county EMA staff and be passed on to the State EOC for additional resources.

j. Understanding legal authorities.

Public health officials including the County Board of Health, the Secretary of Health, or the Governor who specifically can take action to control communicable disease or the spread of a disease:

- Impose quarantine/isolation
- Impose quarantine/isolation
- Travel restrictions
- Conduct investigations and contact tracing
- Require inoculations/ or medical examinations med. Exams

One of the basic legal provisions under the law (35 P.S. § 521.7) is that a person suspected of infection with communicable disease shall undergo exam or approved diagnostic procedure; if person refuses, the Secretary or qualified local Board of Health Medical Health Officer (who’s this) may:

- have the person quarantined until no longer infectious; or

- file a petition with Court

Understanding a Governor’s Declaration of Emergency

In the event of an outbreak that significantly affects the Commonwealth or overwhelms a county, the Governor can announce a Declaration of Emergency that allows State agencies to operate under emergency provisions. A Governor’s Declaration also opens up emergency funding for dealing with the emergency, and may set the stage for application for a Federal Disaster Declaration which allows for Federal assistance (financial and direct federal assistance) to mitigate the emergency.

Common Questions Regarding a Governor’s Declaration

1. What are the parts of a governor’s declaration?
The declaration will detail the event, what areas of the state are affected, what State resources are to be made available, and any special direction to State Agencies.

2. What can you expect to see in a governor’s declaration?

The areas affected, the resources to be made available, and any necessary waivers or provisions to allow emergency response.

3. What are the governor’s emergency powers?

The Governor can make additional funding available, make state resources available for local assistance, institute emergency purchasing procedures, issue quarantine or isolation orders, or suspend additional regulations to mitigate the emergency.

4. Is there a process for communities to request certain specific things to be included in a governor’s executive order?

As with all unmet needs, all requests should be sent through the county EMA staff to the PEMA State EOC for additional resources.

k. Summary.

Response to a Pandemic outbreak is similar to general disaster response in several ways. The National Incident Management System (NIMS) is going to be used to coordinate response to any pandemic outbreak. If a local area is overwhelmed, there are resources available through the State EOC to various State and Federal entities, Strategic National Stockpile, and through the Emergency Management Assistance Compact to help cope with the outbreak. In the event of a public health emergency, additional legal powers are available to help contain the response spread of the pandemic.
Step 4: Decide how, what, when, where, and to whom how to communicate

a. First Point of Contact.

The local area should have a central point of contact for their area responsible for the communications regarding pandemic information. This contact may be the emergency management coordinator, or may be someone from the public health office. This contact should have the information and resource list available in order to reach out for additional information or to coordinate information response to an pandemic.

b. How information about a pandemic will be shared.

A communications plan information plan should be determined developed before an outbreak occurs. This plan should contain media outlet information, additional agencies that may need to be involved in providing information, resources for additional information, and contact information to release where the public can go for additional information. The use of pre-scripted or “canned-boiler-plate” messages is a proactive measure in preparing for information releases.

c. Role of the local Emergency Management Agency.

The local Emergency Management Agency (EMA) is the coordinating agency for all disaster or emergency response in the local area. The EMA has plans and structure in place for responding to various types of emergencies and disasters, and has the ability to make the requests for resources and assistance through the County and State.

d. Joint Information Center

The mission of the Joint Information Center (JIC), an entity required under NIMS, is to contribute to the well-being of the community following a disaster by ensuring the dissemination of information that:

- Is timely, accurate, consistent and easy to understand,
- Explains what people can expect from their government; and
- Demonstrates clearly what is occurring and what residents should expect

- Is timely, accurate, consistent and easy to understand;
- Explains what people can expect from their government;
- Demonstrates clearly what is occurring and what residents should expect
The Joint Information Center (JIC) should be staffed with Public Information Officers from all agencies, from all levels of government that have responsibilities relating to the Pandemic response so that a unified message is conveyed to the public. The StatePEMA maintains a JIC at the State EOC.

e. Maintaining a consistent, accurate public message.

During a pandemic outbreak, there will be a constant desire for information from the media and the general public. It is important to work through the JIC to release any information relating to the pandemic outbreak and response so that efforts appear coordinated and a universal message is being conveyed to the public giving them direction and information that is consistent and helps to overcome fears generated by lack of information or inconsistent information.

f. Availability of pre-developed press releases.

The availability of pre-developed scripted or “cannedboiler-plate” press releases is effective for general information about pandemic flu, including precautions and preventative actions. Additional information should include contact numbers or websites that can be published for the public to get additional information. The availability of pre-developed press releases enables verified information to be provided quickly without having to do research during the pandemic emergency.

g. Asking for help – who to contact.

To begin planning and coordination for local pandemic response, the County Emergency Management Agency is the lead agency for all emergencies in that County. The County EMA can help to coordinate the location and staffing of the JIC and to determine the paths of communication in the event of an outbreak.

h. Summary.

Communication and information release during a pandemic outbreak is critical. It is important that during the planning process, lines of communication are established between agencies and local officials, so that a unified front is presented during a pandemic response. A Joint Information Center should be established to ensure that information presented to the media is timely and accurate and presents information from all agencies involved. The State will be coordinating a JIC at the State EOC. The County Emergency Management Agency is the coordinating agency for County level response, and should be your first level of contact for information or assistance in a pandemic.
Step 5: Determine how to coordinate local resources

a. Role of the Regional Counterterrorism Task Force (RCTTF)

Pennsylvania has developed the Regional Counterterrorism Task Force concept to provide a coordinated regional response [the big question – do RCTTFs have response capabilities or are they better used as planning and pre-event coordinators] to all hazards. There are nine Task Forces in the State comprised of five to thirteen counties. Many of the task forces have developed regional teams for responding to emergencies within the task force counties. The task forces have conducted regional planning for large scale incidents, including receiving the Strategic National Stockpile in the event or a disease outbreak. The chain of command for requesting resources remains the same, if a local level EMA is overwhelmed, the request is given to the County, if the County can not fill the request, the County may ask the RCTTF for assistance if there are resources available through the RCTTF, if not, the request would go through the State EOC.

b. Coordinating the use of facilities.

Each of the Task Forces has developed a plan for receiving the Strategic National Stockpile, this plan involves using coordinated facilities for storage and dispensing of the stockpile. Working through the representative counties, the task forces may have established coordinated facilities such as a regional command center or a regional JIC to provide assistance during an emergency. Coordinated facilities may also be needed due to staff shortages due to during a the pandemic. Coordination of emergency facilities should be worked through the County EMA.

c. Coordinating the supply from vendors.

Regional purchasing may result in cost savings and greater availability if supplies are coordinated and purchased at the regional level for responding to a pandemic. The County EMA, working through the RCTTF will know of any regional purchasing activities that have been coordinated through standard vendors.

d. Summary.

The Regional Counterterrorism Task Forces provide another level of resources that may be available to an area during a pandemic response. The RCTTF may have access to coordinated facilities or regional caches of supplies or equipment necessary for a pandemic response. The County EMA is the conduit to the RCTTF for local officials.
Step 6: Protect the essential community infrastructure

a. "Three deep" staffing.

It is very clear to all that the influenza pandemic will create tremendous strains on the human resources of every level of government. This will require plans to replace the primary and alternate person with another qualified individual. This requires cross-training in every facet of the operation. The limited personnel may require that one person will be responsible for the duties of two or three others. This planning should be based on potential need and priority or required functions, and others may have to be put on a temporary hold until conditions improve. For some critical positions it is recommended to attempt to identify and train up to 5 people per position.

c. Setting community priorities: essential functions and priorities.

Every community will need to define essential functions. These are the activities that are the responsibility of the government and must be executed regardless of the situation. Set its own priorities. Some priorities in one place may be less of a priority in another community. In all communities there will be the required basic services including emergency services. Based on the time of year, weather conditions and other external factors may require adapting the community priorities to current events. The priorities should be well documented and provided to all in advance so that there is no confusion or disarrangement when these limited community priorities essential functions must be implemented as a result of a potential pandemic.

d. Sewer/Garbage.

The sanitary sewer system for most communities works on gravity until it flows to the sanitary pumping and treatment facility. Plans must be made to ensure that there will be sufficient crews to operate the treatment facility on a 24/7 basis for an extended time with limited personnel. Contingency plans should be in place for ensuring that utility service to pumping stations and treatment facilities are not interrupted.

The collection of garbage is a mandatory service that if not done on a timely and regularly basis will result in additional other potential health problems. Therefore, plans must be in place to pick up the garbage with limited staff, by possibly adding additional equipment. Non-mandatory collections of recycling and yard waste may need to be temporarily suspended.

e. Water.
Water is a resource that we can not live without, and is often taken for granted. It is important for living as well as fire protection. The water utility has to have contingency plans in place to operate with fewer personnel. Water utilities must ensure that not only that the water flows freely, but has been chlorinated treated and made potable for drinking.

g.Fire.

Personnel shortages will be evident with the fire service as with all groups. This will require that as many staff as possible bare prepared to respond to any fire emergency. Further, this will require greater coordination and use of mutual aid, due to limited fire fighters being available. numbers of personnel. Call triaging may need to be implemented to determine the best use of scarce resources.

h.Police.

The Police will have shortages of officers since they have daily contact with numerous citizens, with a greater potential to be infected. Plans must be in place to patrol with limited officers, and focusing on required services. Some community services such like DARE and Crime Watch may have to be temporarily suspended. Each community must plan for operations with less officers, requiring many to work extended shifts.

i.EMS.

EMS will not have limited personnel to work with (Is this true?), but and will be subject to a greater call volume. Planning for EMS will not only require covering existing shifts, but planning for additional crews. It is important to realize that all ambulance services will be overwhelmed, meaning that there will no other service to call on for help. Planning now requires for additional crews, and additional units and equipment. Enhanced call triaging may need to be implemented to determine the best use of scarce resources.

j.First Responders/Volunteers.

First Responders will be short just like everyone else, but may be called upon to help other emergency services who are short. The use of first responders to supplement other services must be done with care so that they are not used multiple plans to supplement others. Use of the State Emergency Registry of Volunteers in Pennsylvania (SERVPA) will assist in deploying and controlling the use of volunteers in response situations.

k.Meals on wheels.

Many depend on this vital link to the outside world, so it is imperative that this continue. Plans should be made to have alternate drivers and volunteers ready to fill the gap in any personnel short falls, due to
a potential influenza pandemic. Also, MOW coordinators should contact their major suppliers to find out what their plans are for continuity of service if their staff are unavailable to transport food products on time. MOW may be used to support quarantine and isolation operations.

1. Summary.

It is very clear that normal community essential functions and priorities may need to be changed to adapt to changing conditions. It is almost certain that there will be a high absenteeism potentially at a rate as high as 40%, based on infection thereby creating personnel shortages that require planning now for “three deep” staffing. All normal services may not be able to continue and the volume of emergency services will greatly increase.
Step 7. Identify and support vulnerable populations

a. Homebound.

Many residents are confined to their home and have limited contact with the outside world. Plans must be in place to check on these individuals as well as procedures to ensure that vital services are provided to them. This may be accomplished by asking others to check in on these individuals on a regular basis.

b. Ventilator/medically fragile dependent children and adultspatients in the community, including ventilator dependent populations.

These citizens will need special medical attention and some will require electric power to operate life-sustaining this equipment. Lists should be made in advance along with coordination with the utilities to ensure non-interrupted electric supply. It is imperative that a system be put in place to regularly check on their needs and safety.

c. Boarding schools.

This unique facility brings on the added responsibility to care for these children, but also to maintain contact with the families. It is important that plans be in place to move the children to alternate facilities or to safely return them to their families.

Schools

Large amounts of children in one location may increase the spread of disease and requires special consideration and special planning. The Department of Health and the Department of Education have developed a tool kit for School Preparation for Pandemic. Refer to this tool kit for guidance on school preparedness.

d. Summer camps.

Summer camps provide bring a large amount of children in one location, thatlocation that may need to receive treatment and/or be returned to their families. It is important that transportation plans are in place as well as sufficient personnel to address the needs of the youth.

e. College student populations.

The large amount of students will create logistics challenges that may exceed the capacity of the campus health clinic. Plans must be in place to expand the clinic staff and hours of operations. This is will require good internal communications with all students, to ensure that clear and concise communications information is are provided to all.
f. Culturally or linguistically isolated.

Communications Information and assistance must be able to reach all populations. Prior planning with culturally or linguistically isolated groups allows the local emergency manager to understand the unique needs of this community in advance of an emergency and can assist in preparing this isolated community for an emergency, requiring providing information in multiple languages. Communications mechanisms must be sensitive to diverse groups of citizens with many different cultural and ethnic concerns.

g. Summary.

There are many diverse populations that may require special accommodations and needs. It is best to plan for these special populations well in advance, including having listings of citizens and their special needs. Each of these target groups can be engaged in advance to ensure that all special needs are addressed and planned for. The above list is not comprehensive of all special needs populations in the Commonwealth.
**Step 8: Understand everyone’s role**

By meeting with as many groups as possible in advance of an emergency, emergency managers it will establish a dialoguee for communication, that will prove invaluable during any all hazard event. Its important that plans clearly establish lines of authority and responsibility.

By implementing and using NIMS all roles and responsibilities should be clear during a response. it will be clear to all what duties and responsibilities each person is accountable for. If multiple personnel are cross trained to do different jobs during normal work days,, it responding during personnel shortages will bewill make it much eas much easier. ier for them to take on other responsibilities in a pandemic influenza emergency.

By Ccreating collaborative partnerships now, it will ensure that everyone will know what to expect from one another, if there is an emergency.knows their role in an emergency.
It is like a football team, everyone knows their position and duties, along with that of others on the team, so they can be more effective on the field. By practicing the same for all hazards everyone will be more effective if there is an influenza pandemic.

**Step 9. Test and evaluate your plan**

The most effective plans are the ones that are tested and practiced. Testing a response plan allows emergency managers the opportunity to evaluate what works and what doesn’t work. Testing and evaluating plans is also an opportunity to train during normal operations for activities during an emergency. If the plans are tested there will be opportunities to see what works well, needs refinement, and what does not work at all.

By testing and evaluating it will become clear what areas need extra training or resources. Further, it will highlight shortfalls in the plans such as duplicate use of the same limited resources. After evaluating a response plan an After Action Report of Corrective Action Plan should be developed. This report will provide a written The evaluation will give a written benchmark or baseline showing of the current status, and highlight areas for improvement. Establishing a baseline to improve. This will be invaluable during in subsequent testing to validate improvement and progress.

Testing must include all stakeholders and be done in a manner that maximizes the opportunity to improve and be better prepared for any potential emergency event.

DOH/PEMA plans and timetables for full scale exercises.

PEMA and the Department of Health have several exercises scheduled in the upcoming grant year. Contact your PEMA Area Coordinators or your Department of Health Emergency Preparedness contacts using the numbers listed below for more information on participating in exercises or for assistance or additional information related to this document.
Additional Information Resources and Contacts:

Web sites:

PA Pandemic Flu Preparedness: www.pandemicflu.state.pa.us

Pennsylvania Emergency Management Agency: www.pema.state.pa.us

Center for Disease Control and Prevention: http://www.cdc.gov/flu/pandemic.htm
US Department of Health and Human Services:
www.pandemicflu.gov


DOH Preparedness Coordinators Contacts:

Office of Public Health Preparedness: (717) 346-0640
Bureau of Emergency Medical Services: (717) 787-8740
Bureau of Community Health Systems: (717) 787-4366
Northwest District Office: David Dinger: dadinger@state.pa.us (724) 662-6086
Southwest District Office: Richard Packer: cpacker@state.pa.us (412) 565-5101
North Central District Office: Donald Hessert: dhessert@state.pa.us (570) 327-3400
South Central District Office: Samuel Tabak: stabak@state.pa.us (717) 787-8092
Northeast District Office: Joseph Shamonsky: jshamonsky@state.pa.us (570) 826-2062
South East District Office: Robert Pisch: rpisch@state.pa.us (610) 378-4352

PEMA District Representatives:

Western Area: Tim Baughman: tbaughman@state.pa.us (724) 357-0100
Central Area: Fern Harmon: fharmon@state.pa.us (800) 272-7362
Eastern Area: Anthony Camiloce: acamiloce@state.pa.us (610) 562-3003
PANDEMIC PLANNING PREPARATION FOR SCHOOLS
FREQUENTLY ASKED QUESTIONS

Below is a list of questions that the Department of Education (PDE) has received from various members of the Commonwealth’s education community, as well as responses provided by PDE and/or the Department of Health (DOH). The list is organized by topics. Questions 1 through 8 pertain to school closings, questions 9 through 14 pertain to the use of school facilities in the event of an emergency, and questions 15 through 25 pertain to the provision of education and services at the local level.

(1) What will a pandemic outbreak mean for schools at the local level? Will schools be asked to close?

During a large pandemic outbreak, through a collaborative decision, public health officials may recommend that many “non-essential” public facilities, such as schools, be closed during the day to reduce the chances of exposing large populations to the identified virus. It is also important to be aware that schools may be used as emergency shelters or as Points of Dispensing (PODs) vaccine or other forms of medical treatment. The length of time that schools would be used as shelters or PODs would vary, depending on a number of factors, including the extent of the pandemic outbreak. School districts should plan for this possibility and may wish to contact other school districts to share ideas concerning the most effective procedures for efficient school closings. If appropriate, school districts may elect to use the same communication procedures that they use in the event of a weather emergency. In any event, any procedures that are adopted should ensure that parents and primary caretakers receive proper notification about school closings or scheduling changes and updates regarding any new developments.

(2) Who will decide when to close a school and what events may trigger a school closure?

The decision to close a school may be made by either the Commonwealth, in order to address a public health threat or disaster emergency, or by the local school officials in response to local concerns. In the event of a communicable disease outbreak of the magnitude of pandemic flu, the Governor or DOH, after consultation with the Governor, may order the closing of a school or schools. The decision of whether to order school closures in the event of a communicable disease outbreak will depend upon: the nature of the disease; the ease with which the disease spreads from person to person; the manner in which the disease spreads from person to person (i.e., whether it is airborne through droplets, whether it is water-borne, whether it is carried through other bodily fluids or whether it is carried in some other manner); and the lethality of the disease.

The closure of individual schools, by DOH, may also be triggered by a rise in the number of students who are absent from school. DOH currently requires school
nurses to report to it any unusual rise in the level of absenteeism in a school. The school nurses, who are familiar with their own schools, are in the best position to recognize unusual occurrences or patterns with respect to absenteeism.

Clearly, school officials have the authority to close schools in the event of an emergency, such as a contagious disease. See 24 P.S. § 2523 (discussed below in the response to question 4). However, it will be helpful for school districts to use their current contacts with DOH District Offices to discuss potential outbreaks and the need for disease control actions, including a possible school closure.

(3) **If a school is closed because of contagious disease, who has the authority to determine that the school should be reopened?**

When DOH closes a school in response to a disease outbreak of the magnitude of pandemic flu, DOH will decide when it is safe to allow the school to reopen. When local school officials close a school, they will make the decision to reopen. However, if local school officials believe that a school should reopen before DOH agrees that the threat to public health has passed, DOH may exercise its authority to order the school to remain closed.

(4) **What are the consequences of closing a school district or school because of a pandemic?**

It is clear from Section 2523 of the School Code (24 P.S. § 25-2523) that a local school board may close schools because of an emergency, including contagious diseases. This provision states:

When any board of school directors or intermediate unit with respect to area technical schools is compelled to close any school or schools on account of any contagious disease, natural disaster or other emergency or for the school year 1979-1980 on account of major construction or renovation to a school building, not including labor disputes involving school employees, and therefore is unable to keep such school or schools open for the minimum term required by this act, *the Secretary of Education may pay to such school district or intermediate unit any or all of its share of the annual State appropriation as he deems proper.*

24 P.S. §25-2523 (emphases added).

This provision affords the Secretary of Education (Secretary) the discretion to pay all or part of a school district or intermediate unit’s share of its state subsidy for days on which the school was closed because of an emergency; however, it does not specify the number of hours or days of instruction that must take place during that school year, notwithstanding the closing of schools. Thus, restrictions concerning the required number of hours and days of instruction are established by the Secretary at the Secretary’s discretion. The restrictions that are presently in effect are set forth in BEC 24 P.S. § 25-2523, Emergency School Closing. In the past, the General
Assembly has introduced legislation to address reimbursement for lost instructional time resulting from emergency closings, so it is possible that it would do so again in the event of a pandemic. It is, at this point, difficult to provide specific guidance because actual events will necessarily influence the decision-making processes.

(5) **How does a school district or school close in the event of a pandemic?**

Unless it is infeasible, local school officials should follow the same procedures used to inform students, parents and staff about other school closings, such as closings resulting from inclement weather. If the circumstances require the development of additional procedures, local school officials should develop procedures that address the specific concerns presented by the situation.

(6) **How does the closing of a school district or school affect the school district’s state subsidy?**

As indicated above, the Secretary has the discretion, under 24 P.S. §25-2523, to determine whether to pay the school district subsidy for days on which schools were closed on account of contagious disease. Even if a school is closed for a period, it will have to meet requirements concerning the minimum number of days and hours of instruction that must be provided. Current requirements are set forth in the BEC concerning 24 P.S. § 25-2523, Emergency School Closings. It is possible that these requirements will be revised in the event of a pandemic or supplanted by legislative requirements. However, it is impossible, at this point in time, to predict what will occur with respect to school subsidy as we do not yet know whether and where a pandemic will occur, how severe it will be, or how long it will last.

(7) **Do schools pay staff when a school is closed on account of contagious disease?**

This situation is governed by section 1153 (24 P.S. § 11-1153) of the School Code, which provides, in pertinent part, that:

When a board of school directors is compelled to close any school or schools on account of contagious disease, the destruction or damage of the school building by fire or other causes, the school district shall be liable for the salaries of the teachers of said schools for the terms for which they were engaged. Whenever a teacher is prevented from following his or her occupation as a teacher, during any period of the school term, for any of the reasons in this section specified, the school district shall be liable for the salary of such teacher for such period, at the rate of compensation stipulated in the contract between the district and the teacher, in addition to the time actually occupied in teaching by such teacher.

24 P.S. § 11-1153.
If schools are open, but individual employees are absent because of the emergency, the school district would be expected to follow collective bargaining agreements and established local practices to determine whether the individual should be paid for the time missed.

(8) **If an emergency situation results in absences of faculty and staff, under what authority can local school officials reassign staff?**

Local school officials should follow any applicable procedures prescribed by the collective bargaining agreement and, if applicable, follow the procedures that it has used in other emergencies. Also, local school officials should work cooperatively with the local leaders of the unions representing their employees to plan for the possibility of this situation and to address any potential concerns.

(9) **Who has the authority to take over a school building?**

In the event that the Governor declares a state of emergency, he would have the authority to use school buildings as points of dispensing, shelters or quarantine facilities. However, the fact that this power exists does not mean that the Commonwealth intends to take over buildings if this can be avoided. The preference is to obtain buildings from volunteers.

(10) **Are teachers/administrators/school personnel expected to provide support if the school building is needed for emergency reasons, such as for use as a Point of Dispensing or as an emergency shelter?**

Generally speaking, the responsibilities of school employees are delineated by collective bargaining agreements and other types of employment contracts, such as Act 93 agreements. Thus, unless a particular agreement includes the requirement that staff provide support when a school is used for emergency purposes, school personnel would not be required to assist. If certain individuals, such as custodians, who are familiar with building operations are needed and the collective bargaining agreement does not address this type of situation, the employee may be asked, but not required, to assist in the emergency. In addition, school staff may volunteer to assist, just as other members of the community may volunteer.

(11) **What is a Point of Dispensing (POD), and who is responsible for the building when such a designation takes effect? For example, who would be responsible for maintenance?**

A POD is a “Point of Dispensing.” PODs are readily identifiable community locations (and frequently are schools), which can be used for the dispensing of medication and/or vaccine administration in the event of a large-scale, health-related disaster, such as pandemic influenza. Schools were identified as potential PODs because the facilities are usually easily accessible, and have large parking areas, large interior rooms and premises that can be easily secured. The DOH will request
reimbursement for appropriate costs related to the activation of a POD. As the planning process evolves, DOH will be requesting information from local school authorities pertaining to building maintenance and other infrastructure-related needs.

(12) Who chose the schools that have been designated as PODs and under what authority?

Under its general authority to protect the health of the citizens of the Commonwealth, DOH worked with Regional Counter Terrorism Task Forces, county Emergency Management Agencies and contractors to identify potential POD locations throughout the State. Contractors initially identified potential POD locations using geo-mapping technology. The list of potential POD locations was further refined through coordinated efforts among other state, county and local agencies. DOH notified the principals of schools that were identified as potential PODs. The designation is voluntary. Local school boards can elect whether to allow the identified schools within their districts to be used as PODs.

(13) How can superintendents find out which, if any, schools in their districts have been designated as PODs?

In April 2006, letters were sent to the principals of all schools that had been designated as potential PODs. Since that time, there has been regular correspondence with the principals of those schools, with courtesy copies of the correspondence provided to superintendents. Since notification, a security assessment has been conducted and a facility survey has been or will be completed to determine whether that facility meets the criteria to serve as a POD. All the assessments are to be provided to DOH by September 30, 2006. At that time, letters will be mailed to all schools informing them whether their school has been designated as an official POD. If you have not heard, there are probably no schools in your district, but you may contact your County Emergency Management Agency (EMA) who has the list of potential PODs.

(14) Does the State plan to address liability issues that could arise from the use of school facilities as PODs or shelters?

Because school buildings are frequently used by the community for non-instructional purposes, it is anticipated that the same laws that apply to these situations (such as the Political Subdivision Tort Claims Act) would apply if the building is used for emergency purposes. As more specific information regarding the nature of a possible pandemic and the demand for school buildings becomes available, we will determine whether it is necessary to address specific liability issues.

(15) Are school buses and bus drivers required to assist in an emergency?

Unless school bus drivers are considered to be Commonwealth employees, there is no statute that allows the Commonwealth to require them to serve in an emergency.
Thus, unless their collective bargaining agreements require them to work overtime or provide services in the event of an emergency, the school district cannot require their participation. Bus drivers may, of course, choose to volunteer their services, just as other persons may.

With respect to the use of school buses, there is a specific provision in the Emergency Management Services Code that states that school buses and transportation vehicles owned or leased by universities, colleges and school districts shall be made available to local, county, and state officials for emergency planning and exercise purposes and actual services in the event of an emergency evacuation. (See 35 P.S. § 7701(e)). Similar provisions exist with respect to publicly funded universities, colleges, and elementary and secondary schools. These school buses are to be made available for emergency planning and exercise purposes and actual service as mass-care facilities in the event of an emergency evacuation.

(16) Presumably, the use of school facilities in response to an emergency would disrupt the school schedule. What plans or accommodations might PDE make in order to relieve school districts of their responsibility to provide 180 days of instruction under these circumstances?

To the extent possible, precautions should be taken to prevent an unnecessary disruption of the educational process. If it becomes necessary to close a building for reasons other than illness among students and staff and it is not feasible to educate the students at other locations, PDE will issue more specific guidance based upon the circumstances.

(17) Are there any examples of well-written school district Emergency Preparedness Plans that others could use?

School districts do not currently submit this type of plan to PDE. The Pennsylvania Pandemic Preparedness Website (www.pandemicflu.state.pa.us) provides school districts with resources, including the Pennsylvania Pandemic Action Plan and a plan template. By using these materials and working with local Emergency Management contacts and DOH field staff, school districts can develop effective emergency plans to address their own particular situations and the needs of their communities.

(18) How are school nurses being informed of their responsibilities?

School nurses are receiving information pertinent to pandemic planning and a web-based toolkit in several different ways. School nurses have been using DOH’s School Health website, which now links to the PA Pandemic Preparedness website (www.pandemicflu.state.pa.us) and includes the new toolkit for schools. DOH, through its six regional school health consultants, provides school health updates, orientation for new nurses, and electronic communications to school nurses in their respective areas. The consultants have received information on DOH’s pandemic planning toolkit for schools.
(19) Should masks be worn?

At this time, DOH is still reviewing the issue of whether the use of masks is advisable. Thus, masks for the public are not, at this time, recommended. However, if DOH changes its position on this issue, school districts and schools will be notified.

(20) How can school districts help students receive medical care?

There is support for medical situations from the local Emergency Management Agency and local DOH office. It would be helpful for students and their parents if the school district provides the contact information for these local agencies in the event the school is closed for an indeterminate amount of time.

(21) How can school personnel provide support for families experiencing an emotional crisis because of a pandemic flu outbreak?

As part of the Commonwealth of Pennsylvania’s Public Health Preparedness Strategic Plan for 2006-2009, specific goals and objectives have been established to address the issue of schools, students, and parents. Under this plan, children and non-English speaking citizens are considered a “special population.” As such, DOH, the Department of Public Welfare and PDE’s Division of Student and Safe School Services will work cooperatively to:

- Assist parents in accessing medical care by identifying public and non-governmental organizations that provide medical and/or social services during a public health emergency;
- Provide support to families experiencing emotional trauma related to a public health emergency; and
- Assist migrant and non-English speaking families in preparing and responding to a public health emergency.

Please note that the web-based toolkit mentioned in the response to question #18 includes resources for families and information that schools can send to families.

(22) What supports should be in place for the deaf community and the schools for deaf students?

Hearing parents of deaf children should receive the same notification that parents of other students receive (i.e., written materials, telephone messages, etc.). Another method of notification should be established for deaf parents of deaf children. Ideally, this decision would be made during the annual IEP (individual education plan) meeting. Parents who did not attend the IEP meeting should be required to consult with school officials to establish a plan of notification. This plan may include the use of the relay system, email messages, the telephone of a hearing neighbor, a relative’s phone or other vehicles for communication. The plan should be reviewed
and, if necessary, revised yearly. These procedures should apply both at schools for the deaf and at other schools serving deaf children.

(23) **How can schools assist the migrant community in responding to a pandemic flu outbreak?**

Information in the appropriate language should be provided to parents. The pandemic planning toolkit (referenced in question #18) provides resources in languages other than English. It is also recommended that school districts provide hotlines, if feasible, or information regarding access to other hotlines pertinent to pandemic flu. Meetings with the employers of migrant workers are also recommended. PDE can provide a list of the types of industries that should be contacted. Local school officials are encouraged to inform the Migrant Education field staff and PDE of their planning efforts.

(24) **Is there any way the school can or should provide support to students who depend on the school for breakfast and lunch on a daily basis?**

Although school districts do not have a legal duty to provide meals for students in the event of an emergency school closing, a district may include in its all-hazards plan a procedure for distributing perishable and other foods in the event of a closure. However, pursuant to federal regulations, school districts may not receive reimbursement from the United States Department of Agriculture for meals if food is sent home with students.

(25) **Can schools provide packets or other home support to maintain a learning environment during long-term school closure?**

Certainly, though school officials and teachers will need to be flexible in terms of expectations, given that circumstances, such as illness, will prevent some students from completing school work.
To Teachers of Pennsylvania’s Students:

With the start of 2009-2010 school year upon us, your school district, the Pennsylvania Department of Education and the Pennsylvania Department of Health want to discuss our preparations and plans for the upcoming influenza season. To lessen the flu’s impact on you, your families and your students, we are committed to keeping you informed about the status of influenza throughout the commonwealth, and to help you better understand the need to plan in advance to safeguard your health.

Over the course of the summer, this new flu strain has continued to produce illness in Pennsylvania, although not at levels seen in May and June.

To combat this new flu strain, we plan to continue many of the measures previously put in place to protect our citizens. Additionally, new guidance from the federal Centers for Disease Control and Prevention (CDC) now stipulates that anyone with the flu will need to stay home until they are fever-free for at least 24 hours without the use of fever-reducing medications (Tylenol, Motrin, etc.). In most cases, this would be anywhere from three to five days where individuals would not be in the classroom.

We are asking all teachers to carefully observe your students. If you see a student who appears ill with influenza-like illness, please refer the student to the school nurse or other designated school official if the nurse is unavailable. If a student is found to be sick with flu-like symptoms, he or she will be sent home.

Your school will be taking steps to reduce the spread of infections like the flu. Frequent hand washing will be encouraged, and surfaces that are commonly touched or handled will be regularly cleaned and disinfected.

School closure will remain an option, but our current recommendations are to take such action only if there is evidence that other measures are not working. School districts will be working closely with their local and state health departments in making decisions. Each situation will be evaluated to guarantee the best course of action is taken to protect you and your students, minimizing the impact and burden on affected families and communities.

Many of you have questions about the availability and use of vaccines. Recently, persons between ages five and 24 were identified as a priority group to receive vaccine against the new flu strain. Currently, the Department of Health estimates the first doses of the new vaccine will be available in October and details of distribution of the vaccine will be forthcoming.
We also expect to see illness due to the seasonal (or regular) flu in the coming fall and winter. The seasonal flu vaccine has been recommended for all school-aged children and is especially important for children with underlying health problems (like asthma and diabetes), since these conditions increase the risk of flu complications. Therefore, parents have been encouraged to have their children vaccinated and we also provide that same guidance to our teachers, administrators and all school staff to curb the spread of the seasonal flu.

Information on the flu and how you can protect your students and yourselves is available at www.health.state.pa.us, www.cdc.gov and www.flu.gov. For further information, contact your local health department or the Pennsylvania Department of Health at 1-877-PA-HEALTH.

Your health as well as the health of your students is very important to us, and we hope to partner with you during the school year to assure that both can be achieved.

Sincerely,

Gerald L. Zahorchak, D.Ed.
<table>
<thead>
<tr>
<th>Mitigation and Prevention</th>
<th>Responsible Person(s)</th>
<th>Existing Resources</th>
<th>Information Needed</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task</strong></td>
<td>Example: Donna will contact Jim Jones, Chairman of Health and Safety Comm.</td>
<td>Health and Safety Comm. formed 2 years ago and group developed SARS plan.</td>
<td>When &amp; how often does HSC meet? Who sits on HSC? Could group provide guidance on PanFlu?</td>
<td>Donna will discuss needs of PanFlu planning with Jim Jones from HSC and get info back to group via email within the week.</td>
</tr>
<tr>
<td><strong>Examples for first task:</strong></td>
<td>Identify or create district committee to provide guidance to school sites regarding pandemic flu preparations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>Review district emergency response and communicable disease policies and procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>Determine if any additional policies/procedures need to be in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>Develop communications plan for possible school closures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>Work with Human Resources regarding schools functioning with 30% of work force absent. Look at alternatives such as staggered school times, changes in bussing, and telecommunications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>Assess financial impact of alternate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Pennsylvania Pandemic Action Planning Tool

<table>
<thead>
<tr>
<th>Mitigation and Prevention</th>
<th>Responsible Person(s)</th>
<th>Existing Resources</th>
<th>Information Needed</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>scheduling or school closures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify school-based individual(s) to educate staff about pandemic flu</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify school-based individual(s) to educate students about hand washing, covering cough, and staying home when sick</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify individual(s) to educate families about pandemic flu and school plan (&quot;Fact Sheet for Families&quot; found at <a href="http://www.tpchd.org/files/library/756a4a9007953477.pdf">http://www.tpchd.org/files/library/756a4a9007953477.pdf</a>)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify individual(s) to ensure each room has soap/water for hand washing or alcohol-based hand washing product</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distribute and post in each classroom &quot;Stop the Spread of Germs&quot; poster found at <a href="http://www.tpchd.org/files/library/14d0a439d205e86.pdf">http://www.tpchd.org/files/library/14d0a439d205e86.pdf</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitigation and Prevention</td>
<td>Task</td>
<td>Responsible Person(s)</td>
<td>Existing Resources</td>
<td>Information Needed</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>--------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td>Track the number of staff and students absent daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Report numbers absent to the appropriate Department of Health office if over 10% or when requested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure that the District committee includes representatives from the appropriate community organizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure collaboration with the appropriate local Emergency Management Agency (EMA) for integration of the school into the community plan and effective communication between the school and community planning committees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish an Incident Command Center that receives communication from the district office and local EMA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Pennsylvania Pandemic Action Planning Tool

<table>
<thead>
<tr>
<th>Preparedness</th>
<th>Responsible Person(s)</th>
<th>Existing Resources</th>
<th>Information Needed</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review district’s pandemic flu plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue educating staff, families, and students on pandemic flu prevention and school plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify chain of command in case of illness. Establish a back-up chain of command if necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop procedures for communicating with staff, students and families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify information to be translated. Identify which languages are represented in student population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify and recruit translators; translate information into template form so only minor changes will need to be made</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop procedures for communicating with the Pennsylvania Departments of Health and Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Pennsylvania Pandemic Action Planning Tool

<table>
<thead>
<tr>
<th>Preparedness</th>
<th>Task</th>
<th>Responsible Person(s)</th>
<th>Existing Resources</th>
<th>Information Needed</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>as well as with the media during normal and emergency conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify or review procedure for communicating possible school</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>schedule changes, bussing changes, and school closures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review procedures for sending ill students and staff home and make</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>adjustments if necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Pennsylvania Pandemic Action Planning Tool

<table>
<thead>
<tr>
<th>Response</th>
<th>Task</th>
<th>Responsible Person(s)</th>
<th>Existing Resources</th>
<th>Information Needed</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Track the number of staff and students absent daily with pandemic flu.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Report numbers absent to appropriate Department of Health office if over 10% or when requested</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have translators review information templates and finalize the information that will be provided to non-English speaking families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finalize the information that needs to be communicated to staff, students, and families and the frequency and method of communication.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hold staff meetings to provide information on the extent of infection at school site and potential changes that may take place</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct timely debriefings to identify lessons learned and make necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Pennsylvania Pandemic Action Planning Tool

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Person(s)</th>
<th>Existing Resources</th>
<th>Information Needed</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>changes to the response plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify process of documenting critical actions taken during the response</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Pennsylvania Pandemic Action Planning Tool

<table>
<thead>
<tr>
<th>Recovery Task</th>
<th>Responsible Person(s)</th>
<th>Existing Resources</th>
<th>Information Needed</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-planning for recovery: Identify and pre-screen health and grief service providers, develop template letters, and provide training for school staff regarding grief and possible health problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobilize the Crisis Recovery Team that provides emotional-psychological support. If there is a loss of life in the school community establish location site or “Safe Room” for counseling services to be provided</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hold staff meeting and provide information on extent of pandemic flu in the community and activities that may assist students; signs and symptoms to look out for and safe room function and location. Also announce counseling support services available to faculty and staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Announce counseling support services that are available to students</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide rest places for those that tire easily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide physical assessments if needed or make appropriate community health referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Pennsylvania Pandemic Action Planning Tool

<table>
<thead>
<tr>
<th>Recovery</th>
<th>Responsible Person(s)</th>
<th>Existing Resources</th>
<th>Information Needed</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make educational materials available to families and staff on topics such as how to support your student with their recovery from pandemic flu, common symptoms of loss and grief, and constructive ways to cope with stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilize Employee Assistance Programs for assistance with coping with loss and stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify students, families, and staff who may need long-term physical and mental health support or intervention and develop school and community resources to provide these services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor the effects of cumulative stress on caregivers such as office staff, school nurses, teachers, aides, school counselors, and other crisis team members</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider offering school-based health and mental health services if available by community, university, or public/non-profit mental health agencies and identify funding to support these services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modify work roles and responsibilities or add volunteer or support staff as needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up with student referrals made to community agencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct debriefings with Crisis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery Task</td>
<td>Responsible Person(s)</td>
<td>Information Needed</td>
<td>Next Steps</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------</td>
<td>--------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Recovery Team</td>
<td>Document &quot;lessons learned&quot; and incorporate them into revisions and trainings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Pennsylvania Pandemic Action Planning Tool

Adapted with permission of the Tacoma-Pierce County Health Department

Supporting Documents
Tacoma-Pierce County Health Department Avian Pandemic Flu School Preparedness website
http://www.tpchd.org/page.php?id=288
World Health Organization
www.who.int/csr/disease/avian_influenza/updates/en/
Centers for Disease Control and Prevention, Avian Flu
www.cdc.gov/flu/avian/
Centers for Disease Control and Prevention, Influenza
www.cdc.gov/flu/
Washington Department of Health, Flu News:
www.doh.wa.gov/FluNews/
Washington Department of Health, Flu Materials in Multiple Languages
www.doh.wa.gov/FluNews/#external January 12, 2006 9
www.nasponline.org
Coping with a Traumatic Event, The Center for Disease Control
The Institute for Trauma and Stress at The NYU Child Student Center: Caring for Kids After Trauma and Death: A guide for Parents and Professionals (2002)
www.aboutourkids.org/aboutour/articles/crisis_guide02.pdf
Pennsylvania Pandemic Planning Template

I. Mitigation

A. Education of Faculty/Staff, Students & Families
   1. Commonly Used All-Hazard (including Pandemic) Planning Acronyms*
   2. National Incident Management System (NIMS)*
   3. Identification of Symptoms & What to Do
   4. Hand washing & Cough/Sneeze Etiquette
   5. Flu Shots
   6. Basic Readiness/Pandemic Readiness Activities

B. Surveillance
   1. Develop Means to Monitor Illness
   2. Monitor Staff, Students & Families
   3. Conduct Risk/Vulnerability Assessment

C. Communication
   1. Develop Partnerships with Community Agencies*
   2. Develop a Variety of Communication Channels

D. Infection Control Procedures
   1. Sanitation and Disinfection Procedures
   2. Personal Protective Equipment (PPE)

E. Mental Health Concerns
   1. Identification of At-Risk Students
   2. Develop Partnerships with Community Agencies
II. Preparedness

A. Continue all Mitigation Phase activities

B. Education
   1. Tools for Planning
   2. NIMS
   3. Identification of Symptoms & What to Do
   4. Hand washing & Cough/Sneeze Etiquette
   5. Flu Shots
   6. Basic Readiness Activities

C. Surveillance
   1. Student/Staff Illness
   2. Keep Abreast of Activity in the Community

D. Collaboration with Community for Resources
   1. Identify Key Stakeholders
   2. Care for Families of Volunteers

E. Infection Control Procedures
   1. School Building
   2. Families
   3. Staff/Faculty

F. Development of Emergency Response Plan
   1. Be Familiar with the NIMS Model
   2. Collaborate with Community EMAs, Police, Fire, etc. (including drills, tabletop exercises and other practice activities)
   3. Communication
   4. Disease Confinement Procedures
5. Special Needs

6. Continuity of Operations

7. Use of School Building as POD or Evacuation Center

8. Sample State Plans for Schools
III. Response

A. Implement the Emergency Response Plan
   1. Collaborate with Community EMAs, Police, Fire, etc. (as planned)
   2. Communication (use NIMS)
   3. Disease Confinement Procedures (as needed)
   4. Special Needs (continuing assessments & actions as needed)
   5. Continuity of Operations (as possible)
   6. Use of School Building as POD or Evacuation Center (as needed)

B. Surveillance
   1. Monitor illness of students & staff
   2. Monitor community/state/country/world

C. Infection Control
   1. Evacuation
   2. Quarantine
   3. Preventing Disease Transmission

D. Health Concerns
   1. Providing for Mental Health Care
   2. Providing for Physical Health Care
III. Recovery

A. Communication
   1. Regular debriefing
   2. Keep communication lines open among school, family & community
   3. Community-wide meetings to facilitate addressing how they will cope

F. Mental Health Concerns
   1. Returning to school
   2. Long-term Recovery

G. Restoring Community
   1. Re-building Community

H. Evaluation
   1. Evaluate Efficacy of Disaster Plan
WHAT IS A FLU PANDEMIC?

An influenza (flu) pandemic is a global outbreak of disease that occurs when a new flu virus appears that can spread easily from person to person. Because people have not been exposed to this new virus before, they have little or no immunity to the virus; therefore serious illness or death is more likely to result than during seasonal flu.

It is difficult to predict when the next influenza pandemic will occur or how severe it will be. In addition, a pandemic may come and go in waves, each of which can last months at a time. The effects of a pandemic can be lessened if preparations are made ahead of time.

The illness rates for both seasonal and pandemic influenza are high among children, and schools are likely to be an important contributor to the spread of influenza in a community.

Scientific models support school closure as an effective means of reducing overall illness rates within communities and suggest that the value of this intervention is greatest if school closure occurs early in the course of a community outbreak.
Differences between **seasonal flu** and **pandemic flu**:

**Seasonal Flu**

**THE VIRUS**
- Caused by influenza viruses that are closely related to viruses that have previously circulated; most people will have some immunity to it.
- Symptoms include fever, cough, runny nose, and muscle pain.
- Complications such as pneumonia are most common in the very young and very old and may result in death.
- Vaccine is produced each season to protect people from the three influenza strains predicted to be most likely to cause illness.

**IMPACT ON THE COMMUNITY**
- Seasonal flu kills about 36,000 Americans each year and hospitalizes more than 200,000 children and adults.

**Mild to Moderate Pandemic**

**THE VIRUS**
- Caused by a new influenza virus that has not previously circulated among people and that can be easily spread.
- Because most people will have no immunity to the new virus, it will likely cause illness in high numbers of people and more severe illness and deaths than seasonal influenza.
- Symptoms are similar to seasonal flu, but may be more severe and have more frequent serious complications.
- Healthy adults may be at increased risk for serious complications.

**IMPACT ON THE COMMUNITY**
- May cause a moderate impact on society (e.g., some short-term school closings, encouragement of people who are sick to stay home).

**Severe Pandemic**

**THE VIRUS**
- A severe strain causes more severe illness, results in greater loss of life, and has a greater impact on society.
- During the peak of a severe pandemic, workplace absenteeism could reach up to 40% due to people being ill themselves or caring for family members.

**IMPACT ON THE COMMUNITY**
- Schools and day care/child care facilities may be closed.
- Public and social gatherings will be discouraged.
- The patterns of daily life could be changed for some time with basic services and access to supplies possibly disrupted.

How does influenza spread?

Human influenza virus is mainly transmitted from person to person when an infected person coughs or sneezes. A lesser mode of transmission occurs when a person touches something that has the flu viruses on it and then touches his or her mouth or nose. Some individuals who are infected may never show symptoms or have mild symptoms, but could still spread the virus to others.

**When a pandemic begins, a virus-specific vaccine may not be available until 4-6 months after identification of a pandemic virus.**

The supply of antiviral drugs will likely be limited throughout the pandemic. Moreover, scientists cannot be certain that antiviral drugs will be effective against a pandemic virus. For these reasons, infection control and social distancing measures will be the keys to limiting transmission, delaying the spread of the virus, and protecting people. Social distancing is a measure to decrease the frequency of contact among people in order to diminish the risk of spread of communicable diseases.
Measures to limit the spread of the flu:

**Severe Pandemic:**

All of the seasonal and mild to moderate flu methods plus:

- Possible extended school closure, which could range from weeks to up to 3 months. Presently, the Department of Health and Human Services, the Centers for Disease Control and Prevention, the Department of Education, and other agencies are conducting a comprehensive review of school closure and its feasibility and effects in mitigating a severe pandemic. The results of this study will be shared in the coming months.
- Promote social distancing of children and teens outside the school setting by reducing their social circulation and contacts to the greatest extent possible. This could include canceling extracurricular activities.

**Mild to Moderate Pandemic:**

All of the seasonal flu methods plus the following:

- Encourage the use of social distancing at the workplace, at school and in the community.
- Possible school closure for a short amount of time (possibly days to a couple of weeks).
- Work with community planning team to assess whether any additional measures should be taken.

**Seasonal Flu:**

- Promote hand washing and cough hygiene via school-wide campaigns and modeling by school staff.
- Encourage vaccination of staff and students for whom the flu vaccine is recommended.
- Persons developing symptoms at school should be sent home as soon as possible and instructed by appropriate officials not to return until they are well.

**Infection control**

The primary strategies for preventing spread of pandemic influenza:

- Persons with flu symptoms should:
  - Stay at home;
  - Cover nose and mouth when coughing or sneezing;
  - Wash hands with soap and water or use alcohol-based hand sanitizers frequently; and
  - Try to maintain spatial separation of at least three feet from others if possible.

**Hand, Cough and Sneeze Hygiene**

- When sneezing or coughing, cover the nose and mouth with a tissue or upper arm if a tissue is not available.
- Dispose of used tissues in a wastebasket and wash hands after coughing, sneezing, or blowing nose.
- Use warm water and soap or alcohol-based hand sanitizers to clean hands.
- Wash hands before eating or touching eyes, nose, or mouth.

**Social distancing**

In a pandemic, the risk of getting the flu is greatest when one has close contact with an infected person. Social distancing measures such as school closure, telecommuting or staggered shifts for the workforce, and cancellation of public gatherings may be effective in reducing transmission risks.
Basic Components of Pandemic Planning

- Every district should have an Emergency Management Plan.
- The Plan should be flexible to encompass all hazards.
- Every district should develop a Pandemic Flu Plan.
- Plans should address four phases of emergency management planning: Mitigation and Prevention, Preparedness, Response and Recovery. For more information: www.ed.gov/emergencyplan.
- Plans should be practiced on a regular basis.
- Plans should be developed and communicated in an interactive manner with stakeholders, including parents, faculty, other community partners and first responders.
- Plans should be based on sound data and information; www.pandemicflu.gov should be the main resource for pandemic planning and information.
- Plans should be continually reviewed and updated as new information is available. The complete planning checklist can be viewed at www.pandemicflu.gov.

Detailed information on each component along with sample plans can be viewed at www.ed.gov
Pennsylvania Department of Health
Guidance for School (K-12) Responses to Influenza during the 2009-2010 School Year

The Pennsylvania Department of Health is providing updated guidance to schools throughout the Commonwealth to help decrease the spread of flu among students and school staff during the 2009-2010 school year. This document builds upon school guidance issued last spring and is compatible with recently issued guidance from the U.S. Centers for Disease Control and Prevention. It provides a series of recommendations that schools can use to prevent and limit the spread of influenza. The recommendations should be adapted to fit local conditions and circumstances, since no two educational settings are the same. The general preventive measures in this document are designed to reduce the risk of introduction or spread of influenza in a school and are recommended for all schools. If influenza does occur in a school, the appropriate course of action should be tailored to the unique needs and circumstances of that school and the population it serves. Decisions should be made with active consultation between school officials and local and/or state public health authorities. All schools are encouraged to establish in advance clear lines of communication and points of contact with their local or state public health agencies to assure the best management of problems should they occur.

The guidance in this document is appropriate for influenza with similar characteristics and disease severity seen in last spring’s wave of pandemic influenza and over the summer in Pennsylvania. If disease severity increases, PADOH will issue updated recommendations for prevention and control in school settings. Since the scientific information regarding pandemic influenza A/H1N1 is continuously evolving, current recommendations may need to be revised as more information becomes available.

BACKGROUND

Since pandemic influenza A H1N1 was first identified in April 2009, school age children have posed a particular concern. More than half of all confirmed cases in Pennsylvania have occurred in persons between 5-19 years of age. During the first wave of pandemic influenza, schools were disproportionately impacted, serving as settings for disease introduction and spread. As a result, schools throughout the Commonwealth experienced disruption of day-to-day activities, and in some instances had to close to control disease. It is expected that in the coming school year, disease incidence will continue to be high in children. Therefore, all educational facilities should (1) take preventive measures to minimize the risk of introduction of influenza and its subsequent spread and (2) develop plans for response if and when influenza is identified in a member of the school community. PADOH continues to support a graduated response to findings of influenza in a school that accomplishes the goal of minimizing the health risk while allowing vital educational activities to continue to take place.

Information from the World Health Organization (WHO) shows that in the southern hemisphere, where the winter influenza season has been occurring over the last several months, most influenza is due to the pandemic influenza A H1N1 strain and the disease severity is similar to that seen in the United States last spring. Data from the United States, including Pennsylvania, over the summer shows the same pattern. In children, illness due to the new flu virus was typical of illness seen for seasonal influenza.

---

1 Adapted from CDC Guidance for State and Local Public Health Officials and School Administrators for School (K-12) Responses to Influenza during the 2009-2010 School Year
influenza. Therefore, this guidance focuses on appropriate prevention and control measures for the type of illness expected to be seen this fall and winter.

Decisions regarding appropriate actions to take in response to the introduction of influenza into a school should be tailored to the circumstances of that setting. The least disruptive measures should be employed to control the spread of disease. This means that in general, school dismissal will not be necessary, especially if less disruptive measures described below can be effectively and properly implemented. In making decisions about an appropriate response, schools should consider the affected age group (elementary versus secondary), the likelihood that ill students or staff were infectious when present at the school, the ability to implement prompt identity and exclusion of ill children, and compliance with exclusion recommendations by parents and guardians. School absenteeism rates and patterns are a critical element of sound decision-making. Every school should closely monitor school absenteeism. Decisions regarding what measures to take when influenza appears are best made by school officials in consultation with local and state health officials. The goal should be to minimize social disruption and safety risks to children. Based on the experience and knowledge gained in jurisdictions that had large outbreaks in spring 2009, the potential benefits of preemptively dismissing students from school are often outweighed by negative consequences, including students being left home alone, health workers missing shifts when they must stay home with their children, students missing meals, and interruption of students’ education. Therefore, school dismissal is considered to be only an option when other measures to control the spread of disease have been unsuccessful.

Basic foundations of infection control in school settings should always be promoted and facilitated, not only during an influenza pandemic. During flu season, schools should be particularly vigilant about keeping sick students and staff home. Schools should be proactive, develop contingency plans to cover key positions (for example, school nurses) when staff are home ill, and regularly remind parents and staff of the exclusion recommendations. Plans should focus on protecting people at high risk for influenza complications as these groups are frequently found in schools. For example, asthma alone affects nearly one in ten school-aged youth.

Successfully addressing influenza in schools requires effective communication with parents, guardians and staff. Every school should have well-established lines of communication to these groups, as well as the general community. Experience in the spring of 2009 suggested that schools that had frequent communications with critical stakeholders were able to minimize disruption of educational activities without diminishing the health and safety of the school population.

IDENTIFICATION

Symptoms of influenza-like illness (ILI) that suggest possible pandemic influenza A/H1N1 include fever (measured temperature of >100°F) and either cough or sore throat. Illness may be accompanied by other symptoms including headache, tiredness, runny or stuffy nose, body aches, diarrhea, and vomiting. Like seasonal flu, illness from H1N1 can vary from mild to severe. There is no way to distinguish influenza due to the pandemic strain from that caused by seasonal flu, and illness may look similar to that caused by other respiratory infections. This is why it is important to be in communication with local and/or state public health authorities and with health care providers.

High-risk populations

Some students and staff are at higher risk for complications of influenza. These individuals should be pre-identified. High-risk populations include:
Recommended school responses for the 2009-2010 school year

1. **Stay home when sick:**
   Students and staff members with influenza-like illness (ILI) should not come to school. In general, individuals with ILI should stay home for at least 24 hours after they no longer have a fever, or signs of a fever, without the use of fever-reducing medicines. This recommendation should be adhered to whether or not the sick individual received treatment with antiviral drugs. Since the usual duration of fever is 2-4 days, this will allow most individuals to return after a period of 3-5 days of exclusion.

   Schools should have in place procedures to promptly identify children who become ill while at school. Schools should also evaluate students who return to school after influenza illness to make sure they are no longer ill with fever and are well enough to attend class. Successfully controlling school outbreaks, especially with the shorter duration of exclusion, is highly dependent on successfully identifying and excluding ill students and staff and not allowing ill persons to return too early.

   In some circumstances, it may be appropriate to extend the duration of the exclusion period. Such decisions should be made in conjunction with your local and state health department. More stringent and longer periods of exclusion – for example, until complete resolution of symptoms – may be considered for people returning to settings where high numbers of high-risk people may be exposed or in settings where the ability to adhere to a lesser exclusion period has been unsuccessful.

   Sick individuals should stay at home until the end of the exclusion period, to the extent possible, except when necessary to seek required medical care. Sick individuals should avoid contact with others. Keeping people with a fever at home may reduce the number of people who get infected since elevated temperature is associated with increased shedding of influenza virus. CDC/PADOH recommend this exclusion period whether or not antiviral medications are used.

2. **Separate ill students and staff:**
   Sick students and staff should always be required to stay home. Students and staff who appear to have an influenza-like illness on arrival at school or who become ill during the day should be promptly separated from other students and staff and sent home as soon as possible.

   Schools should regularly update contact information for parents so that they can be contacted more easily if they need to pick up their ill child.
Recognizing that space is often in short supply, early planning on the location for a sick room is essential. This room should not be one commonly used for other purposes for example, the lunchroom during non-meal times or the nurses’ room where care for other medical issues may be taking place. Nor should it be a space through which others regularly pass. It is not necessary for this room to have a separate air supply (HVAC) system. Ill persons should be placed in well ventilated areas and placed in areas where at least 6 feet of distance can be maintained between the ill person and others.

A limited number of staff should be designated to care for ill persons until they can be sent home. When possible, these should be people with limited interactions with other students and staff and therefore decreased risk of spreading influenza. These persons should not be at increased risk of influenza complications (for example, pregnant women – see categories above) and they should be familiar with infection control recommendations to prevent spread of influenza. When possible and if the sick person can tolerate it, he or she should wear a surgical mask when near other persons.

School nurses, and other staff who act in this capacity, are likely to come into close contact with students and staff with influenza-like illness. **Staff members that provide care for persons with influenza-like illness should use appropriate personal protective equipment, such as a mask.**

3. **Hand hygiene:**
Influenza can spread through contaminated hands or objects that become contaminated with influenza viruses. **Students and staff should be encouraged to wash their hands often with soap and water, especially after coughing or sneezing.** Alcohol-based hand cleaners are also effective at killing flu, but may not be allowed in all schools. If soap and water are not available, and alcohol-based products are not allowed in the school, other hand sanitizers that do not contain alcohol may be useful. However, there is less evidence on their effectiveness compared to that on hand washing and alcohol-based sanitizers.

Schools should provide the time needed for all students and staff to wash their hands whenever necessary, especially after coughing or sneezing into hands, before eating, and after using the restroom. Soap, paper towels and sanitizers are critical for proper hand hygiene and should be readily available in all schools. If it is necessary to provide supervision to students as they wash hands in rest rooms, schools should consider timing and staffing in their planning. Schools also should educate families, students and staff about the importance of good hand hygiene and proper methods for cleaning hands.

4. **Respiratory etiquette:**
Influenza viruses are thought to spread mainly from person to person when an ill individual coughs or sneezes. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and deposited on the mouth or nose or are inhaled by people nearby. **Students and staff members should be educated on the importance of covering their nose and mouth with a tissue when coughing or sneezing and throwing the tissue in the trash after use.** Wash hands promptly after coughing or sneezing. If a tissue is not immediately available, coughing or sneezing into one’s arm or sleeve (not into one’s hand) is recommended. To encourage respiratory etiquette, tissues should be readily available to
students and staff and they should be educated about the importance of respiratory etiquette, including keeping hands away from the face.

5. **Routine cleaning:**
   Schools should regularly clean all areas and items that are more likely to have frequent hand contact (for example, keyboards or desks) and also clean these areas immediately when visibly soiled. Use the cleaning agents that are usually used in these areas. Additional or special environmental control measures are not necessary.

   Schools should ensure that custodial staff and others (such as classroom teachers) who use cleaners or disinfectants read and understand all instruction labels and understand safe and appropriate use. School staff should regularly clean all areas that students and staff touch often with the cleaners they typically use. Special cleaning with bleach and other non-detergent-based cleaners is not necessary.

6. **Early treatment of high-risk students and staff:**
   Persons at high risk for influenza complications who become ill with influenza-like illness should speak with their health care provider as soon as possible for appropriate treatment recommendations. Early treatment with antiviral medications is very important for people at high risk because it can reduce the risk of complications, including the need for hospitalization.

   Schools should encourage ill staff and parents of ill students at higher risk of complications from influenza to seek early treatment.

   High-risk students and staff who have had close contact with others who are sick with an influenza-like illness should contact their health care provider to discuss whether they may need to take influenza antiviral medications. In general, antiviral prophylaxis is not recommended for persons who are not at high risk of complications of influenza. Widespread use of antiviral prophylaxis is not considered an appropriate response to influenza in the typical school setting.

   People on antiviral treatment may still shed influenza viruses and therefore may still transmit the virus to others. These influenza viruses may develop resistance to antiviral medications. To lessen the chance of spreading influenza viruses that are resistant to antiviral medications, adherence to good respiratory etiquette and hand hygiene is as important for people taking antiviral medications as it is for others.

7. **Consideration of selective school dismissal:**
   Selective school dismissals may be considered based on the population and circumstances of an individual school. Although there are not many schools where all or most students are at high risk (for example, a school for medically fragile children or for pregnant students) in some instances this may be the appropriate response. The decision to selectively dismiss a school should be made only in consultation with local and/or state public health authorities and should balance the risks of keeping the students in school with the social disruption that school dismissal can cause. Selective school dismissals are not likely to have a significant effect on community-wide transmission: Instead, this strategy aims to protect students and staff at high risk of severe illness and death.

8. **Absenteesim monitoring**
Every school should closely monitor the patterns of school absenteeism. School absenteeism should be monitored on a daily basis and efforts should be made to determine if student or staff member absence is due to illness. Any increase in school absenteeism due to illness should be promptly reported to local and/or state public health authorities for an appropriate response. Promptly recognizing an outbreak of influenza is one of the best ways to assure the least disruptive measures can be implemented to limit the spread of disease.
ADDITIONAL INFORMATION

- CDC Guidance for State and Local Public Health Officials and School Administrators for School (K-12) Responses to Influenza during the 2009-2010 School Year http://www.cdc.gov/h1n1flu/schools/schoolguidance.htm

- PADOH Public Web Site, H1N1 Flu (Swine Flu) http://www.H1N1inPA.com

- County Health Departments: http://webserver.health.state.pa.us/health/comm/comm.asp?COUNTY=all
Flu Symptom Checklist for School Staff

☐ Yes ☐ No Does the student or staff member have a sore throat or a bad cough?

☐ Yes ☐ No Does the student or staff member have a fever of 100 degrees or more?

Here’s how to tell if a student or staff member has a fever using a thermometer:
  - Put the thermometer under the student’s or staff member’s tongue. Have the student or staff member close her/his lips around the thermometer. If the student is young, stay with the student while the thermometer is in the mouth. You can hold it in place.
  - If you are using a digital thermometer, follow manufacturer instructions. Use prone covers when taking the temperature to any student or staff.
  - It takes about one minute to check a temperature by mouth. A digital thermometer beeps when it is ready to read. The student’s or staff member’s temperature shows on the thermometer like this:
    
    \[100.2\ ^\circ \text{F} \quad \text{One hundred point two} \quad \text{[102 \ ^\circ \text{F} \quad \text{One hundred and two}}\]

If you are unable to take the student’s or staff member’s temperature, you can look for these signs of fever:
  - The student’s or staff member’s face may be red. Skin may be hot to touch or moist.

If a student or staff member has a fever AND you answered “yes” to the other question above (she/he has a sore throat or cough), the student or staff member might have the flu.
Sample Checklist for Pandemic Influenza

**DIRECTIONS:** Use the following checklist to assess the school building’s/school district’s response. Place the date below and mark the individual’s name, in the completed block, who is confirming that the action item has been completed.

**DATE:**

<table>
<thead>
<tr>
<th>Action Item</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pandemic Influenza Procedures:</strong></td>
<td></td>
</tr>
<tr>
<td>Identify or create district committee to provide guidance to school sites regarding pandemic flu preparations.</td>
<td></td>
</tr>
<tr>
<td>Review district emergency response and communicable disease policies and procedures.</td>
<td></td>
</tr>
<tr>
<td>Determine if any additional policies and procedures need to be implemented.</td>
<td></td>
</tr>
<tr>
<td>Work with Human Resources regarding School districts/schools functioning with 30% of work force absent. Look at alternatives such as staggered school times, changes in bussing, and telecommunications.</td>
<td></td>
</tr>
<tr>
<td>Assess financial impact of alternate scheduling or school closures.</td>
<td></td>
</tr>
<tr>
<td>Identify school-based individuals to educate staff about pandemic influenza.</td>
<td></td>
</tr>
<tr>
<td>Identify school-based individuals to educate students about hand washing, covering cough, and staying home when sick.</td>
<td></td>
</tr>
<tr>
<td>Identify individuals or organizations to educate families about pandemic influenza and school plan.</td>
<td></td>
</tr>
<tr>
<td>Ensure each room has soap/water for hand washing or alcohol-based hand washing product.</td>
<td></td>
</tr>
<tr>
<td>Distribute and post in each classroom Pandemic Influenza posters.</td>
<td></td>
</tr>
<tr>
<td>Establish chain of command in case of illness. Establish a back-up chain of command, if necessary.</td>
<td></td>
</tr>
<tr>
<td>Review procedures for sending ill students and staff home and make adjustments, as necessary.</td>
<td></td>
</tr>
<tr>
<td>Track the number of staff and students absent daily.</td>
<td></td>
</tr>
<tr>
<td>Report numbers absent to District Office and local Health Department if over 10% or requested.</td>
<td></td>
</tr>
<tr>
<td>Hold staff meeting to provide information on the extent of infection at school site and potential changes that may take place.</td>
<td></td>
</tr>
<tr>
<td>Identify and pre-screen health and grief service providers.</td>
<td></td>
</tr>
<tr>
<td>Provide training to staff on grief and possible health problems associated with pandemic influenza.</td>
<td></td>
</tr>
<tr>
<td>Mobilize the Mental Health Team to provide emotional-psychological support.</td>
<td></td>
</tr>
<tr>
<td>If there is loss of life in the school district, establish location site for counseling services to be provided.</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Hold staff meeting and provide information on extent of pandemic influenza in the community and activities that may assist students, signs and symptoms to look out for, and safe room function and location.</td>
<td></td>
</tr>
<tr>
<td>Announce counseling support services available to staff and students.</td>
<td></td>
</tr>
<tr>
<td>Provide rest places for those that tire easily.</td>
<td></td>
</tr>
<tr>
<td>Provide physical assessments, if needed, or make appropriate community health referrals.</td>
<td></td>
</tr>
<tr>
<td>Recommend Employee Assistance Programs to deal with loss and grief.</td>
<td></td>
</tr>
<tr>
<td>Identify students, families, and staff who may need long-term physical and mental health support or intervention and develop school and community resources to support these needs.</td>
<td></td>
</tr>
<tr>
<td>Monitor the effects of cumulative stress on caregivers, such as office staff, school nurses, teachers, aides, school counselors, and other crisis team members.</td>
<td></td>
</tr>
<tr>
<td>Modify work roles and responsibilities or add volunteer or support staff, as needed.</td>
<td></td>
</tr>
<tr>
<td>Follow up with student referrals made to community agencies.</td>
<td></td>
</tr>
<tr>
<td>Conduct debriefings with Mental Health Team.</td>
<td></td>
</tr>
<tr>
<td>Call staff meeting to hold a review of the incident and discuss changes to procedures.</td>
<td></td>
</tr>
<tr>
<td>Update checklist, if necessary.</td>
<td></td>
</tr>
<tr>
<td>Communications:</td>
<td></td>
</tr>
<tr>
<td>Notify the Public Information Officer to activate the Communications Plan.</td>
<td></td>
</tr>
<tr>
<td>Communication Plan is activated.</td>
<td></td>
</tr>
<tr>
<td>Cautions/Notes:</td>
<td></td>
</tr>
</tbody>
</table>
Pennsylvania Department of Health
Guidance for School (K-12) Responses to Influenza during the 2009-2010 School Year

The Pennsylvania Department of Health is providing updated guidance to schools throughout the Commonwealth to help decrease the spread of flu among students and school staff during the 2009-2010 school year. This document builds upon school guidance issued last spring and is compatible with recently issued guidance from the U.S. Centers for Disease Control and Prevention. It provides a series of recommendations that schools can use to prevent and limit the spread of influenza. The recommendations should be adapted to fit local conditions and circumstances, since no two educational settings are the same. The general preventive measures in this document are designed to reduce the risk of introduction or spread of influenza in a school and are recommended for all schools. If influenza does occur in a school, the appropriate course of action should be tailored to the unique needs and circumstances of that school and the population it serves. Decisions should be made with active consultation between school officials and local and/or state public health authorities. All schools are encouraged to establish in advance clear lines of communication and points of contact with their local or state public health agencies to assure the best management of problems should they occur.

The guidance in this document is appropriate for influenza with similar characteristics and disease severity seen in last spring’s wave of pandemic influenza and over the summer in Pennsylvania. If disease severity increases, PA DOH will issue updated recommendations for prevention and control in school settings. Since the scientific information regarding pandemic influenza A/H1N1 is continuously evolving, current recommendations may need to be revised as more information becomes available.

BACKGROUND
Since pandemic influenza A H1N1 was first identified in April 2009, school age children have posed a particular concern. More than half of all confirmed cases in Pennsylvania have occurred in persons between 5-19 years of age. During the first wave of pandemic influenza, schools were disproportionately impacted, serving as settings for disease introduction and spread. As a result, schools throughout the Commonwealth experienced disruption of day-to-day activities, and in some instances had to close to control disease. It is expected that in the coming school year, disease incidence will continue to be high in children. Therefore, all educational facilities should (1) take preventive measures to minimize the risk of introduction of influenza and its subsequent spread and (2) develop plans for response if and when influenza is identified in a member of the school community. PA DOH continues to support a graduated response to findings of influenza in a school that accomplishes the goal of minimizing the health risk while allowing vital educational activities to continue to take place.

Information from the World Health Organization (WHO) shows that in the southern hemisphere, where the winter influenza season has been occurring over the last several months, most influenza is due to the pandemic influenza A H1N1 strain and the disease severity is similar to that seen in the United States last spring. Data from the United States, including Pennsylvania, over the summer shows the same pattern. In children, illness due to the new flu virus was typical of illness seen for seasonal

---

1 Adapted from CDC Guidance for State and Local Public Health Officials and School Administrators for School (K-12) Responses to Influenza during the 2009-2010 School Year
influenza. Therefore, this guidance focuses on appropriate prevention and control measures for the type of illness expected to be seen this fall and winter.

Decisions regarding appropriate actions to take in response to the introduction of influenza into a school should be tailored to the circumstances of that setting. *The least disruptive measures should be employed to control the spread of disease.* This means that in general, school dismissal will not be necessary, especially when less disruptive measures described below can be effectively and properly implemented. In making decisions about an appropriate response, schools should consider the affected age group (elementary versus secondary), the likelihood that ill students or staff were infectious when present at the school, the ability to implement prompt identity and exclusion of ill children, and compliance with exclusion recommendations by parents and guardians. School absenteeism rates and patterns are a critical element of sound decision-making. *Every school should closely monitor school absenteeism.* Decisions regarding what measures to take when influenza appears are best made by school officials in consultation with local and state health officials. The goal should be to minimize social disruption and safety risks to children. Based on the experience and knowledge gained in jurisdictions that had large outbreaks in spring 2009, the potential benefits of preemptively dismissing students from school are often outweighed by negative consequences, including students being left home alone, health workers missing shifts when they must stay home with their children, students missing meals, and interruption of students’ education. Therefore, school dismissal is considered to be only an option when other measures to control the spread of disease have been unsuccessful.

Basic foundations of infection control in school settings should always be promoted and facilitated, not only during an influenza pandemic. *During flu season, schools should be particularly vigilant about keeping sick students and staff home.* Schools should be proactive, develop contingency plans to cover key positions (for example, school nurses) when staff are home ill, and regularly remind parents and staff of the exclusion recommendations. Plans should focus on protecting people at high risk for influenza complications as these groups are frequently found in schools. For example, asthma alone affects nearly one in ten school-aged youth.

Successfully addressing influenza in schools requires effective communication with parents, guardians and staff. *Every school should have well established lines of communication to these groups, as well as the general community.* Experience in the spring of 2009 suggested that schools that had frequent communications with critical stakeholders were able to minimize disruption of educational activities without diminishing the health and safety of the school population.

**IDENTIFICATION**

Symptoms of influenza-like illness (ILI) that suggest possible pandemic influenza A/H1N1 include fever (measured temperature of \(>100^\circ\text{F}\)) and either cough or sore throat. Illness may be accompanied by other symptoms including headache, tiredness, runny or stuffy nose, body aches, diarrhea, and vomiting. Like seasonal flu, illness from H1N1 can vary from mild to severe. There is no way to distinguish influenza due to the pandemic strain from that caused by seasonal flu, and illness may look similar to that caused by other respiratory infections. This is why it is important to be in communication with local and/or state public health authorities and with health care providers.

**High-risk populations**

Some students and staff are at higher risk for complications of influenza. These individuals should be pre-identified. High-risk populations include:
- Children <5 years old
- Adults ≥65 years
- Persons with: Chronic lung disease (including asthma); cardiovascular disease (except high blood pressure); kidney, liver, or blood disorders (including sickle cell disease), nervous system, muscular, or metabolic disorders (including diabetes); or a suppressed immune system (due to medications, HIV, cancer, or organ transplant)
- Pregnant women
- Persons <19 years who are receiving long-term aspirin therapy

**Recommended school responses for the 2009-2010 school year**

1. **Stay home when sick:**
   Students and staff members with influenza-like illness (ILI) should not come to school. In general, individuals with ILI should stay home for at least 24 hours after they no longer have a fever, or signs of a fever, without the use of fever-reducing medicines. This recommendation should be adhered to whether or not the sick individual received treatment with antiviral drugs. Since the usual duration of fever is 2-4 days, this will allow most individuals to return after a period of 3-5 days of exclusion.

   Schools should have in place procedures to promptly identify children who become ill while at school. Schools should also evaluate students who return to school after influenza illness to make sure they are no longer ill with fever and are well enough to attend class. Successfully controlling school outbreaks, especially with the shorter duration of exclusion, is highly dependent on successfully identifying and excluding ill students and staff and not allowing ill persons to return too early.

   In some circumstances, it may be appropriate to extend the duration of the exclusion period. Such decisions should be made in conjunction with your local and state health department. More stringent and longer periods of exclusion – for example, until complete resolution of symptoms – may be considered for people returning to settings where high numbers of high-risk people may be exposed or in settings where the ability to adhere to a lesser exclusion period has been unsuccessful.

   Sick individuals should stay at home until the end of the exclusion period, to the extent possible, except when necessary to seek required medical care. Sick individuals should avoid contact with others. Keeping people with a fever at home may reduce the number of people who get infected since elevated temperature is associated with increased shedding of influenza virus. CDC/ PADOH recommend this exclusion period whether or not antiviral medications are used.

2. **Separate ill students and staff:**
   Sick students and staff should always be required to stay home. Students and staff who appear to have an influenza-like illness on arrival at school or who become ill during the day should be promptly separated from other students and staff and sent home as soon as possible.

   Schools should regularly update contact information for parents so that they can be contacted more easily if they need to pick up their ill child.
Recognizing that space is often in short supply, early planning on the location for a sick room is essential. This room should not be one commonly used for other purposes; for example, the lunchroom during non-meal times or the nurses’ room where care for other medical issues may be taking place. Nor should it be a space through which others regularly pass. It is not necessary for this room to have a separate air supply (HVAC) system. Ill persons should be placed in well ventilated areas and placed in areas where at least 6 feet of distance can be maintained between the ill person and others.

A limited number of staff should be designated to care for ill persons until they can be sent home. When possible, these should be people with limited interactions with other students and staff and therefore decreased risk of spreading influenza. These persons should not be at increased risk of influenza complications (for example, pregnant women – see categories above) and they should be familiar with infection control recommendations to prevent spread of influenza. When possible and if the sick person can tolerate it, he or she should wear a surgical mask when near other persons.

School nurses, and other staff who act in this capacity, are likely to come into close contact with students and staff with influenza-like illness. Staff members that provide care for persons with influenza-like illness should use appropriate personal protective equipment, such as a mask.

3. **Hand hygiene:**
Influenza can spread through contaminated hands or objects that become contaminated with influenza viruses. **Students and staff should be encouraged to wash their hands often with soap and water, especially after coughing or sneezing.** Alcohol-based hand cleaners are also effective at killing flu, but may not be allowed in all schools. If soap and water are not available, and alcohol-based products are not allowed in the school, other hand sanitizers that do not contain alcohol may be useful. However, there is less evidence on their effectiveness compared to that on hand washing and alcohol-based sanitizers.

Schools should provide the time needed for all students and staff to wash their hands whenever necessary, especially after coughing or sneezing into hands, before eating, and after using the restroom. Soap, paper towels and sanitizers are critical for proper hand hygiene and should be readily available in all schools. If it is necessary to provide supervision to students as they wash hands in rest rooms, schools should consider timing and staffing in their planning. Schools also should educate families, students and staff about the importance of good hand hygiene and proper methods for cleaning hands.

4. **Respiratory etiquette:**
Influenza viruses are thought to spread mainly from person to person when an ill individual coughs or sneezes. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and deposited on the mouth or nose or are inhaled by people nearby. **Students and staff members should be educated on the importance of covering their nose and mouth with a tissue when coughing or sneezing and throwing the tissue in the trash after use.** Wash hands promptly after coughing or sneezing. If a tissue is not immediately available, coughing or sneezing into one’s arm or sleeve (not into one’s hand) is recommended. To encourage respiratory etiquette, tissues should be readily available to
students and staff and they should be educated about the importance of respiratory etiquette, including keeping hands away from the face.

5. **Routine cleaning:**
Schools should regularly clean all areas and items that are more likely to have frequent **hand contact** (for example, keyboards or desks) and also clean these areas immediately when visibly soiled. Use the cleaning agents that are usually used in these areas. Additional or special environmental control measures are not necessary.

Schools should ensure that custodial staff and others (such as classroom teachers) who use cleaners or disinfectants read and understand all instruction labels and understand safe and appropriate use. School staff should regularly clean all areas that students and staff touch often with the cleaners they typically use. Special cleaning with bleach and other non-detergent-based cleaners is not necessary.

6. **Early treatment of high-risk students and staff:**
Persons at high risk for influenza complications who become ill with influenza-like illness should speak with their health care provider as soon as possible for appropriate treatment recommendations. Early treatment with antiviral medications is very important for people at high risk because it can reduce the risk of complications, including the need for hospitalization.

**Schools should encourage ill staff and parents of ill students at higher risk of complications from influenza to seek early treatment.**

High-risk students and staff who have had close contact with others who are sick with an influenza-like illness should contact their health care provider to discuss whether they may need to take influenza antiviral medications. In general, antiviral prophylaxis is not recommended for persons who are not at high risk of complications of influenza. Widespread use of antiviral prophylaxis is not considered an appropriate response to influenza in the typical school setting.

People on antiviral treatment may still shed influenza viruses and therefore may still transmit the virus to others. These influenza viruses may develop resistance to antiviral medications. To lessen the chance of spreading influenza viruses that are resistant to antiviral medications, adherence to good respiratory etiquette and hand hygiene is as important for people taking antiviral medications as it is for others.

7. **Consideration of selective school dismissal:**
Selective school dismissals may be considered based on the population and circumstances of an individual school. Although there are not many schools where all or most students are at high risk (for example, a school for medically fragile children or for pregnant students) in some instances this may be the appropriate response. The decision to selectively dismiss a school should be made only in consultation with local and/or state public health authorities and should balance the risks of keeping the students in school with the social disruption that school dismissal can cause. Selective school dismissals are not likely to have a significant effect on community-wide transmission: Instead, this strategy aims to protect students and staff at high risk of severe illness and death.

8. **Absenteeism monitoring**
Every school should closely monitor the patterns of school absenteeism. School absenteeism should be monitored on a daily basis and efforts should be made to determine if student or staff member absence is due to illness. Any increase in school absenteeism due to illness should be promptly reported to local and/or state public health authorities for an appropriate response. Promptly recognizing an outbreak of influenza is one of the best ways to assure the least disruptive measures can be implemented to limit the spread of disease.
ADDITIONAL INFORMATION

- CDC Guidance for State and Local Public Health Officials and School Administrators for School (K-12) Responses to Influenza during the 2009-2010 School Year [http://www.cdc.gov/h1n1flu/schools/schoolguidance.htm](http://www.cdc.gov/h1n1flu/schools/schoolguidance.htm)

- PADOH Public Web Site, H1N1 Flu (Swine Flu) [http://www.dsf.health.state.pa.us/health/cwp/view.asp?q=252990](http://www.dsf.health.state.pa.us/health/cwp/view.asp?q=252990)

- County Health Departments: [http://webserver.health.state.pa.us/health/comm/comm.asp?COUNTY=all](http://webserver.health.state.pa.us/health/comm/comm.asp?COUNTY=all)
Appendix 1

Flu Symptom Checklist for School Staff

☐ Yes ☐ No Does the student or staff member have a sore throat or a bad cough?

☐ Yes ☐ No Does the student or staff member have a fever of 100 degrees or more?

Here’s how to tell if a student or staff member has a fever using a thermometer:
  o Put the thermometer under the student’s or staff member’s tongue. Have the student or staff member close her/his lips around the thermometer. If the student is young, stay with the student while the thermometer is in the mouth. You can hold it in place.
  o If you are using a digital thermometer, follow manufacturer instructions. Use prone covers when taking the temperature to any student or staff.
  o It takes about one minute to check a temperature by mouth. A digital thermometer beeps when it is ready to read. The student’s or staff member’s temperature shows on the thermometer like this:

[100.2 °F] One hundred point two [102 °F] One hundred and two

If you are unable to take the student’s or staff member’s temperature, you can look for these signs of fever:
  o The student’s or staff member’s face may be red. Skin may be hot to touch or moist.

If a student or staff member has a fever AND you answered “yes” to the other question above (she/he has a sore throat or cough), the student or staff member might have the flu.
Languages:
English
En Español
Chinese
Korean
Russian
Vietnamese

SCHOOL POLICY UNDER CONDITIONS OF INCREASED SEVERITY

In the event The CDC assesses that H1N1 has reached more severe conditions, local school districts may want to consider these additional measures:

Actively screen students and staff as they arrive each morning, with subsequent separation of the sick.
Keep vulnerable students and staff home preemptively.
Keep students with ill household members at home.
Increase distance between students; moving desks further apart, postponing assemblies, etc.
Extend the period for ill students and staff to stay home beyond the recommended 24 hours until after the fever ends naturally.
Dismiss school

Kids! See How Elmo Does It!

Message to Schools from Secretary James and Secretary Zahorchak

© 2009 Pennsylvania Department of Health. All rights reserved.

Contact Us
Privacy Policy
Facebook
Twitter

http://www.h1n1inpa.com/info-for-specific-groups/information-for-schools/school-policy... 11/30/2009
Languages:
English
En Espanol
Chinese
Korean
Russian
Vietnamese

SCHOOL POLICY UNDER CONDITIONS SIMILAR TO SPRING 2009

Stay home when sick for at least 24 hours after the fever ends naturally (without the aid of fever-reducing medication)
Separate sick students and staff. Designate a room in the school for sick students and staff to rest until they can be sent home. The CDC recommends these individuals, as well as those caring for them, wear a mask.
Promote good prevention techniques, including covering your cough/sneeze and frequent hand washing.
Clean routinely with the school's regular cleaning supplies.
Treat vulnerable students and staff early.

© 2009 Pennsylvania Department of Health. All rights reserved.

Contact Us
Privacy Policy
Facebook
Twitter
November 2, 2009

Dear Superintendent/School Administrator:

The Pennsylvania Department of Health (PADOH) continues to monitor statewide influenza activity and control efforts. As the burden of 2009 H1N1 influenza (H1N1) has increased in our schools and communities, learning from our combined experience is critical to improve our response to the current and future epidemics of influenza.

PADOH, with support from the Pennsylvania Department of Education (PDE) and the US Centers for Disease Control and Prevention (CDC), is conducting a survey of current practices for prevention and control of influenza in our schools. The purpose of the survey (Survey of Non-Pharmaceutical Interventions for Pandemic Influenza A/H1N1 Influenza in Pennsylvania Schools) is to assess the effectiveness and acceptability of various influenza prevention measures, such as school closures, hand hygiene promotion, and cancellation of extracurricular events. Results of the survey will be used to inform future prevention guidelines to make them more effective and feasible.

This brief, 20-30 minute, online survey asks questions about prevention and control policies that your school(s) may be considering or have already implemented following the emergence of H1N1. A few questions regarding school characteristics will also be asked to provide context for the policies at your schools.

We hope that you will lend your endorsement to this voluntary survey and encourage your schools to participate.

How to participate:

We are asking for your help in identifying a point of contact within each of your schools. To minimize the burden on you, we suggest simply forwarding this e-mail with your personal endorsement to a point of contact within each school.

We are asking schools to complete the survey online, or fax a completed printable version by Thursday, November 5th. The secure online survey and printable version can be found at:

http://www.health.state.pa.us/flusurvey
Please remember that this survey is entirely voluntary. Your school district does not need to participate. Furthermore, if you choose to lend your endorsement to this survey, some schools may choose to participate while others may opt out.

**Influenza Prevention Survey FAQ’s**

1. **Is this voluntary?** Participation is voluntary, but we strongly encourage schools to complete this survey to improve our ability to protect our students and staff from influenza.

2. **Is this survey related to the weekly PADOH absenteeism/influenza-like illness (ILI) monitoring system that many schools are participating in? Does my school need to participate in the monitoring system to take this survey?** This survey is separate from the sentinel school weekly monitoring system. Participation in the monitoring system is not a prerequisite for taking this survey. However, both systems provide complementary information about influenza that will greatly enhance our ability to control it. Therefore, all schools are encouraged to participate in both. For more information and to enroll, see:

   [http://www.health.state.pa.us/fluschoolenroll](http://www.health.state.pa.us/fluschoolenroll)

3. **Who should fill out the survey?** Can all the questions be answered by one person? The survey might be best answered with input from various staff (administrator, school nurse, etc). Since the online survey can only be filled out by a single user, the point of contact might find it helpful to print and complete a paper copy (attached to this email as a PDF file and online), prior to entering the data online.

4. **Will survey results be used to judge our school’s flu response in any way?** School responses to the survey are confidential. Schools will not be penalized for any of their survey responses, and the results will not be used in any regulatory action. Individual school buildings will not be identified in any reports or recommendations resulting from this survey.

5. **Is student privacy protected?** Although the survey asks some questions about the demographics of your school, no information about individual students will be collected or used in any way.

6. **Should we be implementing the practices asked about in the survey?** The specific questions and answers do not necessarily imply a recommendation from the PADOH, PDE or CDC. For specific guidance for influenza prevention and control, please consult the PADOH “Guidance for School (K-12) Responses to Influenza during the 2009-2010 School Year,” available at:

   [http://www.health.state.pa.us/assets/media/PA-DOH-Guidance-for-Schools-2009-2010.pdf](http://www.health.state.pa.us/assets/media/PA-DOH-Guidance-for-Schools-2009-2010.pdf)

7. **Will schools be notified of survey results?** A summary of survey results in aggregate form will be made available to participating schools.

8. **When is the survey due?** We are asking participating schools to complete the survey by Thursday, November 5th, 2009.

9. **When will the spring 2010 follow-up survey be distributed?** The follow-up survey will be distributed to participants at a date to be determined, depending on the duration of the current influenza season.

If you have additional questions about this survey, please contact Dr. Vanessa Short of the PADOH at (717) 787-3350 or v-short@state.pa.us.

Thank you for your consideration to participate in this important project.

Sincerely,

Michael Huff, RN

Michael Walsh
FREQUENTLY ASKED QUESTIONS

2009 H1N1 Influenza
Preventing H1N1
Treating H1N1
2009 H1N1 Vaccine
Older Pennsylvanians
Special Populations
Workplace and Employers
Healthcare Providers
Emergency Medical Services (EMS)
Schools (K-12)
2009 H1N1 in Pets

2009 H1N1 Influenza

What is 2009 H1N1 influenza?
2009 H1N1, also called swine flu, is a new influenza A(H1N1) virus that has not previously circulated among humans. The 2009 H1N1 flu virus was first reported in the U.S. in April 2009.

What is an influenza pandemic?
An influenza pandemic occurs when a new flu virus appears for which people have little or no immunity. On June 11, 2009, the World Health Organization (WHO) indicated that a pandemic of 2009 H1N1 flu was underway around the world.
Why are we so worried about 2009 H1N1 when more than 36,000 people die every year in the U.S. from seasonal flu?
Seasonal influenza occurs every year and, although the viruses also change yearly, many people have some immunity to those viruses which helps limit infections. Unlike seasonal flu, 2009 H1N1 is a new virus. Most people have little or no immunity to it, which means it can cause more infections than are seen with seasonal flu.

Is H1N1 different from seasonal flu?
Yes. The symptoms are similar. However, the groups most vulnerable to complications from 2009 H1N1, as well as the patterns the Centers for Disease Control and Prevention (CDC) are noticing as the virus spreads, are different.

How do people become infected with the virus?
The 2009 H1N1 flu virus appears to be as contagious as seasonal influenza and is spreading fast, particularly among people 10 to 29 years of age. The H1N1 virus is spread person-to-person by contact through the coughs and sneezes of people who are sick, as well as by touching infected objects then touching your eyes, nose or mouth.

How do I know if I have 2009 H1N1?
H1N1 causes symptoms similar to seasonal flu and can include: fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills, fatigue, and sometimes vomiting and diarrhea.

*It is important to note that not everyone with the flu will have a fever.
Preventing H1N1

What can I do to keep from getting the H1N1 flu virus?
A flu vaccine is the first and most important step in protecting against flu infection. You should determine if you are among the priority groups who should receive the 2009 H1N1 vaccination.

Reduce your risk for catching H1N1 by practicing good prevention techniques like:

sneezing and coughing into a tissue or your sleeve,
keeping your hands away from your face and not touching your mouth, nose or eyes,
washing your hands frequently with soap and water or using an alcohol-based hand sanitizer,
keeping frequently used surfaces clean, and
avoiding contact with people who are sick when possible and staying home if you get sick.

What is the best way to keep from spreading the H1N1 virus if you are sick?
If sick, you should stay home until at least 24 hours after your fever is gone (without the use of fever-reducing medicines) except to get medical care. Keep away from others as much as possible. Cover your mouth and nose with a tissue when coughing or sneezing and put your used tissue in the trash. Then clean your hands every time you cough or sneeze. Use household disinfectants on commonly used surfaces to reduce the risk of infecting others.

I think I might have some H1N1 flu symptoms. Should I still go to work?
No. Anyone who thinks they have H1N1 flu should stay home from work, school, travel, shopping, social events and public gatherings to reduce the risk of spreading the virus. Treat yourself for the flu until your fever ends naturally (without the use of fever-reducing medications). You should leave home only to seek medical care. If you get sick with flu symptoms and are at high risk of flu complications or you are concerned about your illness, call your healthcare provider for advice.
I have a family member at home who is sick with 2009 H1N1 flu. Should I go to work?
Employees who are well but who have an ill family member at home with 2009 H1N1 flu can go to work as usual. These employees should monitor their health daily and take precautions including covering their coughs and sneezes with a tissue and washing their hands often with soap and water or an alcohol-based hand sanitizer, especially after they cough or sneeze. If they become ill, they should notify their supervisor and stay home. Employees who have an underlying medical condition or who are pregnant should call their healthcare provider for advice because they might need to receive influenza antiviral drugs.

Should I do any special household cleaning if someone at home is sick with H1N1?
Daily cleaning with a household disinfectant will help reduce the spread of the virus to family members who are not sick. Focus on frequently used surfaces like handles, remote controls, bathroom surfaces, etc.

What's the best technique for washing my hands?
The CDC recommends washing with warm water and soap for at least 20 seconds (equivalent to singing the "Happy Birthday" song three times). When soap and water are not available, alcohol-based disposable hand wipes or gel sanitizers may be used. If using gel, rub your hands together until the gel is dry. Also, help children wash their hands. It keeps them healthier and encourages good prevention techniques from an early age.

Treating H1N1
I'm pregnant. Should I take any special precautions?
Pregnant women are among the priority groups of people that are more likely to develop complications from the H1N1 flu. The CDC recommends that pregnant women should consider the H1N1 vaccination. Receiving the vaccination is one step for prevention. Others include good prevention techniques like frequent hand washing, and making sure to protect yourself if a sick person is in your home.

**My child has a fever. Could she have H1N1?**

H1N1 symptoms can include fever over 100°F (although not everyone with the flu has a fever), along with sore throat, cough, runny or stuffy nose, fever, body aches, headache, chills, fatigue and possibly diarrhea and vomiting.

Children are among those most vulnerable to complications from the H1N1 virus so watch for warning signs that may mean your child needs emergency treatment, including fast breathing, bluish or gray skin color and not waking up or not interacting.

**Are antiviral medications (Tamiflu and Relenza) recommended for H1N1?**

Although most people's H1N1 symptoms will resolve without medical treatment, antiviral medications can help lessen the symptoms and are recommended particularly for those considered most vulnerable to complications from the virus. Healthcare providers can prescribe these drugs when appropriate.

**Will a mask help prevent the spread of H1N1?**

The CDC has suggested only a few groups of individuals should consider wearing a mask to prevent the spread of H1N1. A few of these include people most vulnerable to complications from the virus who are taking care of a sick person in their home, those sick from the virus traveling outside their home for medical care and healthcare workers who are treating individuals suspected of having H1N1.
I had H1N1 and have been coughing for several weeks. Is this normal?
In most instances, the duration of illness from influenza is about 7 days, and illness from the pandemic strain has been similar to that seen with seasonal influenza. However, there is a range of duration. For some, it can take several weeks for cough to completely go away. Seek medical care if your flu-like symptoms improve, but then return with fever and a worse cough.

What are the chances that my family can get reinfected with this virus?
Like any influenza virus, individuals already infected with 2009 H1N1 can get it again, especially as the period of time increases from the previous infection. This is because natural immunity decreases over time and the virus may mutate and evolve, meaning prior immunity may not be as effective against later versions of the virus.

2009 H1N1 Vaccine
Who should get vaccinated against H1N1?
Everyone should get vaccinated against H1N1. Five groups have been determined by the CDC as being most vulnerable to complications from the H1N1 virus. They include:

- pregnant women,
- children six months to adults 24 years,
- healthcare providers and EMS personnel,
- parents and caregivers of children under six months, and
- people under 65 years of age with certain pre-existing medical conditions (like chronic lung disease such as asthma, heart disease, kidney disorders, cancer or weakened immune systems).
Initial doses of vaccine in Pennsylvania have been targeted to the priority groups. The PA DOH is encouraging certified providers to begin offering the vaccine to people outside the target groups if they feel they have vaccinated all of their high-
risk patients. The department will also provide vaccine for the general public beginning in January. Check the "What's Hot" section of www.H1N1inPA.com for clinic information.

Are there any side effects to the H1N1 vaccine?
The potential side effects may be similar to those of the seasonal flu vaccine and include soreness, redness or swelling at the injection site, fever, and aches.

As with any medical intervention, there can be immediate complications from flu vaccine. Persons with allergies to eggs, or who have had previous problems with flu vaccine, should not receive it. Many people fear receiving shots, and it is expected that some recipients will be anxious beforehand or may even faint as a result. Vaccine administration sites should always be prepared for allergic reactions to the vaccine.

How much does the vaccine cost?
The federal government is providing the vaccine and the supplies to administer the vaccine free of charge. The vaccine is free at all public health vaccination clinics. Check the "What's Hot" section at www.H1N1inPA.com frequently for clinic information. Private providers may charge a vaccine administration fee.

Will any group be mandated to get vaccinated such as healthcare workers?
No, the vaccination is completely voluntary.

How is the H1N1 vaccine given?
The H1N1 vaccine is available in two forms: by syringe injection (some are thimerisol-free) or by thimerosol-free nasal spray (only for healthy people 2-49 years of age).
Will two doses of vaccine be required?
The U.S. Food and Drug Administration has approved the use of one dose of 2009 H1N1 flu vaccine for persons 10 years of age and older. Children under 10 years of age and under will need two doses of the vaccine, four weeks apart. Infants younger than 6 months are too young to get either the 2009 H1N1 or seasonal flu vaccines.

How will I know where to go to get the vaccine when it's available?
The PA DOH regularly issues press releases to update the public on the status of vaccine availability in Pennsylvania. Information is also updated frequently in the "What's Hot" section of www.H1N1inPA.com. Individuals without Internet access can call 1-877-PA-HEALTH (1-877-724-3258).

I just got the seasonal flu vaccine. Do I need a different vaccine for H1N1?
Yes. The H1N1 vaccine is recommended in addition to your seasonal flu vaccine.

Can the seasonal flu and H1N1 vaccine be given together?
Yes, these vaccines can be given at the same time. Evidence to date suggests there should be no interference or interaction between the two vaccines if they are co-administered. However, the seasonal and 2009 H1N1 nasal sprays should not be given at the same time.

Should I get vaccinated against 2009 H1N1 if I have had flu-like illness since spring 2009?
If you were ill but do not know for certain that you had 2009 H1N1, you should get
vaccinated if your doctor recommends it. The symptoms of flu are similar to those caused by many other viruses. Even when influenza viruses are causing large numbers of people to get sick, other viruses are also causing illnesses. Testing is needed in order to tell if an illness is caused by a specific influenza strain or by some other virus. Since most people with flu-like illnesses will not be tested this season, the majority will not know whether they have been infected with 2009 H1N1 flu or a different virus.

**I was vaccinated against the 1976 swine influenza. Do I need the 2009 H1N1 vaccine?**
Yes. The 1976 swine flu virus and the 2009 H1N1 virus are different enough that it's unlikely a person vaccinated in 1976 will have full protection from the 2009 H1N1. People vaccinated in 1976 should still be given the 2009 H1N1 vaccine.

**Older Pennsylvanians**

**Why aren't people 65 and older in the target groups?**
There are two main reasons why people age 65 and older are not included in the groups recommended to get the initial doses of 2009 H1N1 vaccine:

People age 65 and older are least likely to get sick with this virus. Initial available doses of vaccine are very limited, so the first doses are recommended to go to those who are most likely to get infected and be at risk for complications.

There has been very little 2009 H1N1 illness in people 65 and older since the virus emerged in the spring. This has been true both in the United States and in the Southern Hemisphere during their flu season. Studies of who is most likely to be infected with 2009 H1N1 show that people 65 and older are the least likely to get sick with this virus. Laboratory tests on blood samples indicate that older people likely have some pre-existing immunity to the 2009 H1N1 flu virus.
Will people age 65 years and older be able to get the 2009 H1N1 vaccine this season?
Yes. The PA DOH is encouraging certified providers that have vaccinated all of their at-risk patients to offer the vaccine to individuals outside of those groups. The PA DOH will also hold vaccine clinics beginning in January for Pennsylvanians who do not have access to it through their healthcare provider or do not have a provider. Check the "What's Hot" section of www.H1N1inPA.com or call 1-877-PA-HEALTH (1-877-724-3258) for more information.

Should people age 65 and older get the regular seasonal flu vaccine this year?
Yes. CDC's priority for people 65 and older is to have them get their regular, or "seasonal," flu vaccine as soon as possible while waiting for more doses of the 2009 H1N1 vaccine to become available. Seasonal flu viruses are expected to circulate along with 2009 H1N1 viruses this season. People age 65 and older are at increased risk for complications from seasonal influenza compared to younger people and are recommended for annual seasonal flu vaccines. This year is no exception.

What should people age 65 and older do if they feel like they have the flu?
People age 65 and older should seek medical advice quickly if they develop flu symptoms this season to see whether they might need medical evaluation and possible treatment with antiviral medications. People 65 and older are prioritized to get antiviral drugs if they become sick with the flu according to CDC's antiviral guidance this season.

Special Populations
What would you recommend to parents who have severely disabled children
when H1N1 is in their school?
Not all disabled students are at high risk of complications from influenza. However, for those who are medically fragile, the presence of influenza in a school can be a concern. Since every medically fragile student is different, parents should discuss their concerns with their healthcare provider and seek recommendations and share them with school authorities. If such students are exposed to influenza in the school, they should be strongly considered as candidates for antiviral prophylaxis. If significant levels of influenza are present in the school, authorities may consider separating medically fragile students from the rest of the class or parents may consider keeping their child at home until illness subsides in the classroom.

How is information about the H1N1 virus being shared with Pennsylvanians who have disabilities?
The Department of Public Welfare will be working with its licensed facilities and advocacy groups to communicate information about the H1N1 virus and vaccine availability. The PA DOH, through its Office of Public Health Preparedness, will also share communications with the members of its Special Populations Work Group to distribute.

The PA DOH also conducts mass vaccination clinics at sites that meet Americans with Disabilities Act (ADA) requirements. Clinic information is available by visiting the "What's Hot" section of www.H1N1inPA.com. This information can also be obtained by calling 1-877-PA-HEALTH.

What 2009 H1N1 info is available for the deaf community?
DeafMD and the CDC are working hard to provide the deaf community with the most up-to-date information available to help reduce the spread and severity of the illness, and to provide information to help healthcare providers, public health officials and the public address the challenges posed by this emergency. A signed public service announcement can be viewed at www.cdc.gov/h1n1flu/deaf.htm.
Workplace And Employers

What can employers do to deal with H1N1?
Employers should encourage any employees infected with H1N1 to stay home to stop the risk of spreading the virus throughout the workplace. Employers can also consider using a preparation checklist to plan early regarding business continuity and potential absenteeism, as well as downloadable materials to aid in communication with employees. These items can be found at www.H1N1inPA.com.

What information should I give my employees regarding vaccination?
Encourage employees to get the 2009 H1N1 vaccine when it becomes available in large quantities. You should also encourage your workers to obtain a seasonal influenza vaccine, if it is appropriate for them. This helps to prevent illness from seasonal influenza strains that may circulate at the same time as the 2009 H1N1 flu.

Is it realistic to expect an hourly worker without benefits to stay home unless they're extremely ill or have to stay home with a sick child?
For the large part, this is a workplace issue. However the guidance is to stay home if you are sick. It is clear that this could be unrealistic in some circumstances. Part of the coordinated message from both employers and the PA DOH is to advise employees to plan for this scenario. They need to talk to babysitters ahead of time, speak with their employer to see how they are going to handle this situation, and get vaccinated to avoid illness.

Where can my company get information to help us plan for this pandemic and communicate with our employees?
A section is devoted to Workplaces and Employers on www.H1N1inPA.com, under "Info for Specific Groups." This section, which also includes a
communication toolkit you can use to convey important information to your employees, will help your business prepare for the H1N1 pandemic.

Healthcare Providers

Where can nurses get training in vaccine administration?
The PA DOH District Offices will be offering trainings to nurses who volunteer to participate in mass vaccination clinics. The trainings will be hands-on, with models for both adult and pediatric intramuscular injections. Call 1-877-PA-HEALTH for additional information.

If a facility orders the number of doses they would need to cover their employees, what are they to do with leftover doses?
Any unused vaccinations could be used for patients meeting the priority group guidelines or be sent back to the PA DOH to be used elsewhere. Call 1-877-PA-HEALTH for additional information.

Will the state be providing a generic consent form to be used when administering the H1N1 vaccine or will each site be responsible for creating their own document?
A consent form is available at www.H1N1inPA.com. Vaccination sites can either use this form or create their own.

In our residential adolescent and adult drug and alcohol treatment center where "dormitory" living is the norm, what should our response be to persons with flu like illness?
The guidance for colleges/universities may be helpful in your planning, as it addresses dorm living. The guidance is available at www.H1N1inPA.com.
Emergency Medical Services (EMS)

Are Fire and Law enforcement included in the term "EMS personnel"?
For the priority groups, "EMS personnel" is defined by the CDC as personnel whose primary function is in healthcare provision. The PA DOH will begin offering vaccine in January to any Pennsylvania resident who wants it.

I'm a first responder, how should I manage patients with confirmed or suspected H1N1?
The CDC has specific guidance documents for EMS and 9-1-1 personnel:

Managing Calls and Call Centers during a Large-Scale Influenza Outbreak: Implementation Tool
EMS and 9-1-1 Personnel: Managing Confirmed or Suspected Infections
Both documents can be found on the CDC Web site at http://www.cdc.gov/h1n1flu/guidance/.

Schools (K-12)

What are schools doing to deal with H1N1?
Pennsylvania schools have been advised to prepare for both student and staff H1N1 infections. In addition to encouraging good prevention techniques, commonwealth schools will follow a preparation checklist to best avoid the necessity of closing any schools.

General H1N1 Info

Is there a uniform evaluation matrix that schools should use to assess illness in students?
The general definition used for influenza-like illness is fever over 100°F (although
not everyone with the flu will have a fever) with cough and/or sore throat. Children who meet these criteria should be considered to have flu unless there is an alternate explanation (like strep throat).

The requirement for returning to school is the absence of fever for at least 24 hours without the aid of fever-reducing medications. However, not all infected persons have the classic signs or symptoms of flu. Consideration should be given to this diagnosis whenever there is an outbreak of respiratory illness in a school setting. If in doubt, contact your local and/or state health department.

**Because 2009 H1N1 is the same as regular flu in severity, should schools tell teachers, students, and parents not to worry?**

Influenza is always a serious disease, whether due to pandemic or seasonal strains, and everyone should take steps to control and prevent the flu. While the severity of disease associated with H1N1 has been similar to seasonal flu, there are special concerns due to the pandemic strain. These include its disproportionate impact on school-age persons and the potential for disease associated with it to increase in severity, as has occurred with past pandemics. Students, parents, and other members of the public make better decisions when they are informed about health risks and know the steps they can take to reduce their risks.

**Does someone develop immunity after natural infection against 2009 H1N1? Do people with known infection still need to be immunized with the pandemic vaccine?**

People do develop immunity against the pandemic influenza virus after natural infection, just as they do against seasonal flu. Like with other types of flu, persons with impaired immune systems (due to disease or medication) do not develop as good a level of immunity as others. However, previous infection does not assure protection against subsequent infection, especially because the virus naturally changes over time. This is why people of all ages can repeatedly get the flu. There is no additional risk from vaccination if someone has previously had the disease.
What is meant by prophylaxis?
Prophylaxis refers to a measure taken for the prevention of a disease or condition. Vaccination is a form of prophylaxis. However, with the flu, the term generally refers to giving individuals medications like antivirals to keep them from becoming ill. The medication can be given either before or after someone is exposed to the flu. In general, pre-exposure prophylaxis is not being recommended for H1N1 as the medication would need to be taken for an extended period of time. Post-exposure prophylaxis for H1N1 is appropriate for individuals at high risk of flu complications, and is generally not recommended for other exposed persons.

If a child in a family is identified with H1N1 may schools exclude brothers and sisters or must they wait until they get the flu?
Exclusion of healthy siblings of someone with influenza is not generally recommended. They should be observed for signs or symptoms of illness over the seven days following last exposure to the ill person(s), and if they become ill they should be sent home. In addition, if the individual falls into a group at high risk of flu complications, they should be considered for antiviral prophylaxis.

What constitutes a sick room? A curtain? Wall?
A sick room is an area where an ill individual can be taken prior to evaluation or removal from the school premises. Separation means at least 6 feet of space between ill and well individuals. Ideally, there should be a physical barrier between the ill and well persons, such as a wall and a door that can be closed. If such a location is not available, a curtain is a reasonable alternative.

Preventing/Stopping the Spread of H1N1 in Schools

http://www.h1n1inpa.com/frequently-asked-questions/#schools 2/18/2010
Do you recommend desk cleaning on a daily basis?
Pennsylvania's school guidance recommends routine cleaning and disinfection in schools, with special attention to frequently used surfaces and objects. This would especially apply to surfaces and objects that are handled by many persons (door handles or computer keyboards), where daily cleaning may be necessary when influenza-like illness is occurring.

Do you recommend disinfecting school buses?
Routine cleaning of school buses should be adequate. However, if an ill student has clearly contaminated an area of the bus with respiratory secretions, that area should be cleaned using appropriate cleaning products before the next use.

Are there recommendations for specific alcohol-based or alcohol-free hand sanitizers?
Soap and water or alcohol-based hand sanitizers are the preferred hand hygiene products for use against influenza. However, if there are reasons not to use alcohol-based hand sanitizers, non-alcohol based products are a reasonable alternative when soap and water are not readily available and are preferable to not practicing hand hygiene.

We have heard that alcohol-based hand sanitizers are flammable. Is this a concern?
These products do contain alcohol, and must be properly handled so they do not pose any health or safety risks. They can be safely and effectively used in many school settings. Care should be taken to make sure they are not intentionally or unintentionally in proximity to fire, and they are not for oral consumption.

With young children, efforts should be made to oversee or observe their use. If there are any questions or concerns about alcohol-based hand sanitizers, soap and
water are an acceptable alternative.

**Is there a time-limit for the use of surgical masks?**
No. However, their effectiveness deteriorates over time and they become more difficult to use as they become dirty or moist. In addition, it is generally difficult for an individual to use a mask for an extended period. If in doubt, a used mask should be properly disposed of and a new one substituted. In addition, non-reusable personal protective equipment (PPE) should not be shared, and reusable PPE should only be shared after proper cleaning and disinfection.

**Are masks recommended for the current level of severity or only if the H1N1 virus becomes worse?**
Use of surgical masks while caring for ill individuals with pandemic influenza or to be used on ill individuals if they can tolerate the mask prior to removing them from the school is appropriate regardless of disease severity.

**Student Absences due to H1N1**
**For absenteeism, should we contact the PA DOH only when there is a certain percentage of absent students? What are the guidelines for excessive absenteeism?**
Every school should establish the baseline level of absenteeism that is expected for that school, and how much normal variation there is around that baseline. Every school will have a different baseline. As a result, there is no set definition for "excess" absenteeism, especially when it is caused by illness.

**Is there a reporting vehicle for school absenteeism, such as school nurses reporting flu-like illness?**
When excess absenteeism is identified, schools should promptly contact their local
and/or state health department, either by e-mail or telephone, to discuss the situation and decide on an appropriate course of action. The PA DOH is requesting that some schools around the state routinely report school absenteeism and students seen with influenza-like illness as part of our enhanced monitoring of the patterns of influenza in the commonwealth.

**How should schools handle a high rate of absenteeism due to hysteria/panic versus actual illness?**

It is important to determine whether excess absenteeism is due to actual illness or because parents are keeping their child at home due to concerns about the safety of the school environment. If the latter occurs, frequent communications with parents about what steps are being taken to limit the spread of infection in the school should be the rule. The best method to deter panic is to proactively inform parents, students and the community about ways to prevent the spread of influenza, including vaccinations, frequent hand washing and sneezing into a tissue or upper sleeve.

**Is the PA DOH requiring or recommending a doctor's note when a student returns to school after having been absent for a confirmed case of H1N1 or an ILI?**

Such decisions are best made on a district-by-district basis. However, PA DOH guidance indicates that a student or staff member can return to school once they no longer have a fever for 24 hours without the use of fever-reducing medications. This recommendation is made regardless of whether or not the individual has been cleared by their healthcare provider to return. In addition, if the student or staff member is obviously ill, especially if they have a fever, they should be sent home regardless of clearance from a healthcare provider.

**When monitoring attendance, at what point should schools contact parents to**
check on the child(ren)?
There is no specific answer to this question. In general, the period of fever for 2009 H1N1 lasts from 2-4 days after illness onset. Most children should be able to return to school after an exclusion period of 3-5 days.

How quickly will schools be informed when there is a confirmed case of pandemic influenza among the students?
As with any other disease that could be spread in school, parents are encouraged to inform school authorities if their child develops influenza like illness, or if they are diagnosed with influenza (whether or not the infection has been confirmed through laboratory testing). In this way, the school can take measures to ensure the health and safety of other students and staff, reinforce prevention messages, and be on the lookout for other illness. It is important to note that only a fraction of illness due to influenza is ever laboratory confirmed. There is no requirement for a parent to report illness in their child, even if laboratory confirmed. Under the Disease Prevention and Control Law, the PA DOH is prohibited from releasing patient-specific information unless necessary for public health purposes. However, schools can be informed about the occurrence of illness without divulging patient-specific information for the purposes of assuring an appropriate response.

Who do parents contact at the Department of Education if school officials are not flexible with excessive absence of a child resulting in report of truancy and subsequent fines?
It is the responsibility of each district to determine the validity of excuses and have clear written policies regarding absences. Absences that are reported in a timely manner and qualify as excused absences for health or medical reasons do not meet the definition of truancy, so flu-related absences that are reported in a timely manner would not result in a truancy situation. Under state law, students who miss 10 consecutive school days shall be dropped from the active membership roll
unless the school is provided with evidence the excuse is legal or the school is pursuing compulsory attendance prosecution.

School Closures
Will schools close because of H1N1?
Schools will take significant precautions to keep from closing due to H1N1 outbreaks.

If a school must dismiss due to the H1N1 flu, is the PA DOH still recommending the school stay closed for five school days?
There is no standard recommendation at this time. School dismissal will remain an option, but the current recommendation is to take such action only if there is evidence that other measures are not working. School districts are encouraged to work closely with their local and state health departments to evaluate the situation and respond appropriately. Cooperation between school districts and public health entities will ensure the best course of action is taken to both protect the students and minimize the impact and burden on affected families and communities.

If a school dismisses for a period of time due to H1N1, will either the federal or state education associations grant a school relief from the mandatory 180 school days?
The Pennsylvania Department of Education will review those situations individually and consider granting a waiver from the mandatory 180-day requirement on a case-by-case basis.

How is PDE recognizing these school closings?
In the case of a widespread outbreak in a school, the Pennsylvania Department of Education works closely with the Department of Health and local school officials.
to determine the best course of action. If it is determined that a school closing is the best option, the state will assist the district in determining the how long the school should be closed and whether students affected can be temporarily accommodated.

Should entire districts close or can one school within the district close depending on absenteeism?
School districts should always employ the least disruptive measures that will accomplish protecting the health and safety of students and staff members while allowing educational activities to continue. In most instances, this would mean decisions regarding closure should be made at the individual school level rather than the larger school district.

If we close one school due to an outbreak, but have no problems in others, may we disclose that a confirmed case was at School X, without violating disclosure?
The Disease Prevention and Control Law provisions regarding disclosure pertain to activities of the Department of Health, not to other entities. In general, schools should share with parents and other stakeholders important information such as the occurrence of influenza in their child's school and the actions that are being taken to reduce the potential for disease transmission.

About the H1N1 Vaccine
Are school-age children in the priority groups that should be vaccinated against H1N1?
Yes. Five groups have been determined by the CDC as most vulnerable to complications from the H1N1 virus. They include,
pregnant women,
children six months to adults 24 years,
healthcare providers and EMS personnel,
parents and caregivers of children under six months, and
people with certain pre-existing medical conditions (like chronic lung disease such as asthma, heart disease, kidney disorders, cancer or weakened immune systems).

**Will the H1N1 vaccine be yearly, or is this a one-time vaccination?**
Most experts anticipate that the pandemic influenza A/H1N1 strain will persist and probably replace one or more of the seasonal influenza strains. If that happens, it will then become a seasonal influenza strain and be incorporated into the normal seasonal influenza vaccine. So the need to receive a separate H1N1 vaccine and seasonal vaccine this year, will likely not occur in future flu seasons.

---

**Schools as Vaccine Sites**

*Would a school that volunteers to be a vaccination site have to take in everyone in their area wishing to be vaccinated, such as non-public school students?*
That will be a local, school district by school district decision. Non-public and private schools should contact their school districts for planning if they will not be a vaccination site.

*My school district would like to offer the H1N1 vaccine, but does not have sufficient school nurse coverage to administer to every student who might want it. What are our options?*
Schools can recruit volunteers from the community or they can contact the PA DOH for assistance. PA DOH nurses are available to assist with H1N1 vaccine administration. In addition the PA DOH has contracts in place with temporary nursing agencies and EMS providers to assist schools with vaccine administration.

*Will the PA DOH provide hazardous material disposal assistance for the waste*
associated with H1N1 vaccine administration?
Yes. If a school does not have access to a service that provides hazardous material disposal, contact the PA DOH at 1-877-PA-HEALTH and request assistance.

How should schools handle leftover vaccine?
Any remaining vaccine that will not be utilized should be returned to the PA DOH for use elsewhere. Schools should contact the Department of Health District Office in their area to arrange a timely return of the unused vaccine.

For students who are medically fragile and/or take a variety of medication, should the families go to their family physician for the vaccination rather than a school setting?
Flu vaccine is routinely given to many medically fragile individuals with underlying health problems. These individuals receive the vaccine in a variety of settings. So there is no specific reason that a medically fragile individual cannot be vaccinated as part of a school immunization campaign. However, there may be concerns about them receiving a specific type of vaccine (injectable versus inhaled) or whether or not they should be vaccinated. If there is any question about a student receiving the vaccine, their healthcare provider should be contacted or they should be referred to their healthcare provider to give the vaccine.

2009 H1N1 In Pets
Do animals and humans share influenza viruses?
Many different influenza A virus subtypes occur in animals, such as cats, birds, dogs, ferrets, horses, pigs, seals, turkeys and whales. Most are not known to produce illness in humans. Influenza in pigs is of special concern because the cells that line a pig’s respiratory tract can easily become infected with more than one
influenza virus at the same time, including influenza viruses from both animals and humans. The genetic material of those two subtypes can mix, thereby creating new (also known as recombinant) influenza viruses. An influenza pandemic can occur when a new virus subtype to which animal and human populations have little immunity begins to spread. This happened with the 2009 pandemic H1N1 influenza A virus.

**Can my pet become infected with the H1N1 virus?**
Until recently, it was believed that the pandemic H1N1 virus would not jump between species and produce infections in other animals. However, several instances of pandemic H1N1 infection in cats and ferrets demonstrate that these animals can also become infected too, likely due to spread from ill persons. Domestic pets that live indoors often have very close contact with their owners and that increases their chances of being exposed to human diseases. The best public health advice with regard to your pet is to always use common sense. This includes carefully washing your hands after touching or cleaning up after your pet. Pet owners should consult a veterinarian if their pet is showing any signs of illness.

**Should I get rid of my domestic pet to protect my family from pandemic H1N1?**
No. You are much more likely to catch the flu from an infected person than you are from an animal. So far, all of the domestic pets infected with the H1N1 virus apparently became infected from their ill owners rather than the other way around. When you are ill with the flu, you should probably limit your contact with your pets (as you would with other people) until you are feeling better and are fever-free for at least 24 hours. As always, you should practice good sneeze etiquette (sneeze into your sleeve and/or handkerchief) around animals and people. If your pet begins showing signs of illness you should consult with a veterinarian.
What symptoms would I see in my pet?
An infected animal will exhibit flu-like symptoms that include lethargy (less active), loss of appetite, fever, runny nose and/or eyes, sneezing, coughing, or difficulty breathing.

Should I keep people who have respiratory disease away from my pet and vice-versa?
Until we know more about the risks of spreading the pandemic H1N1 virus from person to pet, pet to pet, or pet to person, it's a good idea to limit contact between an ill person and family members and pets.

Is there a vaccine for pets?
There is not a licensed and approved pandemic H1N1 vaccine for pets. The human H1N1 vaccine is not designed for animals and should not be given to pets. The canine and equine influenza vaccines will not protect dogs and horses against the pandemic H1N1 virus and should not be used in other species.

American Veterinary Medical Association
United States Department of Agriculture
http://www.usda.gov/wps/portal/?navid=USDA_H1N1

© 2009 Pennsylvania Department of Health. All rights reserved.

Contact Us
Privacy Policy
Facebook
Twitter