ROCHESTER
REGIONAL HEALTH

Rochester Regional Rehabilitation & Nursing – St. Mary's (Unity Living Center)

COMPREHENSIVE
EMERGENCY MANAGEMENT PLAN

Annex 20

PANDEMIC EMERGENCY PLAN

To view this plan on the internal network, go to:

https://www.rochesterregional.org/-/media/files/seniors/emergency-preparedness-plans/pandemic-plan-92020prlc.pdf?la=en&hash=5F71B9368B1BE29E071741741E99330137AC5D21

Disclaimer: There are many sources and references for information on pandemic agents, pathogens, and their clinical features, manifestations, and management. Others may be found in print and on the internet. The information presented herein is believed to be current and valid as of the time of publication. However, users are advised to validate information and consult appropriate additional resources as necessary prior to applying this information in a real-world clinical setting.

The local health department should be contacted immediately upon suspicion of any pandemic incident.

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AIIR	Airborne Infection Isolation Room
BSI	Body Substance Isolation
CDC	Centers for Disease Control and Prevention
CEMP	Comprehensive Emergency Management Plan
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EPA	Environmental Protection Agency
HCS	Health Commerce System
HEPA	High Efficiency Particulate Air
HERDS	Health Emergency Response Data System
HICPAC	Health Infection Control Practices Advisory Committee
HSEEP	Homeland Security Exercise and Evaluation Program
IAP	Incident Action Plan
IC	Incident Commander
ICS	Incident Command System
MCM	Medical Countermeasures
MCDPH	Monroe County Department of Public Health
MDRO	Multidrug Resistant Organisms
MERC	Medical Emergency Response Cache
NIMS	National Incident Response System
NYSDOH	New York State Department of Health
OEM	Office of Emergency Management
PEP Annex	Pandemic Annex
PPE	Personal Protective Equipment
RRH	Rochester Regional Health
RSV	Respiratory Syncytial Virus
SNS	Strategic National Stockpile
UP	Universal Precautions

TABLE OF REVISIONS

Pandemic Emergency Plan

Revision #	Date	Section/Page(s)	Change	Revised By
1	9/15/2020	Entire document	New NYS DOH Requirement	Safety Committee
2	10/2/2020	Page 34	Respiratory Hygiene add 6-feet	Safety Committee
3	10/4/2021	Entire Document	No changes	Administration Department

I. Introduction

Having an all-hazard *Emergency Management Plan* includes the need to plan for pandemic emergencies. Pandemic events are somewhat different from other types of crises, such as natural disasters, because of the added risk of the transmission of infection. All disasters have a potential infectious disease impact, but incidents involving a pandemic infectious disease poses a serious threat of the transmission of infection and require specialized interventions to decrease this risk.

A pandemic will place a huge burden on the U.S. healthcare system. Published estimates based on extrapolation of the 1957 and 1968 influenza pandemics suggest that there could be 839,000 to 9,625,000 hospitalizations, 18–42 million outpatient visits, and 20–47 million additional illnesses, depending on the attack rate of infection during the pandemic. Estimates based on extrapolation from the more severe 1918 influenza pandemic suggest that substantially more hospitalizations and deaths could occur. The demand for inpatient and intensive-care unit (ICU) beds and assisted ventilation services could increase by more than 25% under the less severe scenario. Pre-pandemic planning by healthcare facilities is therefore essential to provide quality, uninterrupted care to ill-persons and to prevent further spread of infection. Effective planning and implementation will depend on close collaboration among state and local health departments, community partners, as well as neighboring and regional healthcare facilities. Despite planning and preparedness, however, in a severe pandemic it is possible that shortages, for example of mechanical ventilators, will occur and medical care standards may need to be adjusted to most effectively provide care and save as many lives as possible.

This Annex describes the Rochester Regional Rehabilitation & Nursing – St. Mary's (hereinafter referred to as "LTC Unity") policy and procedure set for managing a pandemic and details the facility's pandemic incident response activities.

A. Purpose

This *Pandemic Emergency Plan (PEP) Annex* has been developed to enable LTC Unity to effectively mitigate, prepare for, respond to, and recover from a high-impact communicable disease outbreak in the community.

Reducing the incidence of transmission of infectious agents caused by a pandemic outbreak, such as the plague, smallpox, influenza, SARS (COVID-19) and viral hemorrhagic fevers to staff, residents, and the community will depend on how rapidly victims, including the worried-well, can be triaged, diagnosed, isolated when necessary, and treated.

The guidelines are consistent with activities described in the New York State Department of Health (NYSDOH) Pandemic Influenza Plan Version 2008 and include lessons learned from the 2009/2010 H1N1 Pandemic Influenza. Early communication with the Monroe County Public Health Department will be essential in controlling or preventing disease transmission and providing public assurance.

As information related to recognizing, diagnosing, treating, and preventing a pandemic outbreak is updated at the federal and state level, this Annex be revised accordingly.

B. Disclaimer

This *PEP Annex* was prepared with the best-available information at the time of its publication. The issues are dynamic, and new information is published regularly that may impact the execution of this Annex. Clinical and infection prevention guidelines in particular are subject to regular reviews and interpretations. At the time of an outbreak or for any other implementation of this Annex, appropriate LTC Unity staff will verify the accuracy and efficacy of this Annex and related procedures from a variety of sources and, if need be, use the structures and processes described herein to modify the plan based on contemporary situations and available clinical information.

When an actual implementation of this plan occurs, additional pathogen-specific contemporary resources (e.g., Centers for Disease Control [CDC], State [NYSDOH] and local [MCDPH] health departments, World Health Organization [WHO], Association for Professionals in Infection Prevention and Epidemiology [APIC]) will be consulted as necessary for the most current information and resources.

The local health department should be contacted immediately upon suspicion of any pandemic incident that would activate this plan.

Monroe County Department of Public Health
111 Westfall Road
Rochester, NY 14692

Phone: 585-753-2991
After hours: 911
Fax: 585-753-5115

C. Scope (Use of Appendix)

This *PEP Annex* applies to all members of LTC Unity administration and staff, in all departments. This Annex provides information related to preparedness and response guidance for any pandemic response, both naturally occurring and man-made.

This PEP Appendix coordinates with and refers to LTC emergency plans and annexes that provide operational details for the actions described. The Comprehensive Emergency Management Plan (CEMP) provides the LTC's all-hazards approach to incident management, including the implementation of the LTC Incident Command System. Procedural detail for this Pandemic Plan may also be found in the Biological Response Plan.

D. Corporate Security and Emergency Preparedness Committee

The Corporate Security and Emergency Preparedness Committee has responsibility for the Emergency Management Plan. The mission of this team is to provide leadership and subject matter expertise in all matters relating to emergency incidents, including pandemic preparedness activities.

E. Assumptions

Pandemic events are different from all other types of incidents. Pandemic planning assumptions have been based on the WHO Pandemic Phases that describe an escalating epidemiologic disease process that correlates to threat and impact levels. The progression of events in the 2009/2010 H1N1 pandemic have demonstrated that the emergence of the disease may not mirror events as described in the WHO phases.

The use of this document during the Pandemic Response Phase will consider the impact of the disease in the community as well as the suggested impact described in the WHO Phases.

This document is based on the following planning assumptions:

- Healthcare facilities and communities must be ready to "stand alone", and not depend on the immediate availability of state and federal resources.
- A novel influenza virus strain or novel coronavirus strain will likely emerge in a country other than the United States, but could emerge first in the United States.
- The onset of the incident may remain unknown for several days before symptoms appear.
- Even when symptoms appear, they may be distributed throughout the community's health system and not be recognized immediately by any one provider or practitioner.
- Once identified, the initial symptoms are likely to mirror those of the flu or the common cold so that the health system will have to care for both those infected and the "worried well."
- Having gone undetected for several days or weeks, some infectious agents may already be in their "second wave" before the first wave of casualties is identified.
- Public confidence in government officials and healthcare authorities may be undermined by the initial uncertainty about the cause of and treatment for the outbreak.
- In the event of a pandemic, the NYSDOH will have minimal resources available for onsite local assistance, and local authorities and institutions will be responsible for community and facility-specific response plans.
- It is likely that vaccine may not be available for a novel virus or, if available, the supplies will be limited or not available early in the course of a pandemic; and supplies of antiviral medications used for prevention and treatment of influenza may be limited or not effective.

- NYS and the federal government have developed materials and guidelines, including basic communication materials for the general public on influenza, influenza vaccine, antiviral agents, and other relevant topics in various languages; information and guidelines for healthcare providers; and training modules. This information is available about influenza and human coronavirus at the following websites:

  www.cdc.gov/coronavirus
  www.flu.gov
  www.nyhealth.gov/diseases/communicable/influenza

F. Coordination of Planning

The LTC Unity Pandemic Response Plan is coordinated with local, state, and federal plans related to pandemic incidents. This is important to ensure that from the outset of a pandemic incident, organizational responses will be cohesive and consistent. LTC Unity coordinates its plans through RRH and their ongoing participation in planning committees at the local and regional levels. In addition, the Corporate Security and Emergency Preparedness Committee maintains an ongoing dialogue and general awareness regarding overall community readiness.

Community-Wide Coordination of Response

During a pandemic incident, timely and effective communication with the Monroe County Department of Public Health and other County Safety and Security Offices will be critical. The LTC Communication Plan and Directory (CEMP Appendix 1) contains emergency contact information, which could shorten the time needed to mobilize a response and increase the possibility of early containment.

G. Annex Evaluation and Maintenance

This PEP Annex is reviewed annually, in accordance with the CEMP review cycle. More frequent updating of the *Pandemic Response Plan* may be necessary to ensure that the plan reflects current recommendations, which tend to be dynamic based on evolving information and world health conditions. In addition, following exercise and actual incident activations, changes may be made based on experiences or evaluations.

II. Overview of Pandemic Incidents:

A. Bioterrorism

Bioterrorism is the deliberate release of pathogenic microorganisms (bacteria, viruses, fungi or toxins) into a community for the purpose of creating civil disruption. According to the Centers for Disease Control and Prevention (CDC) the most likely diseases to be associated with bioterrorism event include smallpox, anthrax, botulism, plague, and tularemia. Additionally, viral hemorrhagic fever (VHF) viruses such as Lassa, Marburg, and Ebola rarely identified in North America, may be deliberately introduced. Other potential agents include brucellosis, western and eastern equine viruses that cause encephalitis, Q fever, glanders, and toxin-producing Staphylococcus aureus. With the exception of smallpox, VHF, and the encephalitis viruses, most bioterrorism agents can be treated with antibiotics or toxin antagonists if promptly diagnosed. The above-mentioned diseases are not meant to be inclusive, as there are many food- or water-borne agents that could potentially be used in a bioterrorist event.

B. Emerging Infectious Diseases

Infectious diseases are the leading cause of death worldwide, and the number of deaths from infectious diseases in the United States has been increasing. Infectious diseases ranked third among the leading causes of death in 1992 in the United States.

The wide use of effective antibiotics, the potential for universal immunization for many childhood illnesses, and success stories such as the imminent eradication of polio encouraged the perception that infectious diseases are no longer a public health threat. However, even as some previously epidemic infectious diseases have been controlled, new diseases emerge and old diseases rebound, sometimes in drug-resistant forms. These events increasingly challenge public health and medical care professionals.

Infectious diseases are a continuing danger to everyone. Some diseases have been effectively controlled with the help of modern technology. Yet new diseases—such as SARS and West Nile Virus—are constantly appearing. Others, such as malaria, tuberculosis, and bacterial pneumonias, are now appearing in forms that are resistant to drug treatments.

Severe Acute Respiratory Syndrome (SARS)

Severe acute respiratory syndrome (SARS) is a recognized, severe febrile respiratory illness caused by a previously unknown coronavirus, SARS-associated coronavirus (SARS-CoV). SARS emerged in the southern Chinese province of Guangdong in November 2002, but the worldwide epidemic was triggered in late February 2003 when an ill physician from Guangdong infected several other guests at a hotel in Hong Kong. These persons subsequently became the index patients for large outbreaks of SARS in Hong Kong, Vietnam, Singapore, and Canada. On July 5, 2003 the World Health Organization (WHO) announced that SARS had been controlled and ended the global public health emergency response. During the epidemic, more than 8,000

probable SARS cases and nearly 800 deaths were reported to WHO from 29 countries.

The official end of the global public health emergency affirmed the rapid and monumental response effort but also signaled the need for continued vigilance. The rapidity of the spread of disease and the high levels of morbidity and mortality associated with SARS call for careful monitoring for the reappearance of SARS-CoV and preparations for the rapid implementation of appropriate control measures. SARS-CoV may still exist in human or animal reservoirs and thus have the potential to establish itself as a seasonal respiratory illness with ongoing epidemics. Although the United States had only eight laboratory-confirmed cases of SARS-CoV disease and no significant local spread, it is clear that we are susceptible to the types of outbreaks experienced in Hong Kong, Singapore, Taiwan, and Toronto.

Smallpox

A single case of Smallpox in the U.S. would almost certainly signal a biological weapons attack. This would require an immediate coordinated response by medical and public health systems at local, state, and federal levels. The Department of Health and Human Services (HHS), and in particular its Centers for Disease Control and Prevention (CDC), has taken a number of steps to ensure preparedness.

Smallpox is characterized by both an enanthem with lesions in the mouth and on the posterior pharynx and an exanthem (rash). Constitutional symptoms prior to onset of rash (exanthem) include fever (100%), which generally occurs about 1 to 3 days before rash onset, headache (90%), backache (90%), chills (60%), and vomiting (50%). Less common symptoms include pharyngitis and severe abdominal pain. The hallmark of the ordinary (or classic) type of Smallpox is a generalized vesiculopustular rash with lesions found more densely on the face and extremities (centrifugal), including the palms and soles. All lesions on any one part of the body are at a similar stage of development and are approximately the same size. Rash progresses from sparse macules (day 1), to papules (days 2), vesicles (days 3 to 4), pustules (days 5 to approximately 12), and scabs (days 13 to 18) for a total duration of 2 to 3 weeks. Less common presentations of the Smallpox rash include flat or hemorrhagic lesions. A rash that progresses through the stages more rapidly and has fewer lesions characterizes modified Smallpox, which occurs more commonly among previously vaccinated persons. Infection via cutaneous inoculation also has a shorter course with appearance of one or several vesicles at the site of inoculation after about 3 days. Asymptomatic cases are very uncommon and their role in transmission is unclear but likely to be minimal.

This Plan provides preparedness and response measures that would be appropriate for any pandemic event, including Smallpox. If there is an emergence of Smallpox there will be additional detailed guidance provided by the CDC and the NYSDOH.

Pandemic Influenza

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

An influenza pandemic will place a huge burden on the U.S. healthcare system. Published estimates based on extrapolation of the 1957 and 1968 pandemics suggest that there could be 839,000 to 9,625,000 hospitalizations, 18–42 million outpatient visits, and 20–47 million additional illnesses, depending on the attack rate of infection during the pandemic. Estimates based on extrapolation from the more severe 1918 pandemic suggest that substantially more hospitalizations and deaths could occur.

Ebola

Ebola hemorrhagic fever is one of numerous Viral Hemorrhagic Fevers. It is a severe, often fatal disease in humans and nonhuman primates (such as monkeys, gorillas, and chimpanzees).

Beginning in March, 2014, West Africa has experienced the largest outbreak of Ebola in history. As of this publication, widespread transmission of Ebola in West Africa has been controlled, although additional cases may continue to occur sporadically and the CDC continues to monitor and assist.

WHO Pandemic Phases

The World Health Organization (WHO) has implemented a new pandemic alert system, one that's designed to focus more on disease risk than geographic spread and to streamline communications to the public. A four-phase alert system replaces the six-phase scheme.

The new phases are:

- **Interpandemic:** the period between pandemics
- **Alert:** when a new subtype has been identified and increased vigilance and risk assessment are warranted
- **Pandemic:** a period of global spread of a new subtype as indicated by global risk assessment based on virologic, epidemiologic, and clinical data
- **Transition:** global risk drops, prompting stepdowns in global actions and response activities

Global Phases[1]

The global phases – interpandemic, alert, pandemic and transition – describe the spread of a new influenza or coronavirus subtype but can pertain to any disease that becomes epidemic and then is declared a pandemic. As pandemic viruses or diseases emerge, countries and regions face different risks at different times. For that reason, countries are strongly advised to develop their own national risk assessments based on local circumstances, taking into consideration the information provided by the global assessments produced by WHO. Risk management decisions by countries are therefore expected to be informed by global risk assessments, but based on local risk assessments.

The pandemic influenza or coronavirus phases reflect WHO's risk assessment of the global situation regarding each virus with pandemic potential that is infecting humans. These assessments are made initially when such viruses are identified and are updated based on evolving virological, epidemiological and clinical data. The phases provide a high-level, global view of the evolving picture.

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1 World Health Organization. Pandemic Influenza Risk Management. Last viewed on 3.22.18 at http://www.who.int/influenza/preparedness/pandemic/GIP_PandemicInfluenzaRiskManagementInterimGuidance_Jun2013.pdf

III. Preparedness

As part of its ongoing programs for infection prevention, employee health, occupational safety, and emergency management, LTC Unity conducts a series of mitigation and preparedness activities in readiness for a pandemic incident, including:

- In conjunction with the state and local health departments, has established a mechanism to identify and report unusual clusters of disease. Data is submitted electronically, through the Health Commerce System to the NYSDOH. The local health department also has access to this information.
- Maintains procedures for notifying appropriate internal experts, including infection prevention;
- Maintains ongoing communications with, and procedures for collaborating with, local and state public health departments during a disease outbreak;
- Tests for influenza and SARS-CoV per normal lab protocol;
- Ensures staff personal protection and communicates appropriate infection prevention instructions to staff in a timely manner;
- Deploys personal protective equipment (PPE) to designated work locations;
- Maintains a sufficient number of people with access to the Health Commerce System (HCS), with the facility able to provide HCS access 24/7;
- Ensures timely updates of HERDS data as requested by NYSDOH;
- Has a designated means of notifying external partners when a pandemic incident is suspected; and
- Has a process for posting signage regarding visitor restrictions at entrances to the facility when an increase in infectious disease cases in the community is recognized, including discouraging visitors with respiratory illness from entering the facility.

A. Education and Training

1. Pandemic Incident Training

All departments have access to the internet to view web-based influenza, coronavirus, and pandemic information when created and placed on the RRH Portal (SharePoint).

As with all education, materials are developed and/or distributed that are reading-level appropriate for the intended audience, in languages reflective of the composition of LTC residents, staff, and family members.

Education and in-service training is completed through the new employee orientation program, the annual in-service education process, and through an ongoing series of tabletop, functional, and/or full-scale exercises, and response specific drills. Training is consistent with best practice recommendations, current threat assessments, and LTC needs.

Regular and Just-in-Time Training Opportunities:
Staff members maintain competence to perform functions related to their job responsibilities. Staff members are also trained to perform other functions in their respective departments. This cross training allows for flexibility in scheduling and assures adequate staff to continue department operations. Each department manager has knowledge of, and maintains a list of staff in the department that can perform multiple job functions.

Infection Prevention Procedural Training:
Effective infection prevention procedures are at the core of all health care activities. On a daily basis, and for each patient, LTC Unity staff is expected to consistently follow RRH infection prevention and control procedures, and strive to eliminate nosocomial disease transmission.

Infection Prevention will ensure that appropriate training is incorporated into the annual training plan to address infection prevention competencies for all staff members.

2. Training and Education of Patients and Visitors:
During a pandemic incident, residents and visitor education will be important to ensure that they understand the risk of disease spread and actions they can take to prevent infection transmission. Information will need to be communicated effectively to residents and their visitors regarding evolving community health conditions and how they are affected. As part of the preparedness process, posters, brochures, media releases, and resident information packet inserts may be created, depending on the need. At the outset and during the course of an incident the Command Team will determine the best process and distribution strategy for the materials.

The designated Public Information Officer (PIO) will collaborate with RRH Infection Prevention on the development and distribution of appropriate readiness and briefing materials for residents and visitors, which will be distributed by the PIO in collaboration with the Command Center. The materials must be available for all individuals, including those with special needs, such as those with visual, learning, or other disabilities, or limited English proficiency.

B. Drills and Exercises:

As described in the CEMP, LTC Unity conducts exercises to assess the Emergency Managements Plan's appropriateness, adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols.

During discussions regarding upcoming drills and exercises, the Director of Facilities, Life Safety, and the Environmental Services departments will collaborate on planning the inclusion of pandemic scenarios into the drill and exercise cycle. The design of the exercises will reflect potential situations and will test the facility's ability to respond to the effects of pandemic incidents on its capabilities to provide care, treatment, and services.

Whenever possible and appropriate, exercises are designed as a community-wide event and may include local, regional, and/or state response partners.

All exercises will incorporate the principles of the National Incident Management System, and comply with applicable elements of the Homeland Security Exercise and Evaluation Program.

C. Surveillance: Detection and Warning Source

LTC Unity, in conjunction with the state and local health departments, has established a mechanism to identify and report unusual clusters of disease. Data is submitted electronically, through the Health Commerce System to the NYSDOH and National Healthcare Safety Network (NHSN). The local health department also has access to this information.

1. Disease Surveillance during an Incident:

Enhanced Monitoring During an Increased Threat Level
During periods of increased threat level, including (but not limited to) community-wide mass gathering events, terrorism threats or incidents, or alterations in the regional or national threat assessment, LTC Unity will implement enhanced syndromic surveillance measures, as instructed by local and/or state public health authorities.

Reporting Syndromic Surveillance Data
In addition to the usual data reporting processes, data discovered during increased threat level monitoring will be immediately reported to the Infection Preventionist (IP). The IP will contact the local county health department and/or NYSDOH as deemed necessary.

Surveillance of Staff Following Contact with an Infectious Resident
Once an incident has been identified and employees have had contact with suspected or actual cases, surveillance of potentially exposed staff will be conducted daily before they report for each shift. Such monitoring will be critical to identifying staff that are symptomatic for disease and need to be excluded from duty. A variety of systems (phone triage, face-to-face temperature screening, etc.) may be used, at the discretion of Employee Health, in collaboration with RRH Infection Prevention.

2. Surveillance of Residents and Visitors
Once an incident has been identified, surveillance of potentially exposed residents and visitors may be conducted before they are granted access to the facility. Such monitoring will be important to identifying those at risk from disease. A risk- and syndrome-appropriate process will be implemented based on the recommendation of appropriate medical staff. For example, residents may be screened using cultures, while visitors/vendors could be evaluated using a face-to-face temperature screening.

D. Contact Tracing and Surveillance:

Contact tracing is a process used in identifying and monitoring close contacts of suspected or confirmed residents meeting the case definition during a pandemic incident. Such contacts might include household and social contacts, family members, and workplace or school contacts; however, LTC-based contact tracing is targeted at identifying healthcare providers and others who had unprotected close contact (e.g., did not use appropriate precautions) starting 24 hours prior to the residents symptom onset (or as instructed by local or state health authorities).

Developing a list of potentially exposed individuals while an infected resident was present, is essential for post-exposure follow-up or treatment. The goal of timely case and contact identification is to limit the spread of a communicable pathogen in order to buy time before therapies (e.g., vaccine, antivirals) are available and to limit the impact on the health care system.

The capacity to do more detailed case and/or contact investigations will be the responsibility of local and state health department partners.

1. Case Definition of Contact
The definition of a contact will be developed by the MCDPH, NYSDOH, and/or CDC, and will be based on available information of the circulating pathogen. RRH Infection Prevention will ensure that the case definition is circulated widely across the facility, and will take or implement those measures necessary to ensure staff awareness.

2. Contact Identification
Cases will be identified using the case definition, data from syndromic surveillance, and other resources. Contact information based on the contact definition will be collected from identified individuals and documented on a case screening form (as required by NYSDOH).

3. Management of Contacts
Asymptomatic contacts should be asked to take their temperature at least twice daily (or as recommended by local or state health authorities). As conditions warrant, appropriate screening methods will be put in place to assure all staff are

screened prior to reporting for duty. MCDPH will monitor asymptomatic contacts according to their response plan.

The decision to quarantine asymptomatic contacts at home or in another facility will be made based on epidemiologic characteristics of the pathogen responsible for the outbreak, and is the responsibility of local health department officials.

Symptomatic contacts of suspected resident should seek medical attention immediately when symptoms develop and should notify their healthcare provider of recent contact with a resident meeting the subject case definition. Employees will immediately contact their immediate supervisor and Employee Health to report their status.

4. Tracking Residents Admitted/Discharged with a possible Communicable Disease

LTC Unity, in consultation with MCDPH, will implement any necessary tracking processes for monitoring residents admitted or discharged with a possible communicable disease.

5. Surveillance during Isolation and Quarantine

As directed by MCDPH or NYSDOH, employees may be placed in quarantine because of a potential exposure to an infected individual. The goal of quarantine is to physically separate those who have been potentially exposed and thus likely to develop disease, from those who have not been exposed. Depending on the pathogen and the circumstances, and the current Monroe County Isolation and Quarantine Plan, the quarantine may be maintained at the employee's home residence or an alternate location.

Under extreme conditions, "work quarantine" may be authorized by NYSDOH, in agreement with LTC Unity leadership. Under work quarantine, a process developed during the Toronto SARS outbreak, employees may be permitted to go to work, using appropriate PPE and other infection prevention precautions; and can drive straight home, where they must maintain appropriate distance and other separation measures from others in the household. However, they would be restricted from engaging in any other activities or going anyplace else. Work quarantine must be approved by the local health department.

IV. Response:

A. Recognizing a Pandemic Incident

The key to rapid intervention and prevention is to maintain a high level of vigilance. The early clinical symptoms of infection for most bioterrorism agents and emerging infectious diseases may be similar to common diseases seen by health care professionals every day. The principles of epidemiology should be used to distinguish cases of a disease currently circulating in the community from those representing an unusual event.

Most of the potential pathogens that could be used as a biologic weapon (e.g., anthrax, plague, and smallpox) would present initially as a non-specific influenza-like illness. Therefore, an unusual pattern of respiratory or influenza-like illness (i.e., occurring out of season or large numbers of previously healthy residents) should result in a notification to Monroe County Department of Public Health/NYSDOH. These disease patterns might represent an early start to the influenza season, the introduction of a new pandemic strain, or could be the initial warning of a bioterrorist event.

Once discovery is made, the following steps may be taken, as appropriate:

- Initiate isolation precautions
- If different or uncertain pandemic agent/disease suspected, contact:
  - RRH Infection Prevention; and
  - Monroe County Department of Public Health/NYSDOH

Implement the following measures for incident management, as appropriate:

- Isolate affected area and deny entry to other residents and staff not already in the area.
- Determine areas where subject resident had spent time or passed through.
- Determine whether resident constitutes an at-risk or routine exposure.
- Consider relocating all unit activities to an alternate site until cleaning is completed.
- Identify all persons present in unit who may have been exposed to the subject resident (including staff, other residents, and visitors), and document their locations, times, and activities.
- Complete a *Pandemic Exposure Epidemiology Tracking Form* for each person exposed (form to be developed or provided by NYSDOH/CDC).
- Notify:
  - Environmental Services on duty for immediate cleaning (after consultation with Infection Prevention to assure appropriate PPE)
  - RRH Infection Prevention
  - Monroe County Department of Public Health

**Unlike other emergency events a pandemic influenza will likely allow healthcare facilities ample time to gear up and prepare for a response. Even in the event that the novel strain is initially found in the U.S., there will likely be adequate time to prepare for response.*

B. Response Activation:
LTC Unity will initiate the CEMP for a pandemic incident during a facility-based or public health emergency when conditions, as detected through syndromic surveillance, or as reported by Monroe County Department of Public Health or the New York State Department of Health, the CDC, and/or the WHO indicate the impending or actual outbreak in the region of a novel influenza virus indicate the impending or actual outbreak in the region of a highly communicable disease, or the occurrence or an act of bioterrorism.

**Unlike other emergency events, a pandemic will likely allow the hospital ample time to gear up and prepare for a response. Even in the event that the novel strain is initially found in the U.S., there will likely be adequate time to prepare the hospital for response.*

Monroe County Department of Public Health should be contacted immediately upon activation of this Plan or presentation of a resident with symptoms of any pandemic concern.

Phone: 585-753-2991
After hours: 911

1. Activation Responsibility
Any staff member becoming aware of a suspected disease outbreak should notify the Infection Preventionist of the outbreak immediately.

The Infection Preventionist, upon receipt of notification regarding a disease outbreak, will immediately confer with the Administrator and Director of Nursing regarding the situation. The Administrator will determine whether activation of this plan is warranted.

2. Activation Process
Upon receipt of such notification or determination to activate the plan, the following actions may take place, as appropriate:

- When the threat and/or recognizing a suspected outbreak/contamination the Administrator should be contacted:
  - Mon-Fri Days: 585-402-9859
  - All other times contact the Administrator-on-Call, as per on-call list

- Under the direction of the Administrator/Incident Commander:
  - The CEMP will be activated as appropriate to the incident and its potential impact on the facility.
  - The Command Center will be activated when organizational concern, mobilization, or impact is sufficient that establishing visible centralized leadership and control is beneficial.

C. Command and Control

LTC Unity uses the Incident Command System in accordance with National Incident Management System (NIMS) requirements for command and control of an emergency event. All emergency response is managed by a designated Incident Commander. In the event that the situation needs expanded management, additional Command Team staff will be activated according to need and span of control.

The Command Center will be activated according to the required response.

Communication with the Monroe County Department of Public Health will be established, according to the impact. Contact information is available in Appendix 1 of the CEMP. Monroe County Department of Public Health can also be contacted by dialing "911".

Command issues may include, depending on the severity of the event:

- Evaluation and monitoring of staff health status.
- Protocols for reassignment of high-risk personnel to low risk duties.
- Review and activation of the Continuity Plan (CEMP Annex 10).
- Determination of essential staff, including those that could work from home.
- Determination of essential medical & support services that must be maintained.
- Review and activation of the Surge Capacity Plan (CEMP Annex 3).
- Discussions with the RRH Ethics Committee regarding the management of potentially limited resources.
- Planning for the potential for altered or crisis standards of care, in consultation with regulating authorities.
- Review inventories and identify trigger points for reordering. Review the 96-hour Plan (CEMP Annex 2).
- Assess anticipated needs for consumable and durable resources and order as needed.
- Ensure that HCS advisories are monitored, communicated, and implemented, as appropriate.
- Maintain surveillance of supply chain watching for disruptions due to conditions in manufacturing or source countries or disruptions in commodities transportation related to a pandemic
- Meet with the Safety Committee to review CDC and NYSDOH updates and recommendations.

Any potential ongoing response will be dictated by the longevity of the event. Information included in this table may or may not be required, but is provided to assist Command Team members in decision-making.

Position	Response Activities	Communications *as needed, according to response*	Demobilization/ System Recovery

Incident Commander	• Activate the Command Center and Incident Command roles (any positions not activated remain the responsibility of the Incident Commander).
	• Notify appropriate RRH experts including RRH Infection Prevention.
	• Formulate initial objectives and the Incident Action Plan (may be delegated to the Planning Section, if activated).
	• Evaluate the availability of vaccine and preventive treatments following state and federal guidance on priority groups.
	• Activate the following Plans as needed:
	  • Medical Countermeasures (MCM) Plan
	  • Continuity of Operations Plan (COOP).
		Communicate current response to affiliate hospitals and LTC facilities.
		Review the overall impact of the ongoing incident on the facility with the Command Team on a regular basis.
			Announce termination of event when appropriate.
			Deactivate Command Center positions and staff when they are no longer necessary.
			Ensure a debriefing is conducted and an AAR is written.

Safety Officer	• Ensure the safe and consistent use of appropriate personal protective equipment by staff. • Conduct ongoing analysis of existing response practices for health and safety issues related to staff, residents, and facility, and implement corrective actions to address, as needed. • Monitor any agent exposures and facility decontamination operations.	Regular meetings/ communications with the Command Team	Ensure safe return to normal operations. Ensure facility decontamination, if needed. *Upon deactivation of your position, ensure all documentation and Operational Logs are submitted to the Incident Commander.*

Position	Response Activities	Communications *as needed, according to response*	Demobilization/ System Recovery
Public Information Officer	***As soon as the Command Center is activated, RRH Public Relations should be contacted (see CEMP Attachment 12 for contact information).*** • Monitor media outlets for updates on the outbreak and possible impact on the facility. • Anticipate an increase in public inquiries about the agent, and implement information hotline, as appropriate. • If activated, work in collaboration with the local Joint Information Center. • Provide briefings and situation updates for staff, residents, visitors, and families.	Regular staff, resident, visitor, and media briefings (as determined by the event). Notify residents regarding any pre-screening requirements for potential visitors. Regular meetings/ communications with the Command Team.	If requested, participate in a final media briefing including facility status, appropriate resident information, and incident status. *Upon deactivation of your position, ensure all documentation and Operational Logs are submitted to the Incident Commander.*
Liaison Officer	Establish communications with: o MCDPH o NYDSOH o Other appropriate agencies • Provide information to EMS, public safety, and commercial ambulance agencies regarding any PPE or pre-screening requirements prior to entry. • Communicate resource needs identified by Operations and Logistics Sections to RRH leadership. • Keep MCDPH advised of any health problems/trends identified, in cooperation with Infection Prevention.	Responsible for ongoing communications with: • Local health department • NYSDOH (initially may be contacted by the IC) • Other, according to the incident Regular communication with Command Team.	Communicate facility status and demobilization to RRH leadership. *Upon deactivation of your position, ensure all documentation and Operational Logs are submitted to the Incident Commander.*
Logistics Section	• Anticipate an increased need for supplies and take action to obtain. • Initiate staff call-in systems to increase staffing, as needed, in collaboration with Operations and Planning Sections. • Prepare for receipt, distribution, and tracking of any external resources, including MERC/SNS activation (see CEMP Annex 5: MCM Plan).	Communications with appropriate vendors, as needed. Regular communication with Command Team. Notify vendors regarding any pre-screening	Restore all supplies to normal levels. Assist in restoring facility to normal operations. Arrange for mental health support and stress management services through RRH, as appropriate.

Position	Response Activities	Communications *as needed, according to response*	Demobilization/ System Recovery
	• Monitor the physical and mental health status of staff that are exposed to infectious residents. Arrange for disaster mental health services through RRH, as needed. <u>Depletion of Supplies</u> If supplies needed to manage the incident start to become depleted (e.g., level falls below 50 percent with no plans available for re-stock), the Logistics Section Chief may develop a "hold strategy." Hold strategies may include the following considerations, as appropriate: ○ Opportunities for substitution for items in short supply ○ Length of time before needed items arrive ○ Implications of terminating the use of the item ○ Ability of other facilities to provide the item and accept resident transfers ○ Need for alterations to the standard of care *RRH, MCDPH, local OEM, and NYSDOH will be contacted regarding the situation and assistance will be requested, as needed.*	requirements prior to their entrance to the facility.	*Upon deactivation of your position, ensure all documentation and Operational Logs are submitted to the Incident Commander.*
Operations Section	• As needed, appoint a Medical Care Branch Director and a Security Branch Director (as well as any other necessary subordinates) and obtain regular status reports. • Obtain regular information regarding resident status – report to the Command Team. • Mobilize appropriate staff (if off duty staff are needed they will be called in).	Regular communications with all appointed Branch Directors. Regular communication with Command Team.	Provide for facility decontamination, if needed. Initiate return to normal activities, as appropriate. Return resident care and services to normal operations.

Position	Response Activities	Communications *as needed, according to response*	Demobilization/ System Recovery
	• Conduct disease surveillance, including number of affected residents/staff. • Coordinate resident management activities. • Consult with Infection Prevention for disinfection requirements for equipment and facility. • Coordinate with Logistics implementation of MCM Plan. **Security Branch Director** • Restrict access to contaminated area(s). • Control facility access to prevent infectious residents from entering the facility without screening. • Manage any EMS traffic. • If appropriate, assist with evidence collection and management of forensic specimens. **Medical Care Branch Director** • Monitor residents status related to the current response. • Collaborate with local and state health departments. • Ensure staff "just-in-time" training on infection precautions and PPE use.		*Upon deactivation of your position, ensure all documentation and Operational Logs are submitted to the Incident Commander.*
Planning Section	Initial • Initiate collection of department specific status and compile data for report to Command Team. This can be done during Daily Safety Check. • Establish operational periods and develop Incident Action Plan (IAP), in collaboration with the Incident Commander and Command Team. Ongoing	Regular communication with Command Team.	Ensure appropriate archiving of incident documentation. Write an after-action report and corrective action plan to include the following: • Summary of actions taken • Summary of the incident • Actions that went well • Area for improvement

Position	Response Activities	Communications *as needed, according to response*	Demobilization/ System Recovery
	• Continue to update and revise the incident objectives and the IAP – for each operational period. • Continue to collect department specific information and share with appropriate Command Team members.		• Recommendations for future response actions
Finance/ Administration Section	Track response expenses and expenditures. Investigate staff or resident exposures or injuries and implement risk management/claims procedures. Facilitate procurement of needed supplies, equipment, and contractors.	Regular communication with Command Team.	Compile final response and recovery cost and expenditure and submit to the Incident Commander for approval and to distribute to appropriate authorities for possible reimbursement. *Upon deactivation of your position, ensure all documentation and Operational Logs are submitted to the Incident Commander.*

D. Communication/Notifications

Information regarding specific resident condition will be shared with family members per HIPAA regulations, according to current protocols. Individuals requesting general information on the current outbreak will be provided with NYSDOH/CDC information or redirected to contact the Monroe County Department of Public Health.

1. Internal Communications:

It will be important to monitor rumors and address misinformation. During any emergency/disaster response it is the responsibility of the designated PIO to provide information and updates to staff, residents, families, and visitors, as appropriate to the event.

Information regarding specific patient condition will be shared with family members per HIPAA regulations. Individuals requesting general information on influenza will be provided with NYSDOH/CDC information or redirected to contact the Monroe County Department of Public Health.

Daily, or as needed, internal communications will be provided to keep staff members apprised of situation and current LTC response. This communication may take place during Daily Safety Check.

***Public Information Officer (PIO)*
A Public Information Officer has been identified to provide updates to the public and to provide internal information to staff. The Incident Commander (using the HICS/NIMS structure) will assign an individual as Liaison officer to communicate with external response partners.
See the LTC CEMP for details regarding emergency communications.

2. External Communications:

Monroe County Department of Public Health should be contacted immediately upon activation of this plan or suspicion of a resident with symptoms of any pandemic of concern. In the event of a pandemic influenza, LTC Unity will take direction from local and state public health authorities regarding reporting procedures.

3. Family & Guardian Communications:

Authorized family members and guardians of individuals infected with the pandemic infectious disease will be updated at least once per day and upon a change in condition.

All residents and authorized family members and guardians will be updated once per week on the number of infections and deaths in the facility.

All residents will be provided daily access to free remote videoconferencing, or similar communication methods, with authorized family members and guardians.

All required communications must be by electronic means or other method selected by each family member or guardian.

The Incident Commander or Liaison Officer, if activated, is responsible for communications with external response partners.

4. Health Commerce System (HCS):
The NYSDOH Health Commerce System (HCS) is a secure website containing specific information about bioterrorism and disaster planning and preparedness. The HCS requires an ID and password in order to be accessed.

During an incident, the Health Emergency Response Data System (HERDS), a component of the HCS, will be accessed by appropriate staff members as needed to provide ongoing current information regarding facility status. HERDS surveys will be completed daily or as required by the NYSDOH.

Receipt of HCS Notifications
Several staff members receive HCS alerts on a regular basis. Alerts are typically received via email, but can be sent to phone(s) and fax(s). Alerts are typically shared amongst those receiving the notification to ensure that information is sent out to appropriate staff members.

5. Communication with Affiliates:
CEMP Appendix 1 contains contact information for both RRH hospitals and LTC facilities. Any emergency plan activation should include notification to affiliates, to provide them with general information regarding the event.

6. Communicating Incident Information to People with Disabilities and Limited English Proficiency
Consistent with existing policy, all public communication regarding a pandemic incident will incorporate the following considerations:

- Written in Plain English and at an appropriate reading level for the community.
- Made available in the languages of the community (English and Spanish).

7. Role of the Media
The media should be informed about pandemic incidents and the potential disease agents by the county or state health department, ***not*** by LTC Unity staff. Following the identification of a pandemic incident, the county or state health department should assume responsibility for contacting the media.

E. Triage and Screening

1. Pre-Entry Screening for Staff, Vendors, and Visitors

Under certain highly infectious communicable disease scenarios (e.g., SARS/COV, plague), it will be necessary to implement pre-entry screening for all people entering the building in an effort to interrupt the disease transmission pathway. Residents arriving will be screened using the pre-triage screening process (below). At the discretion of the Incident Commander, a similar process will be instituted for staff, vendors, and visitors. Under these circumstances, no person will be permitted access to the building without evidence of pre-entry screening clearance.

Those that are ill with respiratory infection and require ED treatment will be referred to their personal physician or an area hospital, and will not allowed to enter the building.

The screening process will be pathogen-specific, and likely guided by NYSDOH/CDC guidelines, but the following general guidelines will be considered, as dictated by the event:

- All individuals whose arrival to the facility is anticipated will be notified in advance if possible, informed of the situation and the case definition, instructed where to report, and given direction regarding what to do if they meet the case definition prior to arrival.
    - Employees (on and off duty) will be notified by their department managers.
    - EMS, public safety, and commercial ambulance agencies will be contacted by the Liaison Officer.
    - Vendors will be notified by their facility contacts that pre-entry screening protocols are in effect, the appropriate reporting location for vendors and deliveries, and the potential for delay.
    - Residents and families will be notified by the nursing staff, and will be asked to inform any potential visitors.
- All persons arriving for pre-entry screening will be queued for screening.
- Screening will be conducted by designated staff. They will use a questionnaire (event specific) that will have key questions that must be answered before the person will be moved on in the process.
- If conditions warrant the careful application of personal protective equipment, Infection Prevention or designee will be assigned to brief, assist, and monitor employees as they don their PPE.
- All persons who are ill/symptomatic will be referred to their personal physician or an area hospital.
- ***Once screening has been implemented, NO PERSON will be granted access to the facility without having been screened and cleared.***

2. Triage Guidelines for Residents

Pre-Triage Screening

The aim of pre-triage screening is to insure early detection of residents meeting a high-risk case definition, early isolation, and interruption of potential disease transmission to others, through targeted screening and adherence to specific precautions. The pre-triage screening process may be implemented in conjunction with facility access restrictions, which funnel all residents to the designated pre-triage screening location.

At a minimum, the pre-triage screening point will be staffed by one RN or LPN. Infection prevention precautions for the screening point staff will be based on guidelines for the suspected agent.

A nurse will evaluate each individual arriving at the facility specifically based on the case definition. If the individual is in need of isolation (criteria to be set by Infection Prevention in collaboration with NYSDOH, based on the incident) they will be given a mask and taken directly into a designated room for additional screening or, if clinically indicated, directed to the nearest ED (EMS may be contacted for ambulance transportation and informed by the caller that the individual matches the case definition). If the individual can be downgraded as a communicable disease threat, they may proceed to facility admission.

F. Visitor Guidance

A visitor is anyone entering a healthcare facility site to visit a resident or staff member, or attend a meeting or event. Visitors have a responsibility to behave in a manner that does not put others at risk, and to respond to staff requests and facility regulations for the protection of themselves and others.

Visitation policies have been developed for all areas of the facility. Visitation information is provided to each resident upon admission.

During high levels of respiratory illness, units may be "closed" to visitors. Signage may be posted outside entry doors to alert visitors to the potential for spread of respiratory illness due to the large number of infections currently in the facility. Visitors with illness are encouraged to refrain from visiting until their condition has improved. In situations where ill visitors insist on visiting (caring for ill or dying family member), they may be allowed and will then be instructed to wear a surgical mask and wash their hands.

Respiratory hygiene etiquette posters have been established at main entry points into the facility to remind visitors of the importance of hand hygiene and "covering a cough" or wearing a mask if symptomatic. Influenza prevention stations will be positioned at all entrances and will include hand sanitizer, gloves, and masks.

G. Infection Prevention Measures

1. Isolation and Quarantine

To contain the spread of a contagious illness, public health authorities rely on many strategies. Two of these strategies are isolation and quarantine. Both are common

practices in public health, and both aim to control exposure to infected or potentially infected persons. Both may be undertaken voluntarily or compelled by public health authorities. The two strategies differ in that isolation applies to persons who are known to have an illness, and quarantine applies to those who have been exposed to an illness but who may or may not become ill.

Indications for Isolation and Quarantine
In the event of a pandemic outbreak, MCDPH may decide to implement healthcare facility isolation and/or quarantine. This decision is legally within the authority of the Public Health Commissioner, and may occur under such circumstances where significant communicable disease exposure has occurred or may occur. LTC Unity will institute isolation and/or quarantine procedures if so directed by MCDPH.

Logistics during an Isolation or Quarantine Event
In the event of facility-wide isolation or quarantine, the provision of necessary supplies, equipment, and necessities to maintain the quarantine may not be possible through conventional deliveries directly to the facility. In such cases, all deliveries including food and perishables will be made under the direction of the Logistics Section Chief. In addition, the Logistics Section Chief will coordinate any equipment/supply needs with RRH.

2. Precautions
There are two tiers of HICPAC/CDC precautions to prevent transmission of infectious agents, Standard Precautions and Transmission-Based Precautions.

Standard Precautions are intended to be applied to the care of all residents in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. **Implementation of Standard Precautions constitutes the primary strategy for the prevention of healthcare-associated transmission of infectious agents among residents and healthcare personnel.**

Transmission-Based Precautions are for residents who are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. Since the infecting agent often is not known at the time of admission to a healthcare facility, Transmission-Based Precautions are used empirically, according to the clinical syndrome and the likely etiologic agents at the time, and then modified when the pathogen is identified or a transmissible infectious etiology is ruled out. There are three types of transmission-based precautions: airborne, droplet, and contact.

3. Standard Precautions
Standard Precautions combine the major features of Universal Precautions (UP) and Body Substance Isolation (BSI) and are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions

include a group of infection prevention practices that apply to all residents, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the residents environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g. wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another resident).

The application of Standard Precautions during resident care is determined by the nature of the healthcare worker to resident interaction and the extent of anticipated blood, body fluid, or pathogen exposure. For some interactions (e.g., performing venipuncture), only gloves may be needed; during other interactions (e.g., intubation), use of gloves, gown, and face shield or mask and goggles are necessary.

It will be important to comply with hand hygiene measures during a pandemic incident. If there is a limitation on the availability of hand hygiene products, it will be important to stress the importance basic soap and water. LTC Unity may increase the number of signs for staff, residents, and visitors to remind them of the importance of compliance with hand hygiene.

STANDARD PRECAUTIONS[1]	
COMPONENT	***RECOMMENDATIONS***
Hand hygiene	After touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between patient contacts.
Personal Protective Equipment (PPE)	
Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and non-intact skin
Gown	During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
Mask, eye protection (goggles), face shield*	During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation

[1] *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings,* ***June 2007;*** (Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings) http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf, viewed on 3.25.17.

STANDARD PRECAUTIONS[1]	
COMPONENT	***RECOMMENDATIONS***
Soiled patient-care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene.
Environmental control	Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break, or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only; use safety features when available; place used sharps in puncture-resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient placement	Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.
Respiratory hygiene/cough etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, >6 feet if possible.

**During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols (e.g., SARS), wear a fit-tested N95 or higher respirator in addition to gloves, gown, and face/eye protection*

4. Personal Protective Equipment

The facility will maintain a two month (60-days) supply of personal protective equipment necessary for both residents and staff including but not limited to:

- N95 respirators;
- Face shields; Eye protection;
- Isolation gowns/gowns;

- Gloves;
- Masks; and
- Hand sanitizer and equipment disinfectants in accordance with current FDA and EPA guidance

The supply par level is determined based on prior pandemic response experience established burn rates, and as required by state and federal requirements. Rochester Regional Health Materials Management team secures the supplies in central storage.

5. Respiratory Hygiene/Cough Etiquette

The need for vigilance and prompt implementation of infection prevention measures at the first point of encounter within a healthcare setting (e.g., reception and triage areas in emergency departments, outpatient clinics, and physician offices). The strategy proposed has been termed Respiratory Hygiene/Cough Etiquette and is intended to be incorporated into infection prevention practices as a new component of Standard Precautions. The strategy is targeted at residents, family members, and friends with undiagnosed transmissible respiratory infections, and applies to any person with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions when entering a healthcare facility.

The elements of Respiratory Hygiene/Cough Etiquette include:

- Education of healthcare facility staff, residents, and visitors;
- Posted signs, in language(s) appropriate to the population served, with instructions to residents and accompanying family members or friends;
- Source control measures (e.g., covering the mouth/nose with a tissue when coughing and prompt disposal of used tissues, using surgical masks on the coughing person when tolerated and appropriate);
- Hand hygiene after contact with respiratory secretions; and
- Spatial separation, ideally more than three feet of separation, of persons with respiratory infections in common waiting areas when possible.

Covering sneezes and coughs and placing masks on coughing resident are proven means of source containment that prevent infected persons from dispersing respiratory secretions into the air. Masking may be difficult in some settings, in which case the emphasis by necessity may be on cough etiquette. Physical proximity of less than three feet has been associated with an increased risk for transmission of infections via the droplet route, and therefore supports the practice of distancing infected persons from others who are not infected.

Healthcare personnel are advised to observe Droplet Precautions (i.e., wear a mask) and hand hygiene when examining and caring for resident with signs and symptoms of a respiratory infection. Healthcare personnel who have a respiratory infection are advised to avoid direct resident contact, especially with high risk residents. If this is not possible, then a mask should be worn while providing care.

6. Transmission-Based Precautions[2]

Background

There are three categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions. Transmission-Based Precautions are used when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone. For some diseases that have multiple routes of transmission (e.g., SARS), more than one Transmission-Based Precautions category may be used. When used either singly or in combination, they are always used in addition to Standard Precautions.

Use Transmission-Based Precautions in addition to Standard Precautions for patients with documented or suspected infection or colonization with highly transmissible or epidemiologically-important pathogens for which additional precautions are needed to prevent transmission. Extend duration of Transmission-Based Precautions, (e.g., Droplet, Contact) for immunosuppressed patients with viral infections due to prolonged shedding of viral agents that may be transmitted to others. See Appendix A *Type and Duration of Precautions Recommended for Selected Infections and Conditions*.

When Transmission-Based Precautions are indicated, efforts must be made to counteract possible adverse effects on patients (i.e., anxiety, depression and other mood disturbances, perceptions of stigma, reduced contact with clinical staff, and increases in preventable adverse events) in order to improve acceptance by the patients and adherence by healthcare personnel (HCPs).

Syndromic and Empiric Applications of Transmission-based Precautions

Diagnosis of many infections requires laboratory confirmation. Since laboratory tests, especially those that depend on culture techniques, often require two or more days for completion, Transmission-Based Precautions must be implemented while test results are pending based on the clinical presentation and likely pathogens. Use of appropriate Transmission-Based Precautions at the time a patient develops symptoms or signs of transmissible infection, or arrives at a healthcare facility for care, reduces transmission opportunities. While it is not possible to identify prospectively all patients needing Transmission-Based Precautions, certain clinical syndromes and conditions carry a sufficiently high risk to warrant their use empirically while confirmatory tests are pending. Infection prevention professionals are encouraged to modify or adapt this table according to local conditions.

Discontinuation of Transmission-based Precautions

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[2] *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, **June 2007;*** (Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings) http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf viewed on 3.25.17.

Transmission- Based Precautions remain in effect for limited periods of time (i.e., while the risk for transmission of the infectious agent persists or for the duration of the illness. For most infectious diseases, this duration reflects known patterns of persistence and shedding of infectious agents associated with the natural history of the infectious process and its treatment. For some diseases, Transmission-Based Precautions remain in effect until culture or antigen-detection test results document eradication of the pathogen and, for RSV, symptomatic disease is resolved. For other diseases, state laws and regulations, and healthcare facility policies, may dictate the duration of precautions. In immunocompromised patients, viral shedding can persist for prolonged periods of time (many weeks to months) and transmission to others may occur during that time; therefore, the duration of contact and/or droplet precautions may be prolonged for many weeks.

3. Contact Precautions

Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment. The application of Contact Precautions for resident-infected or colonized with multidrug resistant organisms (MDROs) is described in the 2006 HICPAC/CDC MDRO guideline. Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. A single resident room is preferred for residents who require Contact Precautions. When a single-resident room is not available, consultation with infection prevention personnel is recommended to assess the various risks associated with other resident placement options (e.g., cohorting, keeping the resident with an existing roommate).

In multi-resident rooms, more than six (6) feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized resident and other residents. Healthcare personnel caring for resident on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning PPE before room entry and discarding before exiting the resident room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., VRE, C. difficile, noroviruses and other intestinal tract pathogens, RSV).

Indications

Use Contact Precautions as recommended in the HICPAC/CDC Isolation Guideline (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf) for residents with known or suspected infections or evidence of syndromes that represent an increased risk for contact transmission.

4. Droplet Precautions[3]

Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission. Infectious agents for which Droplet Precautions are indicated are found in Appendix A of the HICPAC/CDC Isolation guideline at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf and include *B. pertussis*, influenza virus, adenovirus, rhinovirus, *N. meningitides*, and group A streptococcus (for the first 24 hours of antimicrobial therapy).

A single patient room is preferred for patients who require Droplet Precautions. When a single-patient room is not available, the Infection Prevention Coordinator will assess the various risks associated with other patient placement options (e.g., cohorting; keeping the patient with an existing roommate). Spatial separation of patients by greater than six (6) feet and drawing the curtain between patient beds is especially important for patients in multi-bed rooms with infections transmitted by the droplet route.

Healthcare personnel will wear a mask (a respirator is not necessary) for close on Droplet Precautions who must be transported outside of the room should wear a mask if tolerated and follow Respiratory Hygiene/Cough Etiquette.

Indications

Use Droplet Precautions as recommended in Appendix A of HICPAC/CDC Isolation guideline at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf for patients known or suspected to be infected with pathogens transmitted by respiratory droplets (i.e., large-particle droplets >5μ in size) that are generated by a patient who is coughing, sneezing or talking.

5. Airborne Precautions[4]

Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., rubeola virus [measles], varicella virus [chickenpox], Mycobacterium. tuberculosis, and possibly SARS-CoV). The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room (AIIR).

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[3] *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings,* ***June 2007;*** (Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings) http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf viewed on 3.25.17.

[4] *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings,* ***June 2007;*** (Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings) http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf viewed on 3.25.17.

An AIIR is a single-patient room that is equipped with special air handling and ventilation capacity that meet the American Institute of Architects/Facility Guidelines Institute (AIA/FGI) standards for AIIRs (i.e., monitored negative pressure relative to the surrounding area, 12 air exchanges per hour for new construction and renovation and six (6) air exchanges per hour for existing facilities, air exhausted directly to the outside or re-circulated through HEPA filtration before return).

In settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g., physician offices), masking the patient, placing the patient in a private room (e.g., office examination room) with the door closed, and providing N95 or higher level respirators or masks if respirators are not available for healthcare personnel will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned to the home environment, as deemed medically appropriate.

Healthcare personnel caring for patients on Airborne Precautions wear a mask or respirator, depending on the disease-specific recommendations (Respiratory Protection II.E.4, and Appendix A of HICPAC/CDC Isolation guideline at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf) that is donned prior to room entry. Whenever possible, non-immune staff should not care for patients with vaccine-preventable airborne diseases (e.g., measles, chickenpox, and smallpox).

Indications
Use Airborne Precautions as recommended in Appendix A *Type and Duration of Precautions Recommended for Selected Infections and Conditions* for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route (e.g., *M tuberculosis*, measles, chickenpox, disseminated herpes zoster).

Note: LTC Unity does not have airborne isolation capability. Residents needing airborne isolation will be transferred to another facility with this capability.

6. Admissions & Readmissions of Residents to the Nursing Home:

- Residents with any communicable disease or ongoing symptoms of COVID-19 illness require transmission-based precautions.

- Residents with COVID-19 Disease who are no longer contagious
  - At least 24 hours have passed since last fever without the use of fever-reducing medications, and
  - Symptoms (e.g., cough, shortness of breath) have improved, and
  - Twenty-one (21) days have passed since symptom onset, depending on the severity of the patient's illness and presence of severe immunocompromise, as determined by the attending medical provider. If the patient is

asymptomatic throughout his/her infection, the date of the positive test begins the clock for the required isolation time.

Note: Additionally, a resident with persistent symptoms from COVID-19 (e.g., persistent cough) should be placed in a private room (or a room with another confirmed COVID-19 resident), be restricted to their room, and wear a facemask during care activities until all symptoms are completely resolved.

- Residents with confirmed or presumed COVID-19 Disease and PUIs (that is, potentially contagious) (with regulatory permission)
  - Admit to a unit designated to receive COVID-19 residents.
  - Admit the resident to a private room. Residents with confirmed COVID-19 may be cohorted with other residents with confirmed COVID-19 as long as no other contraindications to cohorting exist.

- Residents with known exposure to COVID-19
  - Preferably admit to a unit with prior exposure to confirmed COVID-19 or unit designated to receive COVID-19. If such a bed is not available, the resident may be admitted to a private room on any unit.
  - ***Follow the instructions in Section D, written in the COVID-19 Clinical Workflows for Nursing Home document***

- Admission or re-entry to the nursing home after hospital care for a non-respiratory illness requires no additional review. These new admissions are placed on isolation for 14 days and cohorted separately from other residents.

- Regardless of any prior negative COVID-19 testing, institute contact and droplet precautions for 14 days for residents recently-hospitalized with a systemic illness, or vague or ill-defined symptoms such as malaise, fatigue, weakness, confusion, gait disturbance, or self-care deficits. These precautions may not be necessary for patients after elective surgery, at the discretion of the facility infection prevention nurse or designee.

- Admissions & re-entries to an exposed unit may continue. Avoid new admissions of residents to the exposed unit who are immunocompromised, have diabetes or significant cardiac, kidney, or lung disease, or would have difficulty complying with room confinement or mask usage.

- If a resident is hospitalized due to COVID-19 exposure or diagnosis, the facility with ensure that they preserve a spot within the facility for readmission back to the facility upon discharge from the hospital.

7. Cohorting

Existing Resident Population:

Residents with suspected or confirmed COVID-19 status will be separated as appropriate space allows and in accordance with direction from local and state health officials.

If the positive resident resides in a private room, they will remain in their room with the door closed. If the positive resident resides in a semi-private room, the positive patient is moved out of their room to a private room or non-traditional care space with the door closed, not on a different unit. Residents will discontinue sharing a bathroom with any other resident outside of the cohort. Non-traditional spaces will be identified for use as a COVID unit.

Within 24 hours, the positive resident is moved to a low-traffic space not on a different unit (which may be the non-traditional care space previously mentioned). If the number of positive residents exceeds the unit's low-traffic space capacity, they are transferred to the designated COVID unit within 72 hours. The designated unit will have proper identification of the area including demarcating reminders for healthcare and personnel, and procedures to prevent other residents from entering.

Placement of New Admissions:

Priority Flow:

1. Private room on a dedicated wing for observing new admissions
2. Private room on any nursing unit
3. Semiprivate room, placed with another recently-admitted patient. For all double rooms (semi-private):
   - Privacy curtains are kept closed at all times until both patients have been in the room for at least 14 days.
- Patient must be tested negative within 48 hours prior to admission. (direct admissions from home are not always tested prior to admission because of logistics).

When the resident's home county Percent Positive Test is less than 1 percent:

- Toe-to-Toe Double: First patient completes isolation after 14 days from their admission, Second patient completes isolation after 14 days from their admission. No restriction by admission date, but still trying to keep the admission dates as close as possible.
- Side-to-Side Double: First patient completes isolation after 14 days from their admission, Second patient completes isolation after 14 days from their admission. Admissions are restricted to within 7 days of each other.

When the resident's home county Percent Positive Test is greater than 1 percent:

- Toe-to-Toe Double: First patient completes isolation after 14 days from their admission, Second patient completes isolation after 14 days from their admission. Admissions are restricted to within 5 days of each other.

- Side-to-Side Double: First patient completes isolation after 14 days from the second patient's admission, Second patient completes isolation after 14 days from their admission. Admissions are restricted to within 5 days of each other.

RRH SNFs will provide, to the extent possible, dedicated staffing teams to care of COVID-19 and non-COVID-19 residents.

The number of staff caring for COVID positive residents will be minimized, including clinicians performing non-clinical work or work of other clinicians as long as the work is within their scope of practice.

Nurses fitted for an N95 respirator will be assigned to COVID-19 positive cohorts in the event that they will be required to perform aerosol-generating procedures, including suctioning (if not using an inline catheter), nebulizer administration, manipulation of BiPAP/CPAP mask, chest physiotherapy, and CPR.

Staff caring for the resident with COVID-19 disease should avoid caring for other residents or floating to other units. If caring for residents without COVID-19 disease is unavoidable, for all residents , at a minimum, affected staff will:

- Wear a medical mask and face shield (extended wear permitted)
- Wear gloves (changed between residents and according to all infection prevention principles)
- Wear a gown when performing direct care activities (such as bathing, dressing, toileting, incontinence care, transfers)
- Follow the additional precautions required when caring for residents in workflows.

Note: Affected staff should follow these procedures from the start of the first shift until the end of the last shift each day, until there are no more residents on the unit with COVID-19 Disease.

Facility Administrator and operator will determine cohorting needs and capabilities on a regular bases and notify NYS DOH if facility cannot set up a cohort area or no longer sustain cohorting efforts.

H. Required Communicable Disease Reporting

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (*10NYCRR 2.10*). Although physicians have primary responsibility for reporting, school nurses, laboratory directors, infection control practitioners, daycare center directors, health care facilities, state institutions and any other individuals/locations providing health care services are also required to report communicable diseases.

Reports should be made to the local health department in the county in which the individual resides and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately to local health departments by phone. *See Attachment 1: DOH-389 Reporting Form.*

For more information on communicable disease reporting, call MCDPH or the New York State Department of Health's Bureau of Communicable Disease Control at (518) 473-4439 or, after hours, at 1 (866) 881-2809; to obtain reporting forms (DOH-389), call (518) 474-0548.

I. Decontamination of Residents and Environment

1. Resident Decontamination

In most cases, resident decontamination will not be necessary during a pandemic incident. Because of the incubation period of pandemic agents individuals will not become ill while still contaminated. The exceptions may be following an overt release of a pandemic agent, with gross surface contamination of victims by the agent, or an emergency involving contamination of a resident by material such as raw sewage.

People who were actually exposed to a release (e.g., in the cloud of a disseminated agent, or passing through the area where an agent was released after the fact, or those bearing signs of physical contamination [such as dust or powder evident on exposed surfaces]) should be initially managed with both infectious disease and hazardous materials precautions.

Process for Resident Decontamination

In the rare cases where resident decontamination may be warranted, simple washing with bactericidal soap and water is sufficient.

2. Environmental Decontamination

If necessary, environmental surfaces can be decontaminated with a U.S. Environmental Protection Agency (EPA) registered sporicidal disinfectant or with a 0.5% hypochlorite solution (1 part household bleach added to 9 parts water). **Bleach solution should NOT be used to decontaminate patients.**

Cleaning of any body fluid spills during a pandemic incident will follow current facility protocols. If additional care is recommended, LTC Unity will follow recommendations from the NYSDOH/CDC.

Cleaning and disinfecting of resident care equipment during a pandemic incident will follow current facility protocols. If additional care is recommended, LTC Unity will follow recommendations from the NYSDOH/CDC. If there is a shortage of equipment, any reuse not currently permitted must be approved by the NYSDOH.

Disposal of Regular Trash and Regulated Medical Waste

Standard procedures for handling regular trash and regulated medical waste during a pandemic event will remain in effect, unless modified by RRH Infection Prevention based on pathogen-specific concerns. In the event that a need arises for prolonged storage or on-site management of such materials, such as when routine pick-up of waste cannot occur due to the incident, the Director of Facilities

will, in consultation with Infection Prevention, designate a suitable location for secure storage of necessary items.

J. Staffing

During a pandemic incident, it is likely that healthcare staff will be affected by the event in terms of becoming ill or needing to treat sick family members at home; this will place increased demands for staffing on the facility. In addition, pandemic incidents can cause increased fear/anxiety in staff, which may affect their willingness to report to work. Lastly, pandemic events, such as a pandemic, may affect large parts of the US at the same time, which eliminates the opportunity to obtain staff from other regions. Therefore, pandemic events may create even more of a staffing need than other types of disasters.

It will be important to have a liberal/non-punitive sick leave policy during this time to allow sick employees to stay home until no longer contagious. Staff members that are on sick leave may be monitored by daily call-in. Staff members may be asked to report specific symptoms.

The CEMP contains a series of strategies for maximizing staffing under austere conditions. At the time of an incident, in addition to the CEMP provisions, additional actions may be directed by the Incident Commander. Such actions may include, but are not limited to, one or more of the following:

- Build a list of essential support personnel who are needed to maintain facility operations
- Create a list of less-essential positions that can be re-assigned to support critical services
- Have departments create and/or revise contingency staffing plans for a minimum duration of eight weeks.
- Define what would constitute a "staffing crisis" that would enable the use of emergency staffing and alternative medical care levels, and that would meet NYS approval.
- Implement procedures for rapidly credentialing health-care professionals, including web based licensure check licensed professionals.
- Include an internal volunteer program for the maintenance of non-clinical support functions.
- Include a request for licensed healthcare volunteers through the NYSDOH ServNY.
- Include a protocol to process and receive spontaneous unaffiliated clinical and/or non-clinical volunteers. *CEMP Attachment 14.*
- Establish internal mechanisms to screen, assign, and supervise volunteers.
- Obtain state approval to enact alternative staffing plans and care levels.

- Utilizing the Incident Command System, the Incident Commander will coordinate with the Logistics Section, who will oversee a labor pool of volunteers, staff, retirees, etc. to help address staffing needs.
- Increase cross-training of personnel to provide support for essential care areas at times of severe staffing shortages.
- Consider the use of alternative sources of staffing support, such as students and resident family members.
- Create a list of non-essential positions that can be placed on administrative leave or allowed to work out of their home, to limit the number of persons in the facility (reducing likelihood of disease spread).

1. Employee Reluctance or Refusal to Work

LTC Unity employees, as a condition of employment, do not have the right to refuse to work with certain categories of residents. Existing policy will remain in effect. The following measures will be implemented to allay fears and reduce employee reluctance to work:

- As always, every attempt will be made by department heads to ensure that employees are equipped with incident- and activity-appropriate PPE, and trained in its use.
- Effective communication strategies will be implemented to provide employees with the knowledge base needed to avoid undue concern regarding disease transmission.
- Wherever possible, employees and their immediate families will be provided prophylaxis at no cost to themselves during a pandemic incident (under the guidance of local and state health authorities). *See CEMP Annex 5: Medical Countermeasures Plan.*

- Every effort will be made to avoid placing employees who are themselves at unusual risk for disease (e.g., non-immunized, pregnant, or immuno-compromised) in direct care positions with residents who may transmit the disease.

Safe work practices

Staff members will be reminded to avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to resident care (e.g., door knobs, keys, light switches).

Self-Evaluation

Employees will be provided educational information and a self-evaluation tool (see *Attachment 4*) on signs and symptoms of the current outbreak. Any employee with signs or symptoms will be instructed to notify their direct supervisor via telephone before presenting for duty to determine if they are fit to work. Decisions regarding

an employee's ability to work will be made on a case-by-case basis by the manager, Infection Prevention, and Employee Health.
Decisions regarding transfer of pregnant or immunocompromised employees to non-influenza work areas will be made on an individual basis by the manager, Infection Prevention, and Employee Health.

Symptomatic Employees
Ill employee issues will be reported to the RRH Occupational Health. Decisions regarding work will be made between the employee's manager and Occupational Health, if possible.

If onset of illness occurs at home, the employee will be instructed to notify their direct supervisor and may be instructed not to report to work until symptoms resolve. These recommendations may come from the NYSDOH/CDC.

If onset of employee illness occurs while working, the employee will be instructed to don a surgical mask and report to a designated area.

K. Pharmaceutical or Medical Supply Needs

When leadership determines that internal pharmaceutical or other medical supplies/equipment will not be sufficient to meet the needs of staff and residents, the Command Center may request resources from an external stockpile.

Requests for external resources require the approval of the Incident Commander. Once approved, the request is routed through the Monroe County Emergency Operations Center (via the ESF #8 Desk – managed by MCDPH). The determination as to the source and availability of external stockpile resources, as well as the delivery process, will be coordinated by the Office of Emergency Management.

L. Managing the Psychological Impact

Following a pandemic incident, anxiety and alarm can be expected from infected residents, their families, healthcare workers, and the worried well. Psychological responses may include anger, fear, panic, unrealistic concerns about infection, fear of contagion, paranoia, and social isolation. The following are some points to consider, as appropriate to the event:

- Communicate clear, concise information about the pandemic agent, how it is transmitted, what treatment and preventive options are currently available, when prophylactic antibiotics, antitoxin serum, or vaccines will be available, and how prophylaxis or vaccination will be distributed.
- Provide educational materials in the form of frequently asked questions (FAQ).
- Provide information on quarantine and isolation.

V. Recovery

As the evidence of pathogen-related activity returns to pre-incident levels, the Incident Commander will consider shifting the operation to the recovery phase. In addition to the

CEMP-specified Recovery Phase activities, and those itemized for each ICS position, actions during the recovery phase may include, but are not limited to, the following:

- Continue surveillance activity in anticipation of second-wave disease outbreak.
- Gather data to report how many individuals were treated for the disease.
- Gather data to report how many employees were treated for the disease.
- Conduct evaluation of how the plan worked and document findings in an after-action report.

Pandemic Illness

A pandemic influenza event will not appear and disappear suddenly. There will be a slow beginning and a slow end as healthcare and responder organizations wind down in their response. A pandemic will also likely have waves which will make it seem like the event is over only to have a reemergence.

During the post-pandemic period it will be important to review state and federal guidelines and implement any new guidance.

As appropriate to the event, continue:

- monitoring personnel for fever and respiratory symptoms
- infection prevention measures in accordance with current guidance
- to provide reports to state and local government as required/requested
- surveillance activity in anticipation of a potential second-wave disease outbreak

Additional information related to incident recovery can be found in the CEMP Annex 17: Disaster Recovery Plan.

References

California Hospital Association. August 2006. *Biological Attack.*

CDC 2007. *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.* http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

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Attachment 1: NYSDOH Communicable Disease Reporting (DOH-389)

https://www.health.ny.gov/forms/instructions/doh-389_instructions.pdf

NEW YORK STATE DEPARTMENT OF HEALTH

Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician, more or, laboratories (PHL 2302), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis
Amebiasis
(Animal bites for which rabies prophylaxis is given[1]
(Anthrax[2]
(Arboviral infection[3]
Babesiosis
(Botulism[2]
(Brucellosis[2]
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
(Cholera
(Coronavirus (severe or novel) 2019 Novel Coronavirus (COVID-19)
Severe Acute Respiratory Syndrome (SARS)
Middle East Respiratory Syndrome (MERS)
Cryptosporidiosis
Cyclosporiasis
(Diphtheria
E.coli O157:H7 infection[4]
Ehrlichiosis
(Encephalitis
(Foodborne Illness
Giardiasis
(Gonorrhea[2]
Gonococcal infection
Haemophilus influenzae[5] (invasive disease)
(Hantavirus disease
Hemolytic uremic syndrome
Hepatitis A
(Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
(Measles
(Meningitis[6]
Meningitis
Aseptic or viral
(Haemophilus
(Meningococcal
Other (specify type)
(Meningococcemia
(Monkeypox
Mumps
Pertussis
(Plague[2]
(Poliomyelitis
Psittacosis
(Q Fever[2]
(Rabies[1]
Rocky Mountain spotted fever
(Rubella (including congenital rubella syndrome)
Salmonellosis
Shigatoxin-producing E.coli[4] (STEC)
Shigellosis[4]
(Smallpox[2]
Staphylococcus aureus[4] (due to strains showing reduced susceptibility or resistance to vancomycin)
(Staphylococcal enterotoxin B poisoning[2]
Streptococcal infection (invasive disease)[4]
Group A beta-hemolytic strep
Group B strep
Streptococcus pneumoniae
(Syphilis, specify stage[7]
Tetanus
Toxic shock syndrome
Transmissible spongiform encephalopathies[8] (TSE)
Trichinosis
(Tuberculosis current disease (specify site)
(Tularemia[2]
(Typhoid
(Vaccinia disease[9]
Vibriosis[4]
(Viral hemorrhagic fever[2]
Yersiniosis

WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides.

Contact Person _____

Name _____

Address _____

_____

Phone _____ Fax _____

WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- Phone diseases in bold type.
- Mail case report, DOH-389, for all other diseases.
- In New York City use form PD-16.

SPECIAL NOTES

- Diseases listed in bold type (warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks, while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS are reportable on form DOH-4189 which may be obtained by contacting:**

  Division of Epidemiology, Evaluation and Research
  P.O. Box 2073, ESP Station
  Albany, NY 12220-2073
  (518) 474-4284

  In NYC: New York City Department of Health and Mental Hygiene
  For HIV/AIDS reporting, call:
  (212) 442-3388

1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatox in test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test > 1:16 or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination: eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, postvaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

ADDITIONAL INFORMATION

For more information on disease reporting, call your local health department or the New York State Department of Health Bureau of Communicable Disease Control at (518) 473-4439 or (866) 881-2809 after hours.

In New York City, 1 (866) NYC-DOH1.

To obtain reporting forms (DOH-389), call (518) 474-0548.

PLEASE POST THIS CONSPICUOUSLY

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Attachment 3: HICPAC/CDC Isolation Guide

This attachment is listed separately on the internal network under "Annex 11".

This attachment is also available electronically at
http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf