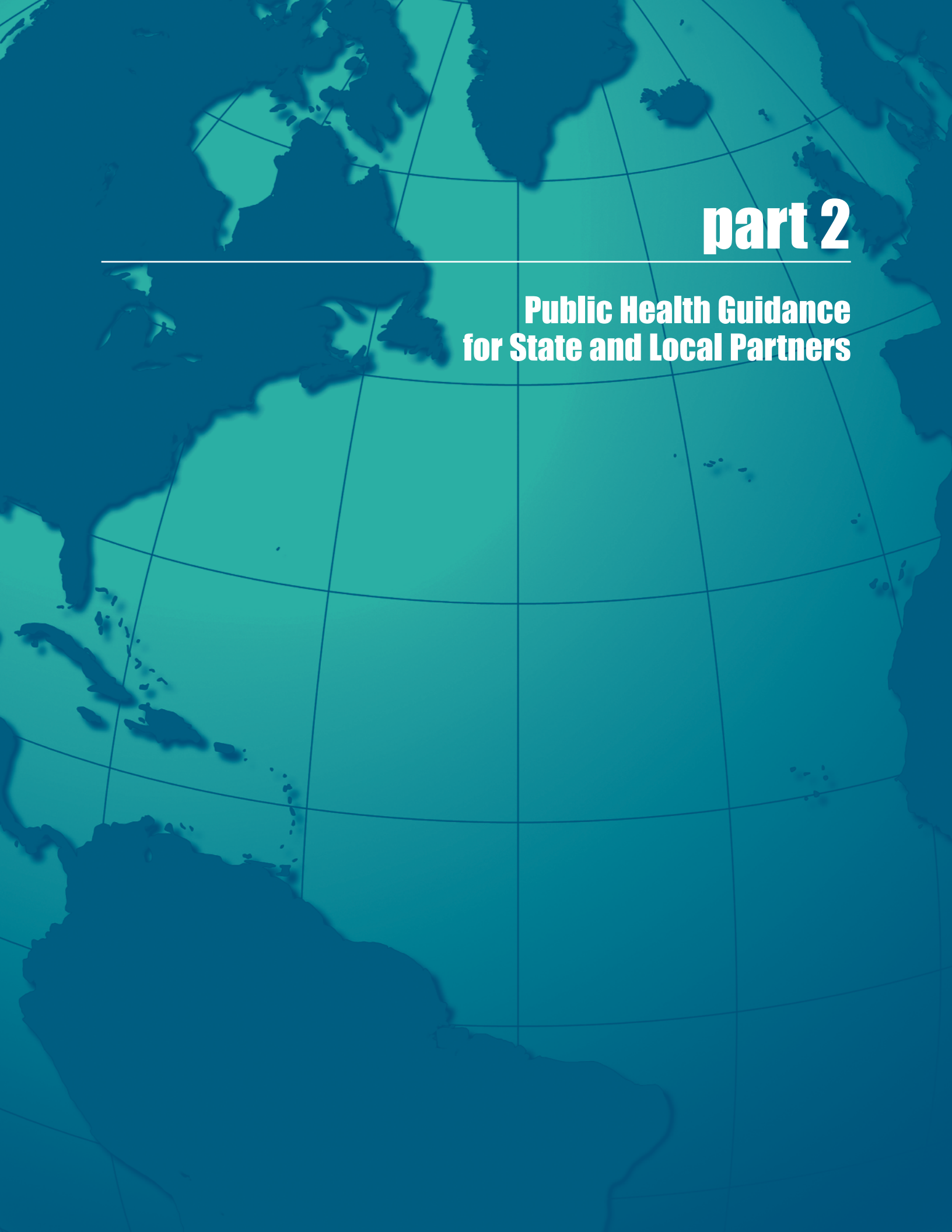

part 2

Public Health Guidance for State and Local Partners

introduction

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PART 2. PUBLIC HEALTH GUIDANCE ON PANDEMIC INFLUENZA FOR STATE AND LOCAL PARTNERS[1]

A. Introduction

An influenza pandemic may emerge with little warning, affecting a large number of people within a short space of time. During the first wave of the pandemic, outbreaks may occur simultaneously in many locations throughout the nation, preventing a targeted concentration of national emergency resources in one or two places—and requiring each locality to depend in large measure on its own resources to respond. A vaccine will not yet be available, and the supply of antiviral drugs will be limited. Local outbreaks may last for weeks or months, and widespread illness in a particular community could lead to shortages in the healthcare sector as well as in essential services.

An effective local response will depend on pre-established partnerships and collaborative planning by public health officials, hospital administrators, and community leaders, who have considered a range of best-case and worst-case scenarios. It will require flexibility and real-time decision-making, guided by epidemiologic information on the pandemic virus. It will also depend on a well-informed public that understands the dangers of pandemic influenza and accepts the potential need for control measures like self-isolation and quarantine that prevent disease spread by reducing social contact. The public must also understand and accept the rationale in prioritizing the use of limited supplies of antiviral drugs and initial stocks of vaccines.

The goal of Part 2 of the *HHS Pandemic Influenza Plan* is to help state and local jurisdictions and healthcare facilities mount an effective response to pandemic influenza. Public Health Guidance on Pandemic Influenza for State and Local Partners was developed with input from many public health and medical partners with front-line responsibility for pandemic influenza response.

Purpose and Aims

All U.S. state, local, and tribal governments must be prepared to detect the earliest cases of disease, to minimize illness and morbidity, and to decrease social disruption and economic loss. The principle aims of the *Public Health Guidance for State and Local Partners* are to:

- Provide guidance for updating state-level pandemic influenza response plans developed in fulfillment of activities under the CDC and HRSA Cooperative Agreements for Public Health Emergency Preparedness and Bioterrorism Hospital Preparedness (*www.bt.cdc.gov/planning/guidance05/index.asp* and *www.hrsa.gov/grants/preview/guidancespecial/hrsa05001.htm*).
- Help healthcare partners address the medical challenges of pandemic influenza (e.g., evaluation and management of large numbers of patients, occupational health risks, and limited supplies of antiviral medications and vaccines).
- Define the public health role in healthcare planning and preparedness for pandemic influenza.
- Strengthen linkages between public health departments and private sector partners—including healthcare facilities, community-based organizations, clinical laboratories, behavioral health experts, and first responders—to protect health and preserve essential services during a pandemic.

Many activities described in the Public Health Guidance for State and Local Partners are similar, if not the same as those required to combat other infectious diseases, such as Severe Acute Respiratory Syndrome (SARS) or intentionally-spread smallpox or plague. Topics covered in the *Public Health Guidance for State and Local Partners* may, therefore, be relevant to—or addressed in—other emergency preparedness plans. (See, for example: *Public Health Guidance for Community-Level Preparedness and Response to SARS:* www.cdc.gov/ncidod/sars/guidance/; *Smallpox Response Plan and Guidelines*: www.bt.cdc.gov/agent/smallpox/response-plan/index.asp).

[1] Through this document, the term "state and local" is inclusive of territorial and tribal governments and health authorities, as applicable.

Organization

Part 2 of the *HHS Pandemic Influenza Plan* provides an overview of

- Pandemic influenza preparedness and response planning by state and local governments (Section B)
- Community planning to support healthcare facilities on a city-wide or regional basis during an influenza pandemic (Section C)

Part 2 also includes eleven supplements that provide guidance on specific aspects of pandemic influenza planning and response:

Supplement 1: Pandemic Influenza Disease Surveillance

Supplement 2: Laboratory Diagnostics

Supplement 3: Healthcare Planning

Supplement 4: Infection Control

Supplement 5: Clinical Guidelines

Supplement 6: Vaccine Distribution and Use

Supplement 7: Antiviral Drug Distribution and Use

Supplement 8: Community Disease Control and Prevention

Supplement 9: Management of Travel-Related Risk of Disease Transmission

Supplement 10: Public Health Communications

Supplement 11: Psychosocial Workforce Support Services

The content of each supplement is summarized in Section D.

Priority activities in each Supplement are organized under the time periods laid out in the WHO classification system proposed in February 2005: the *Interpandemic Period,* the *Pandemic Alert Period,* and the *Pandemic Period.* Some of the Supplements further subdivide Pandemic Period activities according WHO pandemic phases or to local levels of disease spread that will trigger particular activities over the course of the pandemic.

To help state and local public health and healthcare partners prepare for the unexpected, the *Public Health Guidance for State and Local Partners* includes a list of cross-cutting technical resources, including exercises and drills, to facilitate the exploration of different scenarios and local concerns (see **Supplement 3. Healthcare Planning,** Appendix 1). The *Public Health Guidance for State and Local Partners* also identifies disease-control issues whose resolution will require real-time guidance during a pandemic (Box 1).

Definitions of public health terms used throughout the *Public Health Guidance for State and Local Partners* are provided in Box 3 and in the Glossary.

B. Overview of Planning by State and Local Governments

All states and localities must be prepared to coordinate the pandemic influenza response within and between their jurisdictions. State and local responsibilities include:

- Enhancing disease surveillance to ensure early detection of the first cases of pandemic influenza in their jurisdictions (see **Supplements 1 and 2**).

- Distributing public stocks of antiviral drugs and vaccines and providing local physicians and hospital administrators with updated guidance on clinical management and infection control as the situation unfolds (**Supplements 3 to 7**[2])
- Preventing local disease transmission using a range of containment strategies (**Supplements 8 and 9**)
- Providing ongoing communication with the public (about the response effort, including the purpose and duration of containment measures) (**Supplement 10**)
- Providing psychological and social support services to emergency field workers and other responders (**Supplement 11**)

As described in Part 1, the HHS will support affected states or jurisdictions during an influenza pandemic by:

- Conducting outbreak investigations, as requested
- Conducting epidemiologic and laboratory-based studies ("special studies")
- Providing ongoing information from the national influenza surveillance system on the pandemic's impact on health and the healthcare system
- Expanding supply of antiviral drugs by stimulating increased U.S. based production capacity
- Expanding U.S.-based production capacity for pandemic vaccine and working with manufacturers to ensure that pandemic vaccine is produced at full capacity
- Distributing public stocks of antiviral drugs and other medical supplies from the Strategic National Stockpile to the states
- Distributing public stocks of vaccines, when they become available
- Providing guidance on community containment strategies, including travel restrictions, school closings, and quarantine
- Communicating with the public via the news media
- Monitoring the response

Planning Process

The first step in the planning process for state and local governments is to establish a Pandemic Influenza Coordinating Committee to oversee preparedness planning and ensure integration with other emergency planning efforts. The membership of the Coordinating Committee should represent a range of disciplines and expertise in the public and private sectors (Box 2).

The Coordinating Committee should draft and formally adopt a pandemic influenza response plan that:

- Delineates the roles and responsibilities of state and local agencies and offices
- Builds on existing preparedness and response plans for bioterrorism events, SARS, and other infectious disease emergencies
- Addresses legal issues including those that affect hospital staffing, patient care, and quarantine (see below)
- Is periodically reviewed and updated

As part of the planning effort, the Coordinating Committee should:

- Help establish and promote community-based task forces that support healthcare institutions on a city-wide or regional basis (see Section C).
- Identify the authority responsible for state-level declaration of a public health emergency and for officially activating the pandemic influenza response plan.

[2] Supplements 3, 4, and 5 are primarily directed to healthcare providers and hospital administrators, while Supplements 6 and 7 are also directed to state and local health officials.

- Identify an overall coordinator to work with hospitals and communicating with medical and mental health personnel during a pandemic.
- Identify the jurisdiction's controlling authority over intrastate and interstate modes of transportation, which might be curtailed during a pandemic.
- Identify state and local law enforcement personnel who will assist in maintaining public order and enforcing control measures during a pandemic.
- Develop and reinforce relationships with local health authorities in adjoining jurisdictions.
- Make planning decisions on acquisition and distribution of antiviral drugs and vaccines, in accordance with HHS recommendations.
- Ensure that plans take into account tribal populations, where applicable.
- Conduct state-level "table top" exercises to test response capabilities.
- Encourage local jurisdictions to conduct exercises and drills.

Legal Preparedness

The Coordinating Committee should review state and local statutory provisions regarding:

- Laws and procedures for closing businesses or schools and suspending public meetings during a declared state of emergency
- Medical volunteer licensure, liability, and compensation laws for in-state, out-of-state, and returning retired and non-medical volunteers
- Quarantine laws and how they apply in a public health emergency
- Workers' compensation laws as they apply to healthcare workers and workers who provide essential services
- Reimbursement for workers placed in isolation or quarantine (if not addressed in sick leave policies)

Relevant federal law should be reviewed as well and statutes should he harmonized, as feasible.

Additional information on legal preparedness is provided in Appendices 1 and 2.

C. Overview of Community-wide Planning to Support Healthcare Facilities

Without special preparation, a large-scale pandemic could quickly overwhelm local healthcare facilities and resources. Although institutional planning by hospitals is essential (see Supplement 3), it is not sufficient. Hospitals depend on many organizations and groups—e.g., suppliers of food, drugs, and medical supplies, sanitation workers, and telephone companies—to accomplish their day-to-day tasks. If workforce illnesses and absences prevent these organizations from functioning normally during a pandemic, hospitals will be severely affected.

State health authorities should consider promoting the establishment of local pandemic influenza task forces that will ensure community readiness to provide emergency support to healthcare facilities on a city-wide or regional basis. Depending on the state, the task forces may be coordinated by municipal, county, or tribal health departments, or by regional public health offices. Task force activities should be integrated with state-wide planning efforts and should reflect common goals and principles for preparedness and response.

Each local task force should include representatives from hospitals, community service organizations, professional organizations of physicians, nurses, and pharmacists, home health care organizations, long term care facilities, federally qualified health centers (FQHC) and other healthcare safety net providers, emergency medical services (EMS), behavioral health

experts, and public health officials. The task forces should also include private sector partners who provide essential services such as food, electricity, and water. They may also include civil protection authorities such as the police, sheriff's departments, and firefighters.

During a pandemic, the task force would be responsible for coordinating health care activities within the community and should work with local health departments and hospitals to:

- Improve communication with medical care providers and health care organizations.
- Monitor local hospital resources (e.g., adult and pediatric hospital beds, intensive care unit beds, emergency department beds, medical supplies, respirators and other equipment, mortuary capacity).
- Address emergency healthcare staffing needs and other medical surge capacity issues.
- Encourage coordination among state and federal healthcare facilities, such as Veterans Administration hospitals, Indian Health Service facilities, and Department of Defense hospitals.
- Conduct contingency planning with:
  - Private sector groups that support hospital functions, to ensure continuity of operations during the pandemic. These groups may include medical supply companies, medical gas companies, companies that supply food and clean linens, and internet service providers.
  - Public utilities (water, electricity, gas, telephone, sanitation) to ensure continued service during the pandemic.
  - Local law enforcement agencies who can help maintain order if a hospital is overwhelmed by a large volume of patients (ill or worried about being ill).
  - Identify alternative care sites for patient care (child and adult) and sites for quarantine.
  - Identify community-based organizations that can provide psychological and social support to healthcare workers, public health field workers, and other emergency responders (see **Supplement 11**).

Community Planning in Rural Areas

Special efforts should be made to address pandemic planning issues in rural communities and other areas where emergency rooms and other resources for urgent care and emergency treatment are lacking. Without community-wide planning, a surge of pandemic influenza patients could force the closure of local outpatient healthcare clinics. Planning partners may include healthcare providers at outpatient clinics, federally qualified health centers (FQHCs),[3] IHS and tribal health care facilities, and other healthcare safety net providers[4] that deliver care to low-income and other vulnerable populations.

D. Public Health Guidance Supplements

The eleven Public Health Guidance supplements can be found on the following pages. An overview of each supplement is provided below.

Supplement 1. Pandemic Influenza Surveillance provides recommendations to state and local partners on virologic surveillance for influenza viruses and on epidemiologic (disease) surveillance to monitor the health impact of influenza

[3] A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include health centers receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and clinics designated by HHS as FQHC Look-Alikes. More information may be found at: http://www.cms.hhs.gov/providers/fqhc/

[4] Health care safety net providers deliver care to low-income and other vulnerable populations, including the uninsured and those covered by Medicaid. Many of these providers have either a legal mandate or an explicit policy to provide services regardless of a patient's ability to pay (http://www.ahcpr.gov/data/safetynet/faq.htm). Major safety net providers include public hospitals and community health centers as well as teaching and community hospitals, and private physicians.

(outpatient, hospital, and mortality surveillance). The Interpandemic and Pandemic Alert Period recommendations focus on disease surveillance during regular influenza seasons, as well as on surveillance for human cases of infection with avian influenza A (H5N1) or other novel strains of influenza. They also address preparedness planning to lay the groundwork for enhanced disease surveillance during a pandemic.

The Pandemic Period Recommendations focus on surveillance activities that will be undertaken if a pandemic virus is reported overseas or if a pandemic virus emerges in or enters the United States. These activities include ongoing virologic surveillance to monitor genetic and antigenic changes in the pandemic virus, including changes in its drug susceptibilities.

Supplement 2. Laboratory Diagnostics provides recommendations to state and local public health partners on the use of diagnostic tests to detect, characterize, and monitor novel subtypes of influenza, including avian influenza A (H5N1) and other viruses with pandemic potential. The Interpandemic and Pandemic Alert Period recommendations focus on laboratory testing in support of seasonal influenza surveillance, on laboratory-based detection of novel subtypes of influenza, and on preparedness planning to support the laboratory component of the response to an influenza pandemic (e.g., detection and characterization of viruses, case reporting, specimen management, and surge capacity issues).

The Pandemic Period recommendations focus on provision of laboratory support for disease surveillance and for clinicians and hospitals. The Pandemic Period Recommendations also cover occupational health issues for laboratory workers.

Supplement 3. Healthcare Planning provides guidance to healthcare partners on developing effective institutional plans for responding to an influenza pandemic. It focuses on Interpandemic Period guidance for healthcare preparedness planning in such areas as pandemic influenza surveillance, incident management infrastructure, hospital communications, education and training, patient triage, clinical evaluation and admission, facility access, occupational health, vaccine and antiviral drug use, surge capacity, and mortuary issues. Also considered is planning for providing care in non-hospital settings including clinics, physician's offices, and the alternative care sites that will be set up if hospital-bed capacity is exceeded during a pandemic.

The Pandemic Period guidance recommendations focus on activation of institutional pandemic influenza response plans.

Supplement 4. Infection Control provides recommendations to healthcare and public health partners on basic principles of infection control for limiting the spread of pandemic influenza. These principles are common to the prevention of other infectious agents spread by respiratory droplets. Guidance is included on the selection and use of personal protective equipment, hand hygiene, safe work practices, cleaning and disinfection of environmental surfaces, handling of laboratory specimens, and postmortem care. The guidance also covers infection control practices related to the management of infectious patients, the protection of persons at high-risk for severe influenza or complications, and issues concerning occupational health.

Supplement 4 also provides guidance on how to adapt infection control practices in specific healthcare settings, including hospitals, nursing homes and other long-term care facilities, pre-hospital care (Emergency Medical Services), home healthcare, and medical offices and other ambulatory care settings. The section on hospital care covers detection of entering patients who may be infected with pandemic influenza, implementation of source-control measures to limit virus dissemination from respiratory secretions, hospitalization of pandemic influenza patients, and detection and control of nosocomial transmission. Supplement 4 also includes recommendations on infection control measures and care of pandemic influenza patients in the home, as well as in alternative care sites that may be established if local hospital capacity is overwhelmed by a pandemic.

Given some uncertainty about the characteristics of a new pandemic strain, all aspects of preparedness planning for pandemic influenza must allow for flexibility and real-time decision-making that take new information into account as the situation unfolds. If the new virus is unusual in transmissibility, virulence, or in any other way, HHS and its partners will provide state and local partners with updated infection control guidance.

Supplement 5. Clinical Guidelines focus on the initial screening and clinical assessment of patients who present from the community with fever and/or respiratory symptoms during the Interpandemic, Pandemic Alert, and Pandemic Periods. The Appendices include information on the clinical presentation and complications of influenza, the clinical features of human infection with avian influenza A (H5N1), and management of secondary bacterial pneumonia during a pandemic.

During the Interpandemic and Pandemic Alert Periods, early recognition of an illness caused by a novel influenza strain will rely on a combination of clinical and epidemiologic features. During the Pandemic Period (with a setting of high community prevalence) diagnosis will likely be more clinically oriented, as exposure history will become less helpful and the likelihood will be high that any severe influenza-like illness would be pandemic influenza.

Supplement 6. Vaccine Distribution and Use provides recommendations to state and local partners and other stakeholders on planning for the different elements of a pandemic vaccination program. The focus of the Interpandemic Period recommendations is on planning for vaccine distribution, vaccination of priority groups, adverse event monitoring, tracking of vaccine supply and administration, vaccine coverage and effectiveness studies, communications, legal preparedness, and training. The focus of Pandemic Period recommendations is on working with public health and healthcare partners to implement plans for vaccine distribution and use.

Supplement 7. Antiviral Drug Distribution and Use provides recommendations to state and local partners on the distribution and use of antiviral drugs for treatment and prophylaxis during an influenza pandemic. The Interpandemic and Pandemic Alert Period recommendations focus on preparedness planning for rapid distribution and use of antiviral drugs (e.g., procurement, distribution to priority groups, legal preparedness, training, and data collection on use, effectiveness, safety, and the development of drug resistance). The Interpandemic and Pandemic Alert Period recommendations also cover the use of antiviral drugs in management and containment of cases and clusters of infection with novel strains of influenza, including avian influenza A (H5N1) and human strains with pandemic potential.

The Pandemic Period recommendations focus on local use of antiviral drugs in three situations: when pandemic influenza is reported abroad, when there is limited transmission of pandemic influenza in the United States, and when there is widespread transmission in the United States. Recommendations for optimal use of limited stocks of antivirals will be updated throughout the course of an influenza pandemic, in accordance with new epidemiologic and laboratory data. National recommendations will also be updated as an effective pandemic influenza vaccine becomes available.

Supplement 8. Community Disease Control and Prevention provides recommendations to state and local partners on the use of disease containment strategies to prevent disease transmission at different phases of an influenza pandemic. The Interpandemic and Pandemic Alert Period recommendations focus on preparedness planning for implementation of containment measures. They also outline actions that may be taken during the earliest stage of a pandemic when the first potential cases or disease clusters are detected. In this setting, relatively intense individual-level containment measures (e.g., patient isolation and identification, monitoring, and quarantine of contacts) may be used without causing undue strain on limited public health and health care resources.

The Pandemic Period recommendations focus on measures that may be beneficial and practical when there is a large number of cases and extensive viral transmission. In such a setting, individual-level measures may no longer be effective or feasible (e.g., if hospital isolation beds can no longer accommodate all patients, if most contacts cannot be traced in time to prevent further exposures, or if staffing constraints make contact-tracing impractical). In that case, state and local health departments may consider measures that decrease social contact within groups or whole communities (e.g., quarantine of groups of exposed persons, cancellation of public events, snow days, self-shielding, or widespread community quarantine). Effective use of community containment measures during a pandemic will require continuous evaluation of such parameters as viral transmissibility, the number and geographic distribution of cases, the reproductive rate of epidemic propagation, and the nature and severity of illness.

Supplement 9. Management of Travel-Related Risk of Disease Transmission provides recommendations to state and local partners on travel-related containment strategies that may be employed during different phases of an influenza pandemic. These strategies range from distribution of health alert notices, to isolation and quarantine of new arrivals, to restriction or cancellation of nonessential travel. State and local health departments will implement these strategies in association with Quarantine Stations located at 11 ports of entry.

The Interpandemic and Pandemic Alert Period recommendations focus on preparedness planning, as well as on management of arriving ill passengers on international flights or cruise ships. The Pandemic Period recommendations focus on travel-related measures to prevent disease spread into, out of, or within the United States.

Supplement 10. Public Health Communications describes seven key risk communications concepts. During the Interpandemic Period, national, state, and local health communications professionals should focus on preparedness planning and on building flexible, sustainable communications networks. During the Pandemic Alert Period, they should work collaboratively to develop and disseminate consistent and accurate messages. During the Pandemic Period, they should focus on well-coordinated health communications to support public health interventions designed to help limit influenza-associated morbidity and mortality and to address related social and economic changes.

Supplement 11. Psychosocial Workforce Support Services addresses the psychological and social ("psychosocial") needs of occupational groups who participate in the response to an influenza pandemic. These groups include:

- Healthcare workers who provide medical care for the children and adults who fall ill
- Emergency field workers and other public health personnel who help control disease spread
- First responder or non-governmental organizations whose employees assist affected groups (e.g., quarantined persons or patients at home or in hospitals)
- Essential service workers whose activities maintain normal social functions and minimize social disruption
- The family members of all of these groups

Recommendations for the Interpandemic and Pandemic Alert Periods focus on institutionalization of psychosocial support services that help workers manage emotional stress and resolve personal, professional, and family issues related to the response to an influenza pandemic. They also cover preparation of informational materials for distribution to employees and their families during the emergency. Finally, they cover the development of Workforce Resilience Programs that include assistance for families of responders who may be deployed in the field and inaccessible for extended periods of time.

Recommendations for the Pandemic Period focus on delivery of psychosocial support services to response workers, on provision of occupational health information to healthcare providers, and on implementation of Workforce Resilience Programs.

BOX 1. ISSUES FOR STATE AND LOCAL PARTNERS THAT WILL REQUIRE REAL-TIME GUIDANCE DURING A PANDEMIC

- What are the case definitions for suspected and confirmed cases of pandemic influenza? What types of epidemiologic data should be collected? (The answers may change over time, depending on the characteristics of the pandemic virus and the geographical spread of the pandemic.)
- What are the drug susceptibilities of the pandemic virus?
- What amounts of antiviral drugs are available to your state from public and private stocks?
- What amounts of pandemic influenza vaccine are available to your state from public stocks?
- Which groups of people are at greatest occupational and medical risk (i.e., what are the age-specific and occupational attack rates)? What modifications should be made to the national recommendations for distribution and use of antiviral drugs and vaccines to reflect this information?
- Which laboratory tests may be used locally for laboratory confirmation of pandemic-influenza cases? Which isolates should be sent to CDC for subtyping?
- How fast is the pandemic spreading in your area? What does local surveillance data on the number of hospitalizations and deaths suggest in regard to:
  - Distribution of hospital supplies and hospital beds on a regional or statewide basis
  - How fast local and regional hospital resources are being depleted
  - Implementation of school closings and other community containment measures
  - Situating and opening alternative care sites and quarantine facilities
  - Absentee rates at hospitals and at businesses that provide essential services
  - Impact of the outbreak on the public health and medical workforce
- Is anything unusual or unexpected? If so, should any modifications be made in infection control practices or in the detection or management?
- Is there evidence from statistical modeling that predicts where and how fast the pandemic will spread?

BOX 2. ESTABLISHING A PANDEMIC INFLUENZA COORDINATING COMMITTEE FOR STATE-LEVEL PLANNING

Coordinating Committee members may include:

- Representatives from the Governor's Office (supplemented by representatives of the mayor's office for large metropolitan areas)
- Representatives from local, county, or district health departments
- Representatives from territorial and tribal health departments
  - State Epidemiologist
  - State Laboratory Director
- Public Health Information Officer
- Public Affairs/Communications Officer
- Immunization Project Director
- State Strategic National Stockpile (SNS) Coordinator
- Representatives from:
  - State and Local Offices of Emergency Preparedness
  - State Mental Health Office
  - State Transportation Office
  - Office of the General Counsel at the state health department
- Representatives from HRSA and CDC

Membership of the Pandemic Influenza Coordinating Committee may overlap with state or local bioterrorism preparedness coordinating committees.

Stakeholders who provide input to the Coordinating Committee may include:

- Infectious disease physicians
- Public health and private clinical laboratories
- Immunization program personnel
- State public health associations or state associations of county and city health officials
- State primary care associations representing health centers in the state
- Hospitals and other healthcare facilities, including VA Hospitals, DoD Hospitals, and Indian Health Service facilities
- Medical societies and nursing organizations
- Pharmacists
- Community immunizers
- Emergency medical services and emergency departments within hospitals
- Local media officials

Additional participants may include

- Volunteer organizations involved in response and recovery to various disasters
- Social service agencies
- Law enforcement agencies
- Infectious disease experts from universities
- Funeral directors
- Local military installations
- Large industries or employers in the area
- State aviation authorities
- Representatives of public utilities
- Education administrators

BOX 3. INFLUENZA: INFORMATION AND DEFINITIONS

Influenza

- Influenza is an acute viral disease of the respiratory tract characterized by fever, headache, myalgia, prostration, coryza, sore throat, and cough. Otitis media, nausea, and vomiting are also commonly reported among children.
- For surveillance purposes, influenza-like illness (ILI) is defined as respiratory illness with temperature greater than 38°C plus either sore throat or cough.

Seasonal or Interpandemic Influenza

- Seasonal influenza occurs each winter, primarily causing self-limiting disease for 2 to 7 days in most infected individuals. Influenza complications—especially viral and bacterial pneumonias—can cause severe illness or death in infants, the elderly, the immunocompromised, and those with certain chronic medical conditions.
- As seasonal influenza viruses replicate and evolve, they develop small changes in their surface antigens that allow them to evade existing immunity to influenza in the human population. Influenza vaccines must therefore be reformulated each year to provide protection against currently circulating strains of influenza A and B.

Pandemic Influenza

- Pandemic influenza is an uncommon type of influenza A that causes greater morbidity and mortality than seasonal influenza. An influenza pandemic occurs when a new influenza A virus (a "pandemic influenza virus") emerges in the human population, causes serious illness, and then spreads easily from person to person worldwide. Influenza pandemics occurred three times during the twentieth century—in 1918, 1957, and 1968.

Novel Strains of Influenza

- Novel strains of influenza are newly identified influenza viruses that require close monitoring to determine whether they (or their genetic offshoots) are capable of pandemic spread. They may include avian or animal influenza strains that can infect humans (like avian influenza A [H5N1]), or new, or re-emergent, human viruses that cause cases or clusters of human disease.

APPENDIX 1. CHECKLIST OF LEGAL CONSIDERATIONS FOR PANDEMIC INFLUENZA

The following checklist is a planning tool highlighting the relevant partners, resources, planning considerations, due process considerations, and issues of legal liability and immunity that may arise in the context of pandemic influenza. Next to each consideration are listed the legal partners (e.g., public health, hospitals, public safety, emergency management, judiciary) who may be called upon to address these considerations as part of the affected community's response. The challenge of the public health response is to protect the health of many, while safeguarding the rights of the individual. An integrated and coordinated response by attorneys at all levels in the community is essential to achieving this goal.

The checklist format is not intended to set forth mandatory requirements or establish a national standard for legal preparedness. Each state and local jurisdiction should determine for itself whether it is adequately prepared for disease outbreaks in accordance with its own laws and procedures. Relevant federal law also should be reviewed and statutes harmonized, as feasible.

Planning Considerations

- ❑ Ensure that public health personnel have a basic understanding of the intersection among federal, state, local, and tribal laws regarding quarantine and isolation as they relate to international airports and interstate border crossings. [public health/public safety/emergency management]
- ❑ Where applicable, draft or update legal orders, motions, and templates requiring medical evaluation of non-compliant persons who meet the pandemic influenza case definition and have symptoms of pandemic influenza. [public health/hospitals]
- ❑ Ensure that legal counsel has reviewed the feasibility of requiring persons to self-monitor for medical conditions (e.g., temperature checks) and (where applicable) drafted legal orders or agreements. [public health]
- ❑ Ensure that legal counsel has reviewed the feasibility of issuing "exclusion" orders (i.e., excluding contacts from using public transportation, attending public meetings) and, where applicable, drafted templates and legal orders. [public health/public safety/emergency management]
- ❑ Ensure the existence of a statute, regulation, or other administrative mechanism authorizing isolation/quarantine for pandemic influenza. [public health/public safety/judiciary]
- ❑ Draft legal orders, motions, and templates for isolation/quarantine in homes, hospitals, or other designated facilities. [public health/hospitals/emergency management/public safety]
- ❑ Ensure that legal counsel has reviewed the feasibility of using electronic methods to monitor suspected non-compliant individuals in home isolation and/or quarantine. [public health/public safety]
- ❑ Ensure that legal counsel has reviewed draft legal orders, motions, and templates to quarantine facilities and to credential ingress and egress into such facilities. [public health/public safety/emergency management]
- ❑ Ensure that legal counsel has reviewed the feasibility of using faith-based organizations to assist or provide services to persons in isolation and quarantine. [public health]
- ❑ Ensure that public health officials have reviewed the availability of workers' compensation and/or other forms of financial support for persons unable to return to work because of an isolation/quarantine order. [public health]
- ❑ Ensure that legal counsel has considered whether the health department should issue documents designed to assist with reintegration of persons subject to isolation/quarantine order (e.g., letter to employer or school explaining that patient is no longer infectious). [public health]
- ❑ Ensure that legal counsel has reviewed agreements relating to overtime and/or flexibility of hours for staff. [public health/hospitals/public safety/emergency management]
- ❑ Ensure that legal counsel has a clear understanding of legal authorities relevant to environmental remediation of buildings. [public health/hospitals/emergency management]

Partnerships/Outreach

- ❑ Assemble a legal preparedness task force with representation from public health, public safety, hospitals, emergency management, judiciary, and other relevant individuals and/or organizations at various levels of authority (federal, state, tribal, local, cross-border). [public health/public safety/hospitals/emergency management/judiciary]
- ❑ Establish procedures for enforcement of isolation/quarantine orders. [public health/public safety]
- ❑ Provide public safety personnel with educational materials relating to pandemic influenza and have a clear understanding for how to enforce an isolation/quarantine order. [public health/public safety]
- ❑ Ensure that procedures or protocols exist between hospitals and public health to manage a possible or known pandemic influenza case-patient who attempts to leave the hospital against medical advice. [public health/hospitals/public safety]
- ❑ Where applicable, draft memoranda of agreement (MOA) or understanding (MOU) to allow for the loaning of facilities or other services necessary to implement a quarantine and/or isolation order for persons who cannot be isolated at home (e.g., travelers, homeless populations). [public health/hospitals/emergency management]
- ❑ Ensure that judges and attorneys in the area, through local bar organizations or other entities, have received educational materials, training, or information related to SARS and the potential use of isolation/quarantine to interrupt disease transmission. [public health/judiciary]
- ❑ Ensure that legal counsel has reviewed and/or drafted data sharing/data use/confidentiality agreements related to sharing of confidential patient medical information between public health and other partners. [public health/hospitals/public safety/emergency management]

Due Process Considerations

- ❑ Draft legal orders and templates using terms such as "quarantine," "isolation," and "detention" consistently. [public health/judiciary)
- ❑ Ensure that legal counsel has reviewed all draft isolation/quarantine orders and forms, as well as applicable administrative hearing procedures, to ensure concurrence with basic elements of due process (e.g., adequate notice, opportunity to contest, administrative determination). [public health/judiciary]
- ❑ Ensure that procedures or protocols exist to ensure that persons subject to an isolation/quarantine order have access to legal counsel, if desired (e.g., list of attorneys willing to provide services at little or no cost). [public health/judiciary]
- ❑ Ensure that legal counsel has analyzed procedures needed to satisfy due process in different isolation/quarantine scenarios (e.g., "voluntary" home isolation, isolation in a guarded facility, exclusion from certain public activities). [public health/judiciary]
- ❑ Where applicable, ensure that public health officials have worked with the local court system to develop a 24 hours a day, 7 days a week "on call" list of judges or hearing officers to review emergency requests for isolation/quarantine. [public health/judiciary]
- ❑ Ensure that public health officials have worked with the local court system to develop a plan for hearing cases and/or appeals for persons subject to isolation/quarantine orders (e.g., participation via telephone, video conference). [public health/judiciary]

Legal Resources and Statutes

- ❑ Ensure that legal counsel has reviewed and has a clear understanding of the legal resources and tools relevant to a community's public health response. [public health/judiciary/emergency management]

  Such resources and tools include:

  - Draft Model State Emergency Health Powers Act
    www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf

- Emergency Management Assistance Compact (model agreement)
  http://www.emacweb.org/?13
- Emergency Management Assistance Compact (as implemented in a state or jurisdiction)
- Memorandum of Understanding for Establishment of Local Public Health Mutual Aid and Assistance System:
  www.publichealthlaw.net/Resources/ResourcesPDFs/MOU.pdf
- American Bar Association Draft Checklist for State and Local Government
  Attorneys to Prepare for Possible Disasters
  http://www.publichealthlaw.net/Resources/BTlaw.htm
- Legal Authorities for Isolation and Quarantine
  http://www.cdc.gov/ncidod/sars/legal.htm
- Quarantine and Isolation: Lessons Learned from SARS
  http://www.louisville.edu/medschool/ibhpl/images/pdf/SARS%20REPORT.pdf
- Checklists on Legal Preparedness for Bioterrorism and other Public Health Emergencies
  http://www.publichealthlaw.net/Resources/BTlaw.htm
- Legal Materials Related to Public Health Legal Preparedness
  http://www2a.cdc.gov/phlp/sub_menu.asp

Additional materials and resources may be posted at http://www.cdc.gov/phlp/index.htm

❑ Distribute draft letters or fact sheets to hospitals and other healthcare providers describing permissible uses and disclosures of health information for public health purposes under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) (www.hhs.gov/ocr/hipaa/). [public health/hospitals]

❑ Where applicable, ensure that legal counsel understands procedures for declaring a public health emergency (at various levels of government) and consequences of such a declaration. [public health/public safety/emergency management]

❑ Ensure that legal counsel is familiar with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (www.aaem.org/emtala/index.shtml) and has determined if such requirements have been incorporated into public health and hospital planning for pandemic influenza. [public health/hospitals]

❑ Ensure that legal counsel has reviewed hospital screening and admission procedures for potential pandemic influenza patients (e.g., establishment of evaluation clinics for persons with influenza-like symptoms) for compliance with EMTALA. [public health/hospitals]

❑ Ensure that legal counsel has reviewed potential EMTALA implications of a community-wide EMS protocol for transport of pandemic influenza patients (e.g., protocol requiring transport of pandemic influenza patients to a hospital or facility other than the hospital that owns the ambulance). [public health/hospitals/emergency management]

Legal Liability and Immunity

❑ Ensure that legal counsel has reviewed the potential legal liability of implementing "working" quarantine for essential service personnel. [public health/hospitals]

❑ Ensure that legal counsel has reviewed the potential legal liability of housing pandemic influenza patients in home isolation with non-exposed residents subject to infection control precautions. [public health]

❑ Ensure that legal counsel has reviewed liability/immunity for volunteers providing assistance or services to persons in isolation/quarantine. [public health/emergency management]

❑ Ensure that legal counsel has reviewed hospital employment policies on emergency licensure and/or employment of retired or non-medical personnel or personnel from other medical departments or hospitals. [public health/hospitals]

APPENDIX 2. FACT SHEET: PRACTICAL STEPS FOR LEGAL PREPAREDNESS

Step 1: Know your legislation

State and local public health officers need to be familiar with the legal requirements in their jurisdictions regarding isolation of infectious persons and quarantine of exposed persons. Although most states have laws to compel isolation and/or quarantine, procedures may vary widely from jurisdiction to jurisdiction. Key persons, such as legal counsel, judges, and policymakers, should be identified and made part of your jurisdiction's planning for pandemic influenza.

HHS has statutory authority, which has been delegated to CDC, to quarantine or isolate individuals who have been exposed to or infected with pandemic influenza. President Bush added pandemic influenza to the list of quarantineable diseases by Executive Order 13375 on April 1, 2005.

Step 2: Plan "due process"

Procedural due process is implicated when the government seeks to deprive an individual of "liberty" interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment to the U.S. Constitution. Many states, through statute or regulation, have established specific administrative and judicial schemes for affording due process to a person subject to a quarantine and/or isolation order. Schemes in other jurisdictions may not directly address this issue.

Although due process is a flexible concept and calls for procedural protections as the particular situation demands, the basic elements of due process include: adequate notice (typically through written order) of the action the agency seeks to compel; right to be heard (typically through the right to present evidence and witnesses and to contest the government's evidence and witnesses); access to legal counsel; and a final administrative decision that is subject to review in a court of law. These due process protections should not impede the immediate isolation or quarantine of an individual for valid public health reasons in an emergency situation.

Step 3: Draft key documents in advance

State and local public health officers should consider drafting key documents in advance of an emergency. These template documents can be critical time savers in an emergency. Documents that jurisdictions should consider preparing in advance include: draft quarantine and/or isolation orders; supporting declarations and/or affidavits by public health and/or medical personnel; and an explanation of the jurisdiction's due process procedures for persons subject to an isolation/quarantine order. Examples of documents created by other jurisdictions are found at: http://www.cdc.gov/phlp/index.htm

Step 4: Contact other jurisdictions

It is possible for federal, state, tribal, and local health authorities simultaneously to have separate but concurrent legal quarantine power in a particular situation (e.g., an arriving aircraft at a large city airport). Furthermore, public health officials at the federal, state, tribal, and local level may occasionally seek the assistance of their respective counterparts, e.g., law enforcement, to assist in the enforcement of a public health order. State and local public health officers should therefore be familiar with the roles and responsibilities of other jurisdictions: vertically (local, state, tribal, federal), horizontally (public health, law enforcement, emergency management, and health care), and in geographical clusters (overlapping state/local neighbors).

Step 5: Engage the courts in advance

Some jurisdictions may rely on older public health statutes that have not been amended in over half a century, while other jurisdictions may have recently revised their legal authorities to respond to bioterrorism or other public health emergencies. Judges who may be called upon to review a public health order may not be familiar with the state or local health authority's

broad public health powers. During the 2003 SARS outbreak in Toronto, Canada, for example, many judges were unaware of the health officer's broad ex parte authority to compel isolation/quarantine under rarely used laws.

Step 6: Anticipate practical problems

State and local public health officers need to be prepared for the practical problems that may arise in affording adequate due process protections to persons subject to isolation and/or quarantine orders. Such problems may include how to arrange for the appearance and representation of persons in quarantine (e.g., video conference or other remote means); how to serve an isolation/quarantine order (likely through law enforcement) and other procedures to advise persons of their legal rights; and isolation arrangements for transient or homeless populations.

Step 7: Communication

Communication planning is vital not only for an effective public health response but also for an effective legal response to a public health emergency. Public health agency counsel should be aware of media training available to other public health officers. During the SARS and monkeypox outbreaks, CDC, through the Public Health Law Program (http://www.cdc.gov/phlp/index.htm), established telephone conferences for public health legal counsel to share experiences and engage in peer-to-peer consultations. Efforts are now underway to develop materials to assist state and local public health departments in conducting further outreach on emergency public health issues to the legal community through local bar associations.