**DEPARTMENT OF THE NAVY**
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO
BUMEDINST 3500.5
BUMED-M3/5
7 Sep 2010

BUMED INSTRUCTION 3500.5

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: PANDEMIC INFLUENZA PLANNING POLICY

Ref: (a) through (n), see enclosure (1)

Encl: (1) References
(2) Medical Treatment Facility Pandemic Influenza Planning Template
(3) Pandemic Alert Phases Matrix
(4) Guidance for Developing a Mass Prophylaxis/Point of Distribution (POD) Plan
(5) Pandemic Influenza Trigger Table
(6) Communication and Education Plan
(7) Acronyms

1. Purpose. The purpose of this instruction is to issue policy, outline procedures, and identify roles and responsibilities to support prevention, mitigation, preparedness, response, and recovery from an outbreak of Pandemic Influenza (PI). Enclosure (1) lists all references used in this instruction and their availability. Enclosure (2) provides a template instruction for the users use in implementing this instruction. Enclosures (3) through (6) provide amplifying information to assist the user. Enclosure (7) provides a list of acronyms used in this instruction.

2. Scope and Applicability. This instruction defines responsibilities and authority of Chief, Bureau of Medicine and Surgery (BUMED) and responsibilities of subordinate commands in preparing for and responding to PI, per references (a) through (n). This instruction applies to all BUMED activities. This instruction does not apply to mobile, expeditionary, afloat, or other deployable medical forces or personnel when in a deployed status.

3. Background. Influenza pandemics occur when a novel or substantially different influenza virus (or virus strain) emerges to which the population has little immunity. During the 20$^{th}$ century, there were 3 such pandemics, most notably the 1918 Spanish influenza, which was responsible for up to 40 million deaths worldwide between 1918 and 1919. The 1918 outbreak had a detrimental effect on the United States (U.S.) military's ability to support its assigned mission. Public health experts are currently concerned about the risk of another pandemic arising from a novel virus that is capable of human-to-human transmission. While the impact of a pandemic cannot be precisely predicted, a severe pandemic (in the absence of a readily available vaccine) is likely to disrupt all aspects of society, severely affect the national economy, and result in millions of infections and hundreds of thousands of fatalities in the U.S. An analogous impact will be encountered globally, with disproportionate impact occurring in underdeveloped regions.

4. Assumption

a. Pandemics travel in waves; not all parts of the world may be affected at the same time or to the same degree (i.e., multiple waves).

b. A pandemic influenza outbreak will last between 6 to 12 weeks in one location, with multiple PI waves following for a period of 12 to 24 months.

c. Susceptibility to a PI virus will be universal.

d. The incubation period will be 1 to 7 days. Persons who become infected may shed the virus and can transmit the virus for one half to one day before the onset of illness. Viral shedding and the risk for transmission will be greatest during the first 2 days of illness, though the possibility of transmission will continue for up to 7 days from the onset of illness.

e. A vaccine for the specific strain of PI may not be available for distribution for a minimum of 4 to 6 months after the initial laboratory confirmation of sustained human-to-human transmission. Vaccine production may not be sufficient to meet initial demand, requiring prioritization of target groups for vaccination.

f. Developed countries will be quicker in preparing for, detecting, and responding to outbreaks than less developed countries.

g. International and interstate transportation may be restricted to contain the spread of the virus. Current models however, show that transportation restrictions do little to stop the spread of PI, so the U.S. Government and foreign governments may not use this as a precaution.

h. Many plans assume the first sustained outbreak will occur outside of the U.S. However, BUMED policies assume there will be little to no notice of an outbreak reaching the U.S., since the country of origin, speed of the spread, and transmission dynamics are unpredictable.

i. PI in the U.S. due to a highly pathogenic virus might result in 30 to 40 percent of the population being absent from work, 3 percent of those infected being hospitalized, and a case fatality rate of 0.2 to 2 percent over the course of the pandemic.

j. A layered mix of voluntary and mandatory individual, unit, and installation-based public health measures, such as limiting public gatherings, closing schools, social distancing, protective sequestering, personal hygiene measures, and respiratory protection can limit transmission and reduce illness and death if implemented before or soon after the onset of the pandemic. Quarantine, isolation, and other movement restrictions are essential for a successful containment operation.

k. State, local, and tribal jurisdictions will be overwhelmed and unable to provide or ensure the provision of essential commodities and services.

l. Department of Defense (DoD) reliance on "just-in-time" procurement systems will compete directly with U.S. and foreign civilian businesses for availability of critical supplies.

m. DoD Title 10 Reserve component forces may need to be quickly mobilized by BUMED to support medical surge capacity, distribution of mass prophylaxis, or for vaccine administration. Mobilizing Reserve forces will affect civilian health care manpower and may not be permitted by the National Command Authority.

n. Navy Medicine Medical Treatment Facilities (MTFs) may be overwhelmed by DoD active duty and other beneficiaries, necessitating the need to refer patients to alternate care facilities.

o. National Guard forces, minus those subject to the needs of national security, will remain in place to provide support to the governors of the individual states.

p. A surge in private demand for consumer goods (including medical supplies) may cause a DoD shortfall.

q. Resupply of medical stockpiles may be limited if international and interstate transportation is affected. Shortages of Personal Protective Equipment (PPE), tubing, medications, etc., will warrant a reassessment of standard-of-care decisions.

r. Respiratory care shortfalls are anticipated, both for lack of available ventilators and trained respiratory technicians to run them. Intensive respiratory care may have to be triaged and prioritized.

s. MTF staff (both health care providers and support staff) may be reluctant or unable to report for duty, due to concerns about their health and the health of their families, child and elder care responsibilities, and/or their own illness. Staffing shortages are to be anticipated and planned for under the assumption that hospital capacity will surge well beyond normal care levels. Reserve augmentation may not be possible due to health care demands in the civilian sector during a pandemic.

t. The use of antivirals for treatment, post-exposure prophylaxis and pre-exposure prophylaxis will have to be prioritized based on the severity of the disease, risk for influenza-related complications, threat to mission assurance, and the availability of antiviral medications.

u. An influenza pandemic environment will minimize the patient evacuation effectiveness of the National Disaster Medical System (NDMS) due to limited movement and a wide geographic range of pandemic impact.

5. Definitions

a. Epidemic – The occurrence in a community or region of cases of an illness, specific health-related behavior, or other health-related events clearly in excess of the amount expected.

b. Isolation – The separation of a person or group of persons infected ill with a communicable disease from other persons not exposed to prevent the spread of infection.

c. Medical Treatment Facility – A single health care (Naval Medical Center, Naval Hospital, Branch Medical Clinic, or Naval Dental Clinic) or multiple medical and dental facilities under a single commanding officer (CO) or officer in charge (OIC).

d. Public Health Emergency – An occurrence or imminent threat of an illness or health condition, caused by biological warfare or terrorism, epidemic or pandemic disease, or highly fatal infectious agent or toxin, that poses a substantial risk.

e. Pandemic Influenza – A global outbreak of disease that occurs when a new influenza virus appears or emerges in the human population, causes serious illness in people, and then spreads worldwide by person-to-person transmission.

f. Quarantine – Restriction of activities or limitation of freedom of movement of those presumed exposed to a communicable disease in such a manner as to prevent effective contact with those not infected or exposed.

g. Restriction of Movement – A form of quarantine unique to the military most applicable to operational forces, in which movement of a unit, or intermingling of units, is prevented, to prevent the transmission of communicable disease.

h. Social Distancing – For the purposes of PI planning, a series of activities designed to reduce transmission of a communicable disease, such as: avoiding hand-shaking, maintaining greater than usual personal space from other people, canceling public gatherings, implementing teleworking policies, etc.

i. Standard Precautions (Universal Precautions) – Guidelines promulgated to help prevent the spread of infection. These are actions that help protect health care providers, patients and their family and friends from infection, which include: the use of gloves when touching an infected person's mucous membranes; vigorous hand washing immediately after removing gloves and immediately before and after contact with an infected person; and the use of other protective clothing, such as respiratory and eye protection, when in close contact with an infected person.

6. Policy

a. Table 1 outlines the Action Triggers based upon an increase in DoD Pandemic Phases; also refer to enclosure (2) (Pandemic Alert Phases Matrix).

Table 1. Actions Triggers

| | DoD Global CONPLAN Pandemic Phases | Budget Submitting Office (BSO)-18 Actions |
|---|---|---|
| **Inter-Pandemic Period** | | |
| 0 | No new influenza subtypes have been detected in humans. | • Assess preparedness status and identify actions needed to fill gaps.<br>• Coordinate planning with identified stakeholders, state and local public health authorities, civilian MTFs, installation and tenant command leadership.<br>• Integrate pandemic influenza scenarios into existing exercises to evaluate readiness and improve preparedness plans and response capabilities.<br>• Develop strategies to prevent spread of infection.<br>• Develop strategies for rapid administration of vaccines and/or prophylaxis to priority populations.<br>• Assess surge capacity to meet expected needs during a pandemic.<br>• Coordinate communication activities across all Departments and with state, local, and other Service (or host nation) response partners.<br>• Develop awareness campaigns for Category 1 through 5 personnel, as outlined by reference (f), on pandemic influenza preparedness and response.<br>• Develop strategies to stockpile medical supplies and pharmaceuticals to support a pandemic response.<br>• Ensure Public Health Emergency Officers (PHEO) are designated and meet the criteria outlined in references (d) and (e).<br>• Direct Navy Medicine Region Commands to develop pandemic influenza guidance as an appendix to their Navy Medicine Region Emergency Manager (EM) plan, per reference (f).<br>• Coordinate with tenant commanders to ensure unit readiness.<br>• Develop template messages and notes that can be updated with information specific to the influenza strain that is circulating during the pandemic alert period. |

| | DoD Global CONPLAN Pandemic Phases | Budget Submitting Office (BSO)-18 Actions |
|---|---|---|
| | **Pandemic Alert Period** | |
| 1 | Receipt of information of human infections with a new viral subtype, but no human-to-human spread, or at most rare instances of spread to a close contact. | • Assess preparedness status and identify actions needed to fill gaps.<br>• Collaborate with stakeholders and partners to respond to pandemic alert.<br>• Inform stakeholders of pandemic alert status.<br>• Assess capacity of emergency response systems to meet expected needs during a pandemic.<br>• Enhance health care provider awareness of the potential for a pandemic and disseminate guidance on the clinical and laboratory detection of the novel influenza virus in persons with influenza-like illness (ILI), especially after recent travel to potentially affected areas.<br>• Implement strategies and disseminate materials to support a pandemic response and to promote public trust and decrease fear and anxiety.<br>• Direct MTFs to exercise and prepare to implement disease containment measures.<br>• Consider activation of Medical Installation Support Center (MISC), Medical Regional Command Center (MRCC), and/or Hospital Command Center (HCC). |
| 2 | Receipt of information of small cluster(s) with limited human-to-human transmission, but the spread is highly localized suggesting the virus is not well adapted to humans. | |
| 3 | Indications and warnings identify large cluster(s) of human-to-human transmission(s) in an affected region. | • Assess capacity of emergency response systems to meet expected needs during a pandemic.<br>• Provide updated guidance, if indicated, to designated Category 1 and 5 personnel on clinical management and infection control.<br>• Consider institution of disease containment strategies.<br>• Consider restrictions for non-essential travel to affected areas as recommended in reference (c).<br>• Implement public awareness campaign on the potential for a pandemic and the actions to be taken to reduce risk.<br>• Provide guidance for the use of DoD PI stockpile.<br>• Provide Commands with a line of accounting number for the purchase/replacement of critical supplies.<br>• Strongly consider activation of MISC, MRCC, and/or HCC.<br>• Release guidance specifically addressing the influenza strain of current concern (i.e., Frequently Asked Questions (FAQs), stockpile distribution and replenishment, support to operational forces, etc.).<br>• Provide case definitions based upon Centers for Disease Control and Prevention (CDC) guidance. |

| | DoD Global CONPLAN Pandemic Phases | Budget Submitting Office (BSO)-18 Actions |
|---|---|---|
| | **Pandemic Period** | |
| 4 | Receipt of information that a highly lethal pandemic influenza virus is spreading globally from human-to-human signaling a breach in containment and failing interdiction efforts. | • Ensure activation of MISC, MRCC, and/or HCC.<br>• With advice from the PHEO, consider directing implementation of containment measures such as isolation, quarantine, and restriction of movement, as needed.<br>• Review and revise, as needed, plans for health care delivery and community support.<br>• Provide guidance to designated Category 5 personnel on infection control guidelines.<br>• Update stakeholders and public affairs through regular briefings.<br>• Coordinate with Commander, Navy Installations Command (CNIC) for the distribution of antiviral medications, pandemic vaccine, and immunization of target groups, if such medications and vaccines are available.<br>• Assist in providing resources and personnel for vaccine administration.<br>• Implement infection control measures.<br>• Prepare to provide resources for Navy/Marine Corps forces, Fleet Operations, including fast cruise, ship sortie, designated safe havens, and enclaves. |
| | **Recovery Period** | |
| 5 | Receipt of information that disease incidence is decreasing, indicating the slowing of the pandemic wave. Reconstitution of DoD assets and conditions established to return to a previous phase. | • Begin to deactivate MISC, MRCC, and/or HCC.<br>• Collect information for After Action Reports and lessons observed.<br>• Develop a plan to resupply medical materials and pharmaceuticals. |

b. Incident Management

(1) The BUMED MISC will serve as the headquarters Command and Control and Communications ($C^3$) element and will execute its $C^3$ functions in support of any "all hazards" event affecting the Enterprise. Operations of the BUMED MISC are outlined in reference (k).

(2) The BUMED, Navy Medicine Region, and/or Installation MISC, MRCC, and/or HCC will likely be activated, due to direction from higher authority, in support of a pandemic influenza event potentially impacting a Navy or Marine Corps installation.

(3) As outlined in reference (f), MTFs shall implement the Hospital Incident Command System (HICS) as the official type of Incident Command System (ICS).

7. Responsibilities

a. BUMED. BUMED through BUMED-M3/5EPCS, Emergency Preparedness and Contingency Support, and BUMED-M3/5CCPH, Clinical Care and Public Health, shall coordinate with full support from all BUMED codes, and support and special staff, for the following activities:

(1) Establish minimum training requirements for designated Navy Medicine personnel with respect to pandemic influenza and related emergency management training topics.

(2) Exercise plans biennially in coordination with Commander, United States Fleet Forces (USFF) and throughout the year in coordination with other DoD and interagency organizations.

(3) Initiate prioritized immunization of military units when a vaccine becomes available in sufficient quantities.

(4) Coordinate with CNIC to develop and execute a distribution and tracking plan for antivirals, vaccines, and other pharmaceutical supplies and medical equipment.

(5) Identify critical medical supplies, goods, or services that require priority delivery from industry/suppliers to ensure Continuity of Operations (COOP) in a PI environment.

(6) Develop contingencies for medical resupply under constrained resource availability.

(7) Review procedures for the receipt, storage, and distribution of supplies from Federal medical stockpiles.

(8) Develop guidance for the allocation of scarce medical resources and alternate standards of care.

(9) Identify, publish, and direct the Navy Medicine Regions to implement the medical credentialing requirements that MTFs must use to privilege providers during PI surge/ contingency response operations.

(10) Monitor bed capacity across respective Areas of Responsibility (AOR) for situational awareness in preparation for surge capacity in all Regions.

(11) Determine legalities and logistics of partnering MTFs with local civilian hospitals to distribute the patient surge and increase bed capacity. Elucidate the implications for reimbursement.

(12) Develop religious and mental health support plans.

(13) Promote the awareness of community-based disease containment strategies (e.g., school closures, cancellation of public meetings, distribution of PPE in the military community, etc.) to installation commanders and among the personnel at MTFs.

(14) Develop procedures for the BUMED MISC for a PI outbreak, as outlined in reference (k).

(15) Develop plans that incorporate the potential to support civil authorities under local immediate response or through Defense Support of Civil Authority as outlined in references (l) and (m).

(16) Direct the Navy Medicine Regions to capture and report costs during all DoD Concept of Operations (CONPLAN) Pandemic phases for reimbursement.

(17) Direct Navy Medicine Support Command to develop a standard format for Navy Medicine Regions to report to the BUMED MISC and Navy and Marine Corps Public Health Center (NMCPHC).

(18) BUMED-M3/5CCPH will coordinate with the BUMED Public Affairs Office.

b. Public Affairs. The BUMED Public Affairs Office shall be responsible for the following:

(1) Provide targeted and effective public health risk communication messages for use by the Navy Medicine Region and installation command elements as well as to personnel and TRICARE beneficiaries.

(2) Prepare ahead of time written and verbal messages approved, vetted, and rehearsed by CO and appropriate chains of command.

(3) Coordinate emergency public information (EPI) messages with those developed by federal, state, and local public health agencies to ensure that a cohesive, accurate, and timely message can be delivered in the event of a pandemic.

c. Occupational Health. The BUMED Office of Occupational Health, under BUMED-M3/5CCPH, shall be responsible for the following:

(1) Validating medical exemption requests for influenza vaccination to ensure consistent application of policy for Civil Servants and Personal-Service contractors.

(2) Assisting local Human Resource offices in developing programs for early identification of Civil Servants with ILI and applying consistent guidance for sending such workers home on sick leave or administrative leave as appropriate.

(3) Providing guidance on mask use as appropriate to the job's requirements and risks.

d. Navy Medicine Regions. The Navy Medicine Regions shall be responsible for the following:

(1) Ensure active medical surveillance for ILI is done throughout Navy Medicine Regions through implementation of the Navy Disease Reporting System - internet (NDRSi) or via a standardized ad hoc reporting process at each MTF, per reference (n).

(2) Coordinate appropriate reporting of surveillance findings to all pertinent DoD, Federal, regional, and state public health agencies, including the Armed Forces Health Surveillance Center (AFHSC).

(3) Appoint a Regional PHEO, if one has not already been designated.

(4) Prepare to quickly augment clinical staff of MTFs overwhelmed with patients and/or experiencing staff shortages. Particular attention should be paid to the availability of respiratory therapists to run ventilators for the surge in intensive respiratory care that will accompany a pandemic.

(5) Plan for novel uses of smaller hospitals and branch medical clinics within the Region. For instance, small hospitals and branch clinics can be used as triage centers; converted to larger centers for all non-PI related care (while the larger hospital takes in all PI-related care); or closed in order to redistribute staff and resources to larger hospitals in need of staff and supplies.

e. MTF Commanders. Each MTF shall be responsible for the following activities:

(1) Create, review, update, train, exercise, and distribute a PI plan for the MTF. A template is provided as enclosure (2) and shall be used by each MTF; the template is available as a Word file on the Navy Medicine Web site as BMI 3500.5 ENCL (2) at: http://www.med.navy.mil/directives/Pages/SampleFormats.aspx.

(2) Establish procedures to periodically review and update the plan.

(3) Coordinate and rehearse the MTFs PI plan with the Installation and other tenant commands.

(4) Establish personal and professional networks with local hospitals and local public health and emergency management organizations.

(5) Coordinate and rehearse the MTFs PI plan with the local and state civilian public health agencies and local civilian hospitals.

(6) Coordinate and rehearse the MTFs PI plan with branch medical clinics.

(7) Establish a Memorandum of Understanding (MOU) with the local and state civilian public health agencies, local civilian hospitals, and other organizations needed to support the MTF PI plan.

(8) Plan for alternate means of communication with MTF personnel throughout the pandemic and establish a means for staff muster to monitor staff availability and shortages.

(9) Ensure that HICS is utilized as the incident management tool for the duration of the pandemic event.

(10) Ensure that initial and annual pandemic influenza and related emergency management training is completed for all staff and that training completion is tracked in local training records.

(11) Prepare the MTF to provide adequate response functions, including medical surveillance; triage and treatment; transport; shelter-in-place; quarantine; restriction of movement; MTF security; psychological care; and mortuary affairs.

(12) Plan for receipt, staging and integration of medical staff and supplies from military, state, and local chains of command (including Strategic National Stockpile (SNS) from the state). Ensure all equipment and supplies in support of PI efforts are accounted for in the Defense Medical Logistics Standard Support System (DMLSS).

(13) Establish a Point of Distribution (POD) Plan for distribution of medical supplies to base residents during a contagious disease outbreak, i.e., the POD cannot be set up in a large communal space; close contact among people should be minimized during the distribution process. Explore options for drive-thru mass dispensing and vaccination services. Enclosure (3) provides additional guidance.

(14) Provide for dispensing and/or immunizing teams to screen and educate patients, dispense pharmaceuticals, and provide immunizations when available.

(15) Provide medical recommendations for the isolation, quarantine, and restriction of movement of installation personnel.

(16) Provide information on encouraging stay-at-home care for patients with ILI that are not in need of hospital admission, in order to reduce the burden of care at the hospitals.

(17) Maintain a mobile health check system for monitoring the health status of any base residents in quarantine or isolation at home.

(18) Maintain a system and process for daily collection and analysis of the installation population health by reporting ILI to their Navy Medicine Region, and coordinate with local public health surveillance systems.

(19) Ensure adequate personnel are trained to use and monitor the Electronic Surveillance System for Early Notification of Community Based Epidemics (ESSENCE), per reference (n).

(20) Actively participate in PI training and exercises with the regional CNIC and local installations, as well as local civilian community exercises.

(21) Coordinate with local installation commander to appoint an Installation PHEO, if one has not already been designated, as outlined in reference (e).

(22) Ensure suspected patients are isolated immediately upon recognition.

(23) Construct a plan for cohorting PI and non-PI patients separately in the MTF.

(24) Construct a cohorted staffing plan that aligns with the cohorted wards in the MTF. Some personnel will staff the PI ward(s) for a given period, while others will staff the non-PI wards. Ensure that at least one infectious period has elapsed with no signs of disease onset in personnel before allowing PI staff to switch to a non-PI ward.

(25) Establish a community triage system for assessing PI patients before they present in the Emergency Department. For example, the establishment of a nurse/corpsman advice hotline or a TRICARE appointment center triage protocol will allow for potential patients to first present their symptoms over the phone and receive advice on stay-at-home care or presentation to the hospital if their symptoms are severe.

(26) Establish trigger tables and/or timetables and incorporate them within the MTFs PI plan to aid decision-making during a pandemic.

(27) Ensure that the MTF PI Plan contains specific contact information for key responsible parties, and delineated actions for each of those parties during each phase of a pandemic.

(28) Ensure that all staff update their alternative child care plans to reflect a pandemic flu scenario, i.e., schools close for an extended period and transportation is restricted.

(29) During a possible outbreak of a novel influenza strain, ensure all cases of confirmed influenza are reported to the Navy's Medical Event Reporting System, as outlined in reference (n). The NMCPHC will serve as the designated conduit for all Navy Medicine surveillance data transmitted to the AFHSC.

(30) Distribute appropriate PPE to all medical personnel who work closely with PI patients, as per the Occupation Safety and Health Administration (OSHA) and CDC guidelines for respiratory protection for health care workers during a pandemic.

8. Reports. The reporting required for paragraph 7d(1) was assigned report control symbol NAVMED 6220-3 by reference (n). The other reporting requirements are exempt from reports control, per reference (a).

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Distribution is electronic only via the Navy Medicine Web site at:
http://www.med.navy.mil/bumed/directives/Pages/BUMEDDirectives.aspx

References

Ref:
(a) OPNAVINST 3500.41, http://doni.daps.dla.mil/OPNAV.aspx
(b) National Strategy for Pandemic Influenza Implementation Plan of May 2006, http://www.globalsecurity.org/security/library/policy/national/nspi_implementation.pdf
(c) CDRUSNORTHCOM CONPLAN S3591-09, Pandemic Influenza of 13 AUG 2009
(d) DoD Directive 6200.3 of 12 May 2003, http://www.dtic.mil/whs/directives/corres/pdf/620003p.pdf
(e) BUMEDINST 6200.17, http://www.med.navy.mil/bumed/directives/Pages/BUMEDDirectives.aspx
(f) BUMEDINST 3440.10, http://www.med.navy.mil/bumed/directives/Pages/BUMEDDirectives.aspx
(g) CNICINST 3440.2 https://cnicgateway.cnic.navy.mil/app/Registration
(h) DoD HA Policy 06-002 of 10 Jan 2006, http://mhs.osd.mil/Content/docs/pdfs/policies/2006/06-002.pdf
(i) InterAgency Agreement Between Department of Health and Human Services and the Department of Defense for Support of Contingency Medical Materiel Requirements of 5 May 2005 http://usachppm.apgea.army.mil/news/influenzaWebsite/documents/DoD-DHHS_IA_on_SNS_20050505.pdf
(j) OPNAVINST 5100.23G, http://doni.daps.dla.mil/OPNAV.aspx
(k) BUMEDINST 3301.3A (NOTAL), http://www.med.navy.mil/bumed/directives/Pages/BUMEDDirectives.aspx
(l) DoD Directive 3025.15 of 18 Feb 1997, http://www.dtic.mil/whs/directives/corres/pdf/302515p.pdf
(m) National Response Framework of January 2008 http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf
(n) BUMEDINST 6220.12B, http://www.med.navy.mil/bumed/directives/Pages/BUMEDDirectives.aspx

**MEDICAL TREATMENT FACILITY PANDEMIC INFLUENZA PLANNING TEMPLATE**

NAVAL HOSPITAL / CLINIC XXXXX INSTRUCTION XXXX.XX

From: Commanding Officer

Subj: RESPONSE PLAN FOR PANDEMIC INFLUENZA

Ref: *List references here. Suggested references include, but are not limited to, the following:*

(a) *NAVHOSP XXXXINST XXXX.XX, Emergency Management*
(b) *XXXX State Health Department Pandemic Influenza Response Plan*
(c) *Department of Health and Human Services, Pandemic Influenza Plan, 2005 with updates at www.pandemicflu.gov*
(d) *HA Policy 07-014, Department of Defense Pre-Pandemic Influenza Vaccine Policy, of 10 August 2007*
(e) *HA Policy 07-015 and addendum, Policy for Release of Department of Defense Antiviral Stockpile During an Influenza Pandemic, of 10 August 2007 and the Guidelines Memorandum of 4 April 2008*
(f) *OPNAVINST 3500.41, Pandemic Influenza Policy, SEP 2009*
(g) through (l), see enclosure (1)

Encl: (1) References Continued
(2) Annex A, Surveillance
(3) Annex B, Screening, Triage, and Admission
(4) Annex C, Facility Access and Security
(5) Annex D, Guidelines for Patient Management
(6) Annex E, Laboratory Guidelines
(7) Annex F, Infection Control
(8) Annex G, Occupational Health
(9) Annex H, Containment Strategies
(10) Annex I, Surge Capacity, Materials Management, and Alternate Care Sites
(11) Annex J, Mass Vaccination, Mass Prophylaxis, and Points of Distribution
(12) Annex K, Interagency Coordination and Training
(13) Annex L, Communications
(14) Annex M, Staff Education and Training
(15) Annex N, Mass Fatality Management and Mortuary Affairs
(16) Annex O, Points of Contact

1. Purpose.

2. Cancellation.

3. Scope.

4. Mission.

5. Background.

6. Concept of Operation. *Use the Department of Health and Human Services (HHS) Hospital Preparedness Checklist as a guide; it is available at:* http://www.hhs.gov/pandemicflu/plan/pdf/S03.pdf

7. Assumptions.

8. Command and Control. *Include discussion of the Hospital Incident Command System (HICS) and role of the Emergency Operations Center (EOC) in pandemic response.*

9. Supporting Elements

   a. Navy Medicine Region XXXX.

   b. National Disaster Medical Systems (NDMS) Federal Coordinating Center (FCC).

   c. State and Local Public Health and Emergency Agencies.

   d. Local Civilian Hospitals.

   e. Installation Command.

   f. Tenant Commands.

10. Execution. *Include timeline and/or trigger tables for general actions based on incremental increases in Department of Defense (DoD) Phases of Pandemic. Assign actions to responsible parties and include pertinent contact information (updated). More specific actions taken during each phase will be outlined in annexes to follow.*

11. Logistics.

12. Responsibilities. *Responsible parties and their responsibilities include, but are not limited to, the following:*

   a. Commanding Officer.

   b. Executive Officer. *Include detailed responsibilities for developing, maintaining and executing this plan in concert with the Emergency Management Working Group (EMWG);*

*acting as clinical spokesperson for the Command during a pandemic; developing and recommending Command policy and procedures to the commanding Officer (CO);determining the immediate consumable/durable supply, staffing, and medication needs of the medical treatment facility (MTF).*

c. Incident Commander and/or Hospital Command Center (HCC). *Include receiving situation briefs and determining if a local outbreak of Pandemic Influenza (PI) is occurring or is imminent; activating MTFs surge capacity plan; issuing standing orders to limit visitors from MTF and/or base; making recommendations to Installation commander, in concert with Public Health Emergency Officer (PHEO) and Director of Medicine, regarding isolation and quarantine; making policy on duty status of staff that are at high risk of severe complications from PI.*

d. Public Health Emergency Officer (PHEO). *Include detailed responsibilities to review and update the PI plan; provide healthcare providers with updated case definitions and management recommendations; maintain situational awareness of potential public health threats, including review of medical intelligence and public health advisories; act as medical liaison to the Installation EOC; advise commands on travel precautions and restriction of movement; coordinate with local public health.*

e. Public Affairs. *Include responsibilities for coordinating with Public Affairs Officers (PAOs) at BUMED, Navy Medicine Region XXXX, and state and local public health agency public affairs offices; maintaining an open line of communication with the PHEO for development of formal talking points; obtaining approval for messages developed and training commanders and other spokespersons in media relations, anticipating education needs of beneficiary community and preparing and vetting appropriate educational messages for them.*

f. Director for Administration. *Include detailed responsibilities for increase in galley, housekeeping, and laundry needs; security; communications; utilities; and staff education and training. Ensure all contracts for civil service, National Security Personnel System, and contract health care providers contain the requirements for mandatory seasonal and PI immunizations.*

g. Director for Nursing Services. *Include detailed responsibilities for staffing and coverage, briefing nursing staff, equipment/supply support, altered standards of care, isolation/quarantine, identification of high risk medical and support staff who may need to be excluded from health care activities; and ventilator support to the extent that these responsibilities overlap with nursing jurisdiction.*

h. Director(s) for Fleet and Family Medicine, Primary Care, Emergency and/or Internal Medicine Department(s) and/or Clinics. *Include detailed responsibilities for the development of screening and triage protocols, admission and discharge criteria, patient management, physician staffing, briefing of clinical providers, ensuring surveillance and reporting, canceling elective admissions, evaluate bed capacity, early discharge of patients not needing inpatient care; identification of high risk medical and support staff who may need to be excluded from*

*health care activities; estimate numbers of antivirals and other supplies needed during PI and provide estimates to appropriate planning directors and/or the Incident Commander/EOC; reschedule clinics and/or alter hours of operation.*

i. Director(s) for Infectious Disease and/or Preventive Medicine. *Include detailed responsibilities for coordination with local health departments, case confirmation, recommendation and implementation of standard infection control measures, epidemiologic surveillance, and maintenance of a program for prioritized distribution of anti-viral medications and vaccines.*

j. Director(s) for Occupational Health, Health Care Support, Respiratory Protection Program and/or Infection Control. *Include detailed responsibilities for screening and triage of MTF personnel; implementation of infection control programs, including isolation and quarantine; purchase, storage, fit-testing, and distribution of appropriate Personal Protective Equipment (PPE); and staff/patient education programs.*

k. Director of Surgical Services. *Include detailed responsibilities for canceling elective admissions and surgeries, evaluating bed availability and expanding capacity, and early discharge of patients not needing inpatient care.*

l. Director of Public Health. *Include responsibilities for the procurement and maintenance of pandemic influenza vaccine, mobilization of mass vaccination teams, coordination with Federal and state agencies for storage and distribution of strategic national stockpile (SNS) supplies; and distribution of available seasonal flu vaccine to those in the MTF population who remained unimmunized to seasonal flu at the beginning of the pandemic.*

m. Director, Branch Clinics. *Coordination with MTF directors on the restructuring, closure or expansion of resources, and responsibilities of each branch clinic.*

n. Security. *Include detailed responsibilities for instituting force protection measures as necessary, and coordinating with local law enforcement and military for security of personnel and equipment.*

o. Decedent Affairs Officer. *Include responsibilities for management and transport of deceased.*

p. Health Care Providers. *Include responsibilities for staying abreast of the most current case definitions and recommendations for prophylaxis, admission, isolation, quarantine and treatment; reporting suspected or probable cases to the Preventive Medicine, Infectious Disease, or other appropriate department; adhering to infection control measures; using careful judgment for admissions decisions, keeping in mind the need for bed surge; and providing education to patients regarding the nature of pandemic flu.*

q. Mental Health and Pastoral Care Services. *Include responsibilities for providing for emergency workers, providers, caregivers, patients, and their families.*

r. MTF Emergency Manager (MEM). *Include detailed responsibilities for developing and maintaining a list of key partners, resources and facilities; liaisoning with Installation Emergency Manager (EM); coordinate and monitor training for EM teams with regard to PI response.*

s. Head, Materiel Management. *Use information provided by Directors to determine need for consumable and durable resources through the course of a pandemic; develop strategy for acquiring additional supplies and equipment; determine trigger points for ordering more resources; establish contingency plans for situations where resources become limited.*

t. Head, Information Management. *Establish hotline to provide information to beneficiaries; coordinate and communicate with PAO to include pertinent information on the MTFs Web page.*

u. Head, Pharmacy. *Estimate need for antivirals and antibiotics during pandemic and make those needs known to appropriate commands; monitor pharmaceutical usage during pandemic and advise clinicians on any rationing or withholding of supplies that may become necessary based on supply availability.*

v. Comptroller. *Procure supplemental funding for additional supplies; familiarize with resource requirements during a disease outbreak; track PI expenses.*

13. Annexes. *All annexes shall contain designated responsible parties for each action and contact information for responsible departments. Specific triggers and actions pertaining to each annex shall be organized according to appropriate DoD PI Phase, i.e., preparatory actions should be taken in phases 1, 2, or 3 and response actions should be organized within phases 4, 5, or 6. The following section lists examples of plans that should be addressed and actions that should be taken within each annex.*

**REFERENCES (CONTINUED)**

Ref: (g) *Centers for Disease Control and Prevention, Hospital Pandemic Influenza Planning Checklist, June 2007*
(h) *DoD Directive 6200.3, Emergency Health Powers on Military Installations of 12 May 2003*
(i) *Centers for Disease Control and Prevention, Receiving, Distributing and Dispensing Strategic National Stockpile Assets, A Guide for Preparedness, August 2006*
(j) *Providing Mass Medical Care with Scarce Resources: A Community Planning Guide. AHRQ Publication No. 07-0001, February 2007. Agency for Healthcare Research and Quality, Rockville, MD, http://www.ahrq.gov/research/mce/*
(k) *BUMEDINST 6200.17, Public Health Emergency Officers*
(l) *OSHA 3328-05, OSHA Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers, 2007*

Annex A
**SURVEILLANCE**

*Include information on monitoring and reporting of suspected, probable, and confirmed pandemic influenza (PI) cases within the medical treatment facility (MTF) and up appropriate chains of command. Reporting chain should include details on the military chain of command, the Navy disease reporting system (including to the Navy's Medical Event Reporting System (MERS) and the Navy and Marine Corps Public Health Center (NMCPHC)), and civilian health authorities. Include information on interface with Electronic Surveillance System for Early Notification of Community Based Epidemics (ESSENCE) and other pertinent health surveillance systems. Include information on coordination and communication of surveillance results with local and state public health agencies.*

Annex B

## SCREENING, TRIAGE, AND ADMISSION

*Include detailed information on the processes for screening and triage of patients as they present at the hospital, i.e., who will do the screening (corpsmen, nurses, residents), where will the screening take place (main gate, off-base, via telephone, in Emergency Department), and what triage decisions will be made (admit to isolation ward, home care, admit to Intensive Care Unit (ICU), etc.). Avoid creation of mass screening and triage areas, as this will increase contact among potentially infected and uninfected persons. Include mechanisms for isolating and differentiating between pandemic influenza (PI) and non-PI patients. Include information on plans for utilization of branch medical clinics, if at all, for screening and triage purposes. Include triggers for activation of the PI screening and triage protocol. Include discussion of isolation of non-admitted patients in a home care setting, and recommendations for home caregivers, including instructions for care and signs that the patient may need to come back to the medical treatment facility (MTF).*

Annex C

# FACILITY ACCESS AND SECURITY

*Include information on the development, review, training, and execution of protocols for handling a sustained influx of patients to the medical treatment facility (MTF); the control of vehicle and foot traffic into and out of the MTF and/or base; manning of mass prophylaxis or vaccination sites; security of isolation and quarantine areas, including staff berthing, Bachelor Enlisted Quarters (BEQ), etc.; issuance of appropriate personal protective equipment (PPE) to security personnel; limitation of visitors to the MTFs admitted patients.*

Annex D

# GUIDELINES FOR PATIENT MANAGEMENT

*Include current Centers for Disease Control and Prevention (CDC) guidelines and criteria for evaluating, confirming, prophylaxing, admitting, isolating, managing (including anticipating secondary diseases) and discharging a patient with suspected pandemic influenza (PI) or PI exposure. Include information, when known, regarding case definitions, transmission routes, incubation period, and infectious period. Include Bureau of Medicine and Surgery (BUMED) or Medical Treatment Facility (MTF)-specific guidelines as well. Update these guidelines as knowledge about PI evolves. Research and develop ventilator use guidelines, including ventilator triage in a resource-restricted scenario.*

Annex E

# LABORATORY GUIDELINES

*Maintain cache of influenza detection reagents for "rule-in, rule-out" testing for Influenzas A and B; proficiency in influenza testing procedures; and primary and alternate resources for test kits. Maintain cache of shipping supplies for sending samples out for Centers for Disease Control and Prevention (CDC)-laboratory (Laboratory Response Network (LRN)) Polymerase chain reaction (PCR) confirmation of specific influenza strain. Disseminate information to clinical staff on the collection of samples for upper respiratory viruses. Elaborate on results reporting chains and whether those chains change as pandemic phasing advances.*

Annex F

# INFECTION CONTROL

*Ensure command-wide seasonal flu participation in the vaccination and respiratory hygiene programs. Train staff on infection control guidelines for a pandemic. Administer vaccines and/or antivirals as recommended and available. Include recommendations for personal protective equipment (PPE) and other infection control measures for home caregivers and family members of infected patients under home isolation.*

Annex G

# OCCUPATIONAL HEALTH

*Review strategies for prioritizing health care personnel in the receipt of antiviral prophylaxis and/or vaccinations and supervise distribution as necessary. Determine health status of all health care personnel, including those who are pregnant, over 65 and/or immunocompromised, and develop work plans that minimize their exposures. Ensure space and supplies are available for berthing staff, as needed. Identify staff with child and elder care responsibilities and ensure that their written alternate care plans are active, updated, and initiated as necessary. Provide just-in-time training for staff on appropriate use and wearing of personal protective equipment (PPE) and other infection control measures. Design and implement a daily staff health screening and surveillance system, as well as a work quarantine plan, to ensure that sick and/or exposed staff does not come into contact with uninfected patients. Include a plan for monitoring the health of health care personnel, and an appropriate reporting chain for those surveillance results.*

Annex H

# CONTAINMENT STRATEGIES

*The Public Health Emergency Officer (PHEO) will coordinate with local public health authorities on the provision of the following recommended community-based disease containment strategies: Plans for social distancing measures, including school closures, and cancellation of public gatherings. Provision of recommendations to the community on respiratory hygiene (handwashing, cough etiquette, and the use of respiratory personal protective equipment (PPE)). Voluntary home quarantine/isolation of exposed/infected patients not requiring hospital admission.*

Annex I

## SURGE CAPACITY, MATERIALS MANAGEMENT, AND ALTERNATE CARE SITES

*Stockpile and inventory surge capacity supplies, including personal protective equipment (PPE) and ventilators. Develop a Materials Management Plan, including information on surge for consumable and durable resources, and alternate vendors in case the primary vendor is overwhelmed with a surge in the demand for medical supplies. Create and maintain an inventory of existing and surge bed capacity, and update daily log of bed capacity during a pandemic. Identify and utilize off-site alternate care areas, including branch medical clinics that can be quickly scaled up for patient treatment and continuity of care. Extend critical care treatment teams by: (1) providing just-in-time respiratory therapy training to corpsmen/nurses for ventilator function, and (2) creating teams of non-critical care inpatient providers led by critical care specialists to provide all critical care. Create and implement emergency staffing ratios, as above. Discuss and develop altered standards of care for scenarios of limited resources and staffing, and review those standards with the bioethics committee. Develop staffing guidelines and schedules, considering the need for a staff set to man the non-pandemic influenza (PI) ward(s) and a staff set to man the PI ward(s). Ensure that overlap of PI-ward staff with a non-PI ward only occurs after the PI-ward staff has been quarantined for an incubation period to determine their PI status post-exposure. See each commands work quarantine plan.*

Annex J

## MASS VACCINATION, MASS PROPHYLAXIS, AND POINTS OF DISTRIBUTION

*Develop, review, and implement a Mass Vaccination, Mass Prophylaxis, and Points of Distribution (POD) plan, as applicable and in concert with local health authorities (regarding receipt and distribution of Strategic National Stockpile (SNS) supplies). The plan should include discussion of resource needs, including consumables, staff, and equipment; security plans; estimate of the total number of persons to receive vaccines/antivirals and the average dispensing time per person; development of a screening protocol; staffing and training of vaccination/ prophylaxis teams; and plan for receipt and storage of large quantities of medical supplies. Since pandemic influenza is a communicable disease, every effort should be made to limit contact among persons seeking vaccines/antivirals, including novel plans for "drive-thru" prophylaxis/vaccination. Include plans for personal protective equipment (PPE) distribution to all dispensing staff.*

Annex K

## INTERAGENCY COORDINATION AND TRAINING

*Ensure the Medical Treatment Facility (MTF) Pandemic Influenza (PI) Plan is developed, overlapped, and trained in concert with all supported and supporting agencies' PI plans, including, but not limited to: Branch Medical Clinics, Installation, Tenant Commands, Navy Medicine Region XXXX, Navy Environmental Preventive Medicine Units (NEPMU), local public health region, local civilian hospitals, and local emergency management. Develop informal and formal networks with military and civilian counterparts, and establish a Memorandum of Understanding (MOUs) or Mutual Aid Agreements (MAAs) for mutual support during a pandemic. Maintain a formal liaison with supporting commands/agencies.*

Annex L

# COMMUNICATIONS

*Include information on communication with higher authorities (Navy and Marine Corps Public Health Center (NMCPHC), Navy Medicine Region XXXX, Bureau of Medicine and Surgery (BUMED)) and local community (hospitals, public health region, emergency management, beneficiaries). Identification of spokespersons; creation of risk communication tools and products coordinated with civilian and military authorities; dissemination of pandemic flu information to beneficiaries through pamphlets, hotlines, and internet links.*

Annex M

# STAFF EDUCATION AND TRAINING

*Develop and disseminate pandemic flu initial and annual refresher education and training prior to a pandemic event (phases 1 through 3) and provide follow-up, just-in-time training once a pandemic becomes imminent. Develop training briefs to educate incoming military and civilian volunteers about medical treatment facility (MTF)-specific locations, services, and their role as volunteers.*

Annex N

# MASS FATALITY MANAGEMENT AND MORTUARY AFFAIRS

*Design and participate in mass casualty/mass fatality training and exercises; maintain adequate stock of body bags; estimate the need for additional personnel to handle body transport, and design just-in-time training and respirator fit-testing for these additional staff; liaison with Military Mortuary Support Office (MMSO); contract with funeral home assets; estimate and monitor refrigerator storage capacity in morgue, on base, and in community; obtain additional refrigerator trucking assets as needed.*

Annex O

# POINTS OF CONTACT

*Include points of contact for responsible parties as appropriate for medical treatment facility (MTF)-specific activities.*

## PANDEMIC ALERT PHASES MATRIX

| DOD Global CONPLAN to Synchronize Response to PI Phases | | Federal Government Response Stages (Geography Driven) | | WHO Phases (Virus Driven) | |
|---|---|---|---|---|---|
| **INTER-PANDEMIC PERIOD** | | | | | |
| 0 | No new influenza subtypes have been detected in humans. | 0 | New domestic animal outbreak in at-risk country. | 1 | No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human disease is considered to be low. |
| | | | | 2 | No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease. |
| **PANDEMIC ALERT PERIOD** | | | | | |
| 1 | Receipt of information of human infections with a new viral subtype, but no human-to-human spread, or at most rare instances of spread to a close contact. | 1 | Suspected human outbreak from animals overseas | 3 | Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact. |
| 2 | Receipt of information of small cluster(s) with limited human-to-human transmission, but the spread is highly localized suggesting the virus is not well adapted to humans. | 2 | Confirmed human outbreak overseas | 4 | Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans. |
| 3 | Indications and warnings identify large cluster(s) of human-to-human transmission(s) in an affected region. | | | 5 | Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial PI risk). |
| **PANDEMIC PERIOD** | | | | | |
| 4 | Receipt of information that a highly lethal pandemic influenza virus is spreading globally from human-to-human signaling a breach in containment and failing interdiction efforts. | 3 | Widespread human outbreaks at multiple locations overseas | 6 | PI phase, increased and sustained transmission in general population |
| | | 4 | First human case in North America | | |
| | | 5 | Spread throughout the United States | | |
| **RECOVERY PERIOD** | | | | | |
| 5 | Receipt of information that case incident is decreasing, indicating the slowing of the pandemic wave. Reconstitution of DOD assets and conditions established to return to a previous phase. | 6 | Recovery and preparation for subsequent waves | | |

# GUIDANCE FOR DEVELOPING A MASS PROPHYLAXIS/ POINT OF DISTRIBUTION (POD) PLAN

The following provides a very brief synopsis of existing guidance for developing a POD plan for military installations.

## General Guidance

Installations should consider the following factors when deciding on the scale of the mass prophylaxis plan.

- The size and number of target populations needed to maintain installation operations and carry out the base's mission.
- The availability of local civilian medical and public health resources during a public health emergency response.
- The ability of the installation and its supporting medical treatment facility (MTF) to serve as a POD and provide medical countermeasures to its entire beneficiary population.

## Command and Control

- The Public Health Emergency Officer (PHEO) will determine the existence of a public health emergency and advise the MTF and Installation Commander on declaring a public health emergency, implementing control measures, and administering medical countermeasures via the activation of a POD(s).
- The Installation Commander will give the order to activate a mass prophylaxis POD(s) and administer medical countermeasures upon the advice from the PHEO.
- The MTF Commander will (upon notification from the Installation Commander) direct the POD Manager to activate the POD(s) and will stand-up the Medical Operations Center (MOC).

## Organization

The organizational structure may be expanded and/or contracted to fit the size and scope of the event.

- POD Manager: Responsible for the command and control activities of the POD(s), will communicate and coordinate with the Emergency Operations Center (EOC) (if activated) and the MOC. In most scenarios the senior Pharmacist assumes the role of POD Manager.
- Pharmacy Team: Participates in the POD/Strategic National Stockpile (SNS) planning process before, during, and after a mass prophylaxis event; manages prophylaxis dispensing, and tracks/manages prophylaxis inventory.
- Clinical Team: Responsible for providing clinical personnel to perform medical triage, medical evaluation, vaccinations, and other necessary clinical duties.

- Patient Administration Team: Provides administrative support to the POD including management of Information Management/Information Technology (IM/IT) issues, forms distribution, and data collection.
- Mental Health Team: Responsible for assessment of patient's and POD personnel's mental well being; provide courses of action for those who need help beyond the counseling that can be provided at the POD(s).
- Transport Team: Responsible for coordination of patient transportation, when needed.
- Medical Logistics Team: Responsible for medical and non-medical supplies requests and acquisition (i.e., food, water, tables, etc.).
- Medical Security Team: Responsible for security of POD personnel, pharmaceuticals, vaccines, and materials, as well as controlling entry and exit access for the duration of POD operations.
- Manpower Team: Responsible for providing support such as runners, greeters, patient movement, etc.
- Facilities Team: Responsible for facilities operations.
- Public Health Team: Work with the PHEO to develop the scale of the response for the installation and have it approved by the MTF or through the Chain-of-Command (CC). Ensures ongoing coordination with state or local public health officials in the development of the installation's mass prophylaxis plan. Provides epidemiological surveillance in order to guide planning and response efforts. Conducts required briefings and provides educational handouts to patients in the POD briefing room. Participates in risk communication activities for mass prophylaxis operations.

## Planning

- Installation Demographics: Identify and determine the number of active duty and civilian workforce, as well as the location and population size of military dependents residing on the installation, and other health care beneficiaries attached to the installation MTF.
- POD Site: Choice of POD sites should be guided by knowledge of installation demographics, accessibility for various types of transportation (i.e., emergency vehicles, buses, handicap vehicles, military transportation), and handicap access. Capacity and capability to handle traffic volume, size of operation, storage requirements (supplies and stockpiling), equipment, security and communication infrastructure. Potential POD sites to consider include the gymnasium, auditorium, school, or aircraft hangers.
- Communications: POD locations should have landline phone capability to supplement cellular, radio, or satellite communications, which may be unavailable or overloaded during a pandemic period. Additionally, pre-existing video and audio equipment (e.g., audio-visual equipment) may reduce logistical burdens when planning briefings at the POD site(s).
- Facility Support: Proposed POD locations should have space for temporary storage and safe removal of medical waste, on-site potable water supply, electrical wiring capable of supporting multiple electrical and electronic appliances (e.g., coolers, computers), restrooms, and a staff staging/rest area. It is critical to consider backup power generation capacity (arrange coordination with power production on your installation).

- Storage: POD sites should have facilities for controlled storage of antibiotics and vaccines, including electrical outlets for cold storage containers requiring external power supplies. In addition, these sites should have separate areas for storage of medical supplies, communication equipment, and information dissemination material, which may require different levels of security.

## Deactivation

The PHEO will provide guidance to the Installation Commander for determining when prophylaxis is near completion and demobilization should commence.

# Pandemic Influenza Trigger Table

| WHO Pandemic Phase | Activity (Clinical Labor Pool) Human Resources Department, Military (Preventive Medicine – ADHOC) |
|---|---|
| Interpandemic Period: Phases 1 and 2 | • Review and update telephone tree and emergency telephone numbers.<br>• Review the Disaster Plan with all staff. |
| Pandemic Alert Period: Phase 3 | • Review critical elements of the Pandemic Plan with all staff including non-clinical resources.<br>• Complete fit testing of all current employees as needed.<br>• Initiate Web page to keep staff informed on status and provide educational updates.<br>• Monitor employee absenteeism for increases that might indicate early cases of pandemic influenza. |
| Pandemic Alert Period: Phase 4 | • Senior leadership collaborates with local and regional health care groups in an attempt to coordinate response.<br><br>**If the Region/Medical Treatment Facility (MTF)/Hospital/Clinic service area is the localized area with cases of novel influenza, otherwise, implement in Phase 5**<br><br>• **Implement staff rotation restriction.** Staff in cohort areas do not float to non-cohort areas. |
| Pandemic Alert Period: Phase 5 | • Departmental senior personnel to implement telephone tree: first level telephone calls to ascertain if staff is available to come for their next scheduled shift.<br>• Departmental senior personnel to assess current patient staffing needs and available resources; notify Human Resources of status.<br>• Human Resources personnel to notify Non-Clinical Labor Pool Leader of potential needs and status of pandemic.<br><br>**If the Region/MTF/Hospital/Clinic service area is the localized area with cluster of novel influenza cases, otherwise, implement in Phase 6**<br><br>• **Implement staff rotation restriction.** Staff in cohort areas do not float to non-cohort areas. |
| Pandemic Period: Phase 6 | • Activate pandemic staffing plan for clinical and non-clinical resources.<br>• Manager or designee to assess patient needs, communicate with staff on those needs, and keep the Human Resources Department informed of needs and available resources.<br>• Human Resources Department/Clinical Labor Pool to be the central hub for clinical staffing resources under leadership of the Director for Administration.<br>• Human Resources Department to coordinate available resources with non-clinical labor pool leader.<br>• Update Web page and 1-800-number to keep staff informed. (Preventive Medicine)<br>• Staff sick calls*: call in to work center; work center records sick call and notifies senior person on duty (Senior Enlisted Leader (SEL), Lead Chief Petty Officer (LCPO), Lead Petty Officer (LPO)); records to be reconciled at a later date.*<br>• Human Resources Department to coordinate with Emergency Operations Center (EOC) on the need to staff alternate care sites, if needed.<br>• Continual assessment of staffs physical and emotional status and provide intervention as needed.<br>• **Implement staff rotation restriction.** Staff in cohort areas do not float to non-cohort areas. |
| Post Pandemic Period: Phase 7 | • Return to normal operational staffing procedures.<br>• Evaluate staffs physical and emotional status and provide intervention as needed, e.g., critical incident debriefing management program and grief management.<br>• Assess staffs needs for days off, vacation, alternative schedules.<br>• Evaluate effectiveness of pandemic plan, revise as needed. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phase | Activity (Handling of Decedents) Department Head, Laboratory |
|---|---|
| Interpandemic Period: Phases 1 and 2 | • Review standard decedent handling processes and procedures. |
| Pandemic Alert Period: Phase 3<br><br>*Human infection(s) with a new subtype, but no human-to-human spread, or rare instances of infectious spread to a close contact.* | • Continue use of standard decedent handling processes and procedures.<br>• Prepare and finalize new and modified decedent handling procedures needed to meeting each phase of the pandemic.<br>• Develop and implement procedure to comply with pandemic influenza planning guide for decedent handling.<br>• Identify point of contact for securing additional decedent refrigerated/freezer storage. |
| Pandemic Alert Period: Phase 4<br><br>*Small clusters with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.* | • Continue use of standard decedent handling processes and procedures.<br>• Review policy and procedures for decedent handling and update if needed.<br>• Verify refrigerator/freezer unit location(s).<br>• Verify availability and connection process for electrical power to refrigerator/freezer units.<br>• Identify location and transport requirements for high volume decedent storage. |
| Pandemic Alert Period: Phase 5<br><br>*Larger clusters, but human-to-human spread is still localized, suggesting that the virus is becoming increasingly better adapted to humans* | • Continue use of standard decedent handling processes and procedures.<br>• Review policy and procedures for decedent handling and update if needed.<br>• Maintain close communication with Motor Transportation to determine when temporary decedent holding refrigerator/freezers need to be moved and setup at the Region/Medical Treatment Facility (MTF)/Hospital/Clinic.<br>• Regularly notify all departments and staff involved on the status of procedures.<br>• Have Non-Clinical Labor Pool training materials complete and available.<br>• Upgrade or downgrade level of activity as directed by Incident Commander or Public Health Emergency Officer (PHEO). |
| Pandemic Period: Phase 6<br><br>*Increased and sustained transmission in the general population* | • Implement decedent handling Standard Operating Procedures (SOP's) and associated implementation procedures, as directed by Incident Commander or PHEO.<br>• Notify Non-Clinical Labor Pool of staffing needs.<br>• Upgrade or downgrade decedent handling level as directed by Incident Commander or PHEO. |
| Post Pandemic Period: Phase 7<br><br>*Rates of infection return to normal flu season.* | • Evaluate procedures, processes, and activities that were used or occurred during each phase of the pandemic. Modify and update SOP's and implement changes to improve future response and management. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phases | Actions (Disease Surveillance) Department Head, Preventive Medicine |
|---|---|
| Interpandemic Period: Phases 1 and 2<br><br>*No new virus in animals; no human cases*<br><br>Trigger: Cohorting on a patient unit is 5 or more seasonal influenza cases on one in-patient unit | • Daily monitoring of influenza like illness (ILI) for clusters of cases.<br>• Enhanced isolation and surveillance occurs when more than 4 influenza cases are placed on one patient care unit. This is an internal infection control process.<br>• Recommend using the Rapid Influenza Test to rule out Influenza A for patients with ILI in Primary Care Clinics and Emergency Department (ED). Report testing results to the local County Health Department after clearance from the PHEO. |
| Pandemic Alert Period: Phase 3<br><br>*No new virus in animals; no human cases* | **Same as Phases 1 and 2**<br>• Activate and begin updating the Pandemic Influenza (Pan Flu) Web page.<br>• Update the Pan Flu line as necessary. |
| Pandemic Alert Period: Phase 4<br><br>*Small clusters, limited human-to-human spread, clusters highly localized*<br><br>Trigger: Seasonal influenza<br><br>AND<br><br>1) ILI employee or patient with travel or occupational risks suspected/confirmed with novel influenza<br><br>AND/OR<br><br>2) Local birds are identified with novel influenza virus. | **Same as for Phases 1 through 3; PLUS**<br>• Implement surveillance of health care workers in contact with confirmed and hospitalized novel influenza case(s).<br>• Implement surveillance of employees who travel to areas where the novel influenza strain is causing cases.<br>• Implement surveillance of person with occupation exposure to birds or poultry confirmed with a novel influenza virus.<br>• Initiate the Region/MTF/Hospital/Clinic Pandemic Influenza Hotline with current information and status of the outbreak. Update when situation warrants.<br>• Update the Region/MTF/Hospital/Clinic internet page with Pandemic Influenza information. |
| Pandemic Alert Period: Phase 5<br><br>*Larger clusters, cases still localized*<br><br>Triggers: Same as Phase 4 above<br><br>AND<br><br>One novel influenza case identified in Region/MTF/Hospital/Clinic service area | **Same as Phases 1 through 4; PLUS**<br>• Real time ED surveillance within health system.<br>• Employee absenteeism surveillance.<br>• Symptom monitoring in employees.<br>• Continue to update the Region/MTF/Hospital/Clinic Pan Flu line as needed.<br>• Continue to update the Region/MTF/Hospital/Clinic intranet page for staff and internet page for local area personnel. |
| Pandemic Period: Phase 6<br><br>*Sustained transmission in the general population*<br><br>Triggers: 10 cases of novel influenza virus admitted to Region/MTF/Hospital/Clinic | **Same as Phases 1 through 5; PLUS**<br>• Discontinue routine isolate testing or rapid antigen testing.<br>• Discontinue viral isolation. |
| Post Pandemic Period: Phase 7 | • Return to Phase 1 activities.<br>• Review enhanced surveillance procedures and modify if needed.<br>• Analysis of surveillance success. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phase | Activity (Surge Capacity)<br>Director, Nursing Services / Department Head, Patient Administration |
|---|---|
| Interpandemic Period: Phases 1 and 2 | • None |
| Pandemic Alert Period: Phase 3 | • Develop Region/Medical Treatment Facility (MTF)/Hospital/Clinic Surge Plan(s) to address ED capacity, patient placement and bed capacity, patient discharge and transfers, and ventilator capacity.<br>• Coordinate Operations Management and Telecomm to evaluate and concur with proposed modifications to area usage. |
| Pandemic Alert Period: Phase 4 | • Review and update Surge Plan(s) |
| Pandemic Alert Period: Phase 5 | **If the Region/MTF/Hospital/Clinic experiences an influx of clusters of novel influenza patients, implement Surge Plan(s)**<br><br>• Triggers to implement the Surge Plan may include:<br>o The proportion of emergency room visits attributable to influenza.<br>o The proportion of influenza cases requiring hospitalization.<br>o The capacity of the hospital to accommodate influenza cases.<br>o The proportion of cases who normally live with high-risk individuals or who have no support at home and cannot care for themselves. |
| Pandemic Period: Phase 6 | **Implement Surge Plan(s)**<br><br>• Triggers to implement the Surge Plan may include:<br>o The proportion of emergency room visits attributable to influenza.<br>o The proportion of influenza cases requiring hospitalization.<br>o The capacity of the hospital to accommodate influenza cases.<br>o The proportion of cases who normally live with high-risk individuals or who have no support at home and cannot care for themselves. |
| Post Pandemic Period: Phase 7 | • Review and update Surge Plan(s).<br>• Prepare for second or third pandemic wave. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phase | Activity (Vaccines & Antivirals) Public Health Services, Immunizations Program Manager |
|---|---|
| Interpandemic Period: Phases 1 and 2 | • None. |
| Pandemic Alert Period: Phase 3 | • Develop protocols to request pharmaceuticals (antivirals or vaccine) from state or Federal reserves (Strategic National Stockpile or Vendor-managed inventory).<br>• Develop priority lists for persons (staff and patients) to receive vaccine and/or antivirals by risk group based on Centers for Disease Control and Prevention (CDC), Division of Communicable Disease Control (DCDC) Pandemic Influenza Work Group (PIWG), Bureau of Medicine and Surgery (BUMED), and Region/Medical Treatment Facility (MTF)/Hospital/Clinic prioritization strategies.<br>• Develop a stratification scheme for prioritizing vaccination of health care personnel who are most critical for patient care and essential personnel to maintain the day-to-day operation of the health care facility.<br>• Establish projections for numbers of persons (staff and patients) to receive vaccine and/or antivirals by risk group.<br>• Monitor CDC, DCDC Pandemic Influenza Work Group (PIWG), BUMED, and Region/MTF/Hospital/Clinic for updates to prioritization and treatment strategies. |
| Pandemic Alert Period: Phase 4 | • Work with local health department to establish an Memorandum of Understanding (MOU) and procedures for receiving vaccines and antivirals.<br>• Monitor CDC, DCDC, PIWG, BUMED, and Region/MTF/Hospital/Clinic for updates to prioritization and treatment strategies. |
| Pandemic Alert Period: Phase 5 | • Implement mass vaccination and/or dispensing of antivirals as warranted.<br>• Monitor CDC, DCDC, PIWG, BUMED, and Region/MTF/Hospital/Clinic for updates to prioritization and treatment strategies. |
| Pandemic Period: Phase 6 | • Continue mass vaccination and/or dispensing of antivirals.<br>• Monitor CDC, DCDC, PIWG, BUMED, and Region/MTF/Hospital/Clinic for updates to prioritization and treatment strategies. |
| Post Pandemic Period: Phase 7 | • Review and make adjustments to procedures for vaccination and antiviral drug use to prepare for second wave.<br>• Provide vaccination for individuals missed during first wave. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phase | Actions (Occupational / Employee Health) Department Head, Occupational Medicine / Human Resources |
|---|---|
| Interpandemic Period: Phases 1 and 2 | • Participate in pandemic planning. |
| Pandemic Alert Period: Phase 3 | • Work with Mental Health to develop pandemic psychological counseling resources list.<br>• Develop exposure prevention, surveillance, testing, and quarantine procedure(s) and protocols.<br>• Develop procedures for large scale novel influenza testing.<br>• Review influenza exposure prevention practices.<br>• Work with Infection Control and Safety to ensure respirator availability for designated employees.<br>• Complete all physicians and medical student respirator fit testing.<br>• Proceed with season influenza immunization plans. The goal is an 85%-plus immunization rate.<br>• Participate in mass immunization/antiviral dispensing drills. |
| Pandemic Alert Period: Phase 4 | **If the Region/Medical Treatment Facility (MTF)/Hospital/Clinic service area is experiencing clusters of cases, implement the actions in Phase 5.**<br>• Review, update, and modify Occupational and Employee Health pandemic plans and procedures.<br>• Review and develop pandemic education materials with Infection Control, Preventive Medicine and Staff Education and Training.<br>• Devise expanded Occupational Medicine staffing schedule. |
| Pandemic Alert Period/Pandemic Period: Phases 5 and 6 | **If the Region/MTF/Hospital/Clinic service area is experiencing clusters of cases, implement the actions in Phases 5 and 6.**<br>• Distribute exposure prevention, surveillance, testing, treatment protocols, and psychological resource list to departments.<br>• Trial high volume Occupational Health influenza testing process.<br>• Ensure that testing locations, staffing, and supplies are adequate.<br>• Revise service estimates.<br>• Promote seasonal influenza immunizations.<br>• Coordinate with Infection Control and Pharmacy for final antiviral/vaccination plan.<br>• Finalize employee quarantine plan, including possible resources and locations, with administration. |
| Post Pandemic Period: Phase 7 | • Review employee quarantine, testing, and infection logs.<br>• Assess inventory/staffing needs for second pandemic wave.<br>• Assess effectiveness of Occupational Health procedures and practices.<br>• Prepare for second mass inoculations if indicated by Preventive Medicine and Infection Control. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phases | Actions (Clinical Management) Chairman, ECOMS |
|---|---|
| Interpandemic Period:<br>Phases 1 and 2<br><br>*No new virus in animal, bird, or man;, no human-to-human spread*<br><br>Trigger:<br>1) Seasonal influenza cases | **Implement standard procedures for triage, clinical evaluation, admissions, and clinical management of seasonal influenza cases.** |
| Pandemic Alert Period:<br>Phase 3<br><br>*Same as above: Avian influenza subtype H5N1 is currently in phase three*<br><br>Triggers:<br>1) Annual influenza cases<br><br>AND<br><br>2) One case H5N1 identified in Active Duty/Dependent/Employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of H5N1<br><br>AND/OR<br><br>3) One case of a novel influenza virus identified in Active Duty/Dependent/employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of novel influenza virus<br><br>AND/OR<br><br>4) Novel influenza virus is identified in local birds or poultry and one case of novel influenza identified in person handling birds or poultry. | **Implement actions in Phases 1 and 2; PLUS**<br><br>• Emergency Department (ED) to implement standard surveillance and reporting of unusual clusters of respiratory illness or death.<br>• Preventive Medicine, Epidemiology Section, and Infection Control to review Center for Disease Control and Prevention (CDC) and World Health Organization (WHO) Web sites to gather up-to-date information regarding changes to information about exposure risks, travel risks, and occupation risks. |

| WHO Pandemic Phases | Actions (Clinical Management) Chairman, ECOMS (Continued) |
|---|---|
| Pandemic Alert Period:<br>Phase 4<br><br>*Small clusters, limited human-to-human transmission. Spread highly localized*<br><br>Triggers:<br><br>1) Annual influenza cases<br><br>AND<br><br>2) One case H5N1 identified in Active Duty/Dependent/employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of H5N1<br><br>AND/OR<br><br>3) One case of a novel influenza Virus identified in Active Duty/Dependent/employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of novel influenza virus<br><br>AND/OR<br><br>4) Novel influenza virus is identified in local birds or poultry and one case of novel influenza identified in person handling birds or poultry. | **Implement actions in Phases 1 through 3; PLUS**<br><br>**If the Region/Medical Treatment Facility (MTF)/Hospital/Clinic service area is the localized area, implement the items below. If not, the items below are implemented in Phase 5**<br><br>General actions (Hospital and Clinics):<br>• Refer to precautions in infection control within the Region/MTF/ Hospital/Clinic.<br>• Report cases to Preventive Medicine and Infection Control.<br>• Apply case definition (definition is fluid and may change with a novel pandemic virus strain).<br><br>Clinical Evaluation related actions:<br>• Implement rapid detection of novel influenza to quickly contain case(s). Note: rapid detection is not confirmation.<br>• Laboratory evaluation (due to large number of cases is recommended only for the following, per CDC recommendations as of August 2006).<br>• Test for influenza A (H5N1) is indicated for **hospitalized** patients with:<br>o Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, **AND**<br>o History of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans.<br>• Test for influenza A (H5N1) should be considered on a case-by-case basis in consultation with state and local health departments for **hospitalized or ambulatory** patients with:<br>o Documented temperature of >38°C (>100.4°F), **AND**<br>o One or more of the following: cough, sore throat, shortness of breath, **AND**<br>o History of contact with domestic poultry (e.g., visited a poultry farm, household raising poultry, or bird market) or a known or suspected human case of influenza A (H5N1) in an H5N1-affected country within 10 days of symptom onset.<br><br>Clinical Management related actions:<br>• Implement clinical treatment/management for suspected/confirmed novel influenza cases as described in overview for this section. |
| Pandemic Alert Period:<br>Phase 5<br><br>*Larger clusters, human-to-human spread still localized*<br><br>Trigger:<br><br>Same as Phase 4 | **Implement actions in Phases 1 through 4; PLUS**<br><br>**If the Region/MTF/Hospital/Clinic service area is the localized area, implement the items in Phase 4. If not, the items in Phase 4 are implemented in Phase 6.** |

| WHO Pandemic Phases | Actions (Clinical Management) Chairman, ECOMS (Continued) |
|---|---|
| Pandemic Period:<br>Phase 6<br><br>*Increased, sustained transmission in the general public*<br><br>Trigger:<br><br>1) Cases identified on site with admission to the Region/MTF/Hospital/Clinic | **Implement actions in Phases 1 through 5; PLUS**<br><br><u>General actions (Hospital and Clinics)</u>:<br>• Implement real time reporting of cases.<br>• Implement active surveillance of employee absenteeism.<br><br><u>Triage-related actions</u>:<br>• Implement ED pandemic triage and clinical assessment plans<br>o Set up alternate triage site outside of ED or clinic.<br>o Implement modified triage assessment.<br><br><u>Admissions-related actions</u>:<br>• Implement modified/expedited admissions procedures (refer to the Section on Surge Capacity).<br><br><u>Clinical evaluation-related actions</u>:<br>• Relatively high likelihood that ILI during Phase 6 will be novel influenza; discontinue clinical evaluation for novel influenza.<br>• Focus evaluation predominately on clinical, epidemiologic, and basic lab findings with less emphasis on laboratory diagnostic testing.<br>• Areas without pandemic activity should continue to ask patients about recent travel or close contact with a suspected or confirmed pandemic case.<br>o Note: the next pandemic strain might present a different clinical syndrome.<br>• Exposure history will be marginally useful in areas with pandemic activity.<br>• Once the pandemic arrives in the Region/MTF/Hospital/Clinic area, clinical criteria will be sufficient for classifying the patient as a suspected novel influenza case. |
| Post Pandemic Period:<br>Phase 7 | • Return to routine surveillance and reporting.<br>• Review effectiveness of modified procedures for triage, admissions, and clinical treatment/management and update, if needed.<br>• Focus group reviews of pandemic plan strategies. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phase | Activity (Supply Chain / Materiel Management) Department Head, Materials Management |
|---|---|
| Interpandemic Period: Phases 1 and 2 | • Purchasing and Distribution – Coordinate with Prime Vendor and other vendors for critical supply inventory replenishment. Increase par stock levels in hospital, if necessary. |
| Pandemic Alert Period: Phase 3 | • Purchasing and Distribution – Update critical supply inventories with Prime Vendor. |
| Pandemic Alert Period: Phase 4 | • Purchasing and Distribution – Continue monitoring supplies with Prime Vendor. |
| Pandemic Alert Period: Phase 5 | • Purchasing and Distribution – Continue to monitor supply levels with Prime Vendor. If outbreak occurs locally, consider telecommuting.<br>• Notify Prime Vendor to deliver critical supplies held in reserve. |
| Pandemic Period: Phase 6 | • Purchasing, Distribution, Stores and Transportation – May implement telecommuting and re-arrange assignments, based on availability of staff and mission critical needs of the organization.<br>• Monitor critical supply levels at Prime Vendor. |
| Post Pandemic Period: Phase 7 | • Purchasing Manager may recall telecommuting employees.<br>• Monitor critical supplies with Prime Vendor. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phases | Actions (Infection Control) Public Health Services, Infection Control Nurse |
|---|---|
| Interpandemic Period: Phases 1 and 2<br><br>*No new influenza virus in humans; no new animal influenza virus; no human-to-human spread*<br><br>Trigger:<br><br>1) Seasonal influenza cases | **Implementation of standard infection control/environmental guidelines for seasonal influenza per infection control policies, which include:**<br><br>Hospital and Clinics:<br>• Emphasize respiratory etiquette. Strategically place additional boxes of tissues in waiting areas and treatment/exam rooms.<br>• Emphasize seasonal influenza vaccine for all Region/Medical Treatment Facility (MTF)/Hospital/Clinic patients.<br>• Aggressive hand hygiene campaign.<br><br>Patient-related actions (for suspected/confirmed influenza):<br>• Negative pressure rooms are not required for seasonal influenza patients.<br>• Patients placed on isolation (droplet).<br>• Place patients in a private room when possible.<br>• Two patients with confirmed influenza may share a room.<br>• Limit patient transport. Offer in-room portable radiology exams.<br>• Patient wears a surgical mask when outside patient room.<br>• Use respiratory etiquette when patient can't tolerate a mask.<br>• Patient supplies are considered contaminated if opened. Limit supplies taken into room.<br>• Keep area around patients free of equipment to facilitate housekeeping.<br><br>Visitor-related actions:<br>• Families/visitors are considered exposed and should wear surgical masks while visiting. Provide instruction for masks, respiratory etiquette, and hand washing.<br><br>Staff-related actions:<br>• Health care workers avoid touching mouth/eyes with unwashed hands to prevent self-contamination.<br>• Seasonal influenza education for patients and staff.<br>• Continue employee-mandated vaccine administration campaign.<br><br>Environmental Services related actions:<br>• Wear disposable gloves when handling waste and use hand washing after disposal.<br>• No special instructions for soiled linen.<br>• Dishes, utensils, and patient equipment are managed as usual. |

| WHO Pandemic Phases | Actions (Infection Control) Public Health Services, Infection Control Nurse (Continued) |
|---|---|
| Pandemic Alert Period: Phase 3<br><br>*Same as above: Avian influenza subtype H5N1 is currently in phase three*<br><br>Triggers:<br>1) Seasonal influenza Cases<br><br>**AND**<br><br>2) One case H5N1 identified in Active Duty/Dependent/employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of H5N1<br><br>**AND/OR**<br><br>3) One case of a novel influenza virus identified in Active Duty/Dependent/employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of novel influenza virus<br><br>**AND/OR**<br><br>4) Novel influenza virus is identified in local birds or poultry and one case of novel influenza identified in person handling birds or poultry in the local area. | **Employ safeguards in Phases 1 and 2 for annual cases; PLUS**<br><br>Hospital and Clinics:<br>• Review Center for Disease Prevention and Control (CDC) and World Health Organization (WHO) Web sites for updated information regarding novel influenza and update infection plans and procedures as needed.<br>• Emphasize seasonal influenza vaccine for patients/staff.<br>• Distribute updated information on infection prevention.<br><br>**If the Region/MTF/Hospital/Clinic service area is the highly localized area with small number of cases, implement instructions for Phases 1 and 2 - PLUS. If not, the items below are implemented in Phase 4.**<br><br>Staff-related actions:<br>• Staff education campaign regarding necessity for airborne precautions for novel influenza cases.<br>• Broadened N-95 fit testing for staff.<br>• Powered air-purifying respirator (PAPR) testing and fitting/instruction for staff performing nebulization, bronchoscopy, or humidified O2 on the initial cases of suspected novel influenza.<br>• Avoid touching the front of the N-95 respirator.<br>• Avoid shaking hands with patients/staff.<br>• Use dedicated equipment in the room of a novel influenza patient, i.e., blood pressure, etc.<br>• Disinfect equipment before removing it from room of novel influenza patient.<br>• Inform lab to anticipate increased viral specimens.<br>• Employees who travel to an area with known novel influenza cases will self-monitor upon return for fever of >38°C (>100.4°F), cough/ sneeze, and fatigue. If these symptoms occur, report to Occupational Health for evaluation.<br><br>Patient-related actions:<br>• Place Influenza-Like Illness (ILI) patients in a treatment room immediately, if possible.<br>• Implement airborne precautions for initial suspect/confirmed novel influenza cases:<br>  o N-95 or negative pressure isolation for inpatients.<br>  o A negative pressure room may not be available in a Primary Care Clinic. Physician will see a suspect novel influenza case immediately, preferably out-of-doors.<br>• Screen ILI patients for travel/occupational risks for novel influenza:<br>  o Obtain travel history from symptomatic persons when there is one or more reported novel influenza cases in the Region/MTF/ Hospital/Clinic service area.<br>  o Obtain travel history from tourists from areas with known novel influenza cases. Travel should be within 10 days of symptom onset.<br>  o Obtain travel history from a symptomatic employee who may have travel history for an area/country with known cases.<br>  o Obtain work history from symptomatic persons when there are infected birds/poultry in the local area. |

| WHO Pandemic Phases | Actions (Infection Control)<br>Public Health Services, Infection Control Nurse (Continued) |
|---|---|
| Pandemic Alert Period:<br>Phase 4<br><br>*Small clusters, limited human-to-human transmission. Spread highly localized*<br><br>Triggers:<br>1) Seasonal influenza cases<br><br>**AND**<br><br>2) One case of a novel influenza virus identified in Active Duty/ Dependent/employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of novel influenza virus or H5N1 virus<br><br>**AND/OR**<br><br>3) Novel influenza virus is identified in local birds or poultry and one or more cases of novel influenza identified in person(s) handling birds or poultry. | **If the Region/MTF/Hospital/Clinic service area is a highly localized area with a small number of cases, implement instructions for Phases 1, 2, and 3 - PLUS. If not, the items below are implemented in Phase 5.**<br><br><u>Hospital and Clinics</u>:<br>• Wide distribution of the novel influenza case definition to clinicians.<br>• Provide information/documents from County Health Officer to clinicians.<br><br><u>Patient-related actions</u>:<br>• Place admitted patients in a negative pressure room, if possible.<br>• Do not move an in-patient patient from the negative pressure room unless there is a life-threatening reason for movement or room change.<br>o Portable in-room procedures are offered to novel influenza patients to avoid exposing non-influenza patients. If a portable exam cannot be offered THEN, evaluate procedure/scheduling time such that non-influenza patients are not exposed to influenza patients.<br><br><u>Visitor-related actions</u>:<br>• Screen visitors before entering the facility for fever of 100 degrees F, cough/sneeze.<br>• Asymptomatic visitors for suspect/confirmed novel influenza cases wear a surgical mask. Symptomatic visitors require an N-95 mask.<br>• Provide visitors/family of novel influenza patients with guidelines for infection control in home. |

| WHO Pandemic Phases | Actions (Infection Control)<br>Public Health Services, Infection Control Nurse (Continued) |
|---|---|
| Pandemic Alert Period:<br>Phase 5<br><br>*Larger clusters, spread highly localized*<br><br>Triggers:<br>1) Seasonal influenza cases<br><br>**AND**<br><br>2) One case H5N1 identified in Active Duty/ Dependent/employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of H5N1<br><br>**AND/OR**<br><br>3) One case of a novel influenza virus in Active Duty/Dependent/ employee in Region/MTF/Hospital/Clinic service area who visited an area/country with known cases of novel influenza virus<br><br>**AND/OR**<br><br>4) Novel influenza virus is identified in local birds or poultry and one case of novel influenza is identified in person handling birds or poultry. | **Employ safeguards in Phases 1 through 4; PLUS -**<br>**If the Region/MTF/Hospital/Clinic service area is the localized area, with larger clusters of cases, implement the items below. If not, the items below are implemented in Phase 6.**<br><br>Hospital and Clinics:<br>• Post signs at each medical center entryway with instructions for respiratory etiquette, hand hygiene, and isolation procedures.<br>• Implement a designated ILI assessment area which is separate from the non-ILI assessment area.<br><br>Patient-related actions (for suspect/confirmed novel influenza):<br>• Identify an inpatient area to cohort suspect/confirmed novel influenza cases, as recommended by CDC; cohort area to be under negative pressure isolation.<br>• Separate the inpatient areas into cohort units which include:<br>o Suspect cases or those exposed to persons with ILI;<br>o Non-exposed or immune to influenza; and<br>o Non-exposed to ILI but at very high risk for complications.<br>• Patients remain in designated cohort area. Coughing patients may leave their room **only** for urgent/necessary procedures.<br>• As the number of cases increase, cohort of suspect cases and the confirmed influenza cohort may need to be merged.<br>• Patients who leave the cohort area are continuously supervised by staff.<br>• Patients recovered from influenza can be moved into the non-exposed or immune cohort area after the period of communicability of the pandemic strain has passed.<br>• Cancel group activities, i.e. rehab patients eating or socializing together, alumni patients scheduling reunion events, going outside to smoke, etc.<br>• Additional pick-up of laundry and waste containers are scheduled.<br><br>Visitor-related actions:<br>• Inform visitors when influenza patients are present for care. Visitors who have not been ill or immunized against the pandemic strain should not enter.<br>• Asymptomatic visitors for suspect/confirmed novel influenza cases wear a surgical mask.<br>• Restrict visitors with ILI until they are asymptomatic.<br>o Immediate family members of terminally ill patients can be exempt, but should wear N-95 mask upon entry to the facility. Limit the visit to the terminally ill patient only. These visitors have a staff member/volunteer escort them to the patient room and when visit is over, escort them to the exit of the medical center.<br>• Do not restrict visitors who have recovered from the novel influenza strain. Visitor must provide proof from a physician. |

| WHO Pandemic Phases | Actions (Infection Control)<br>Public Health Services, Infection Control Nurse (Continued) |
|---|---|
| Pandemic Alert Period:<br>Phase 5 Continued<br><br>*Larger clusters, spread highly localized*<br><br>Triggers:<br>See above for Phase 5 | **Phase 5 Continued:**<br><br><u>Staff-related actions</u>:<br>• Avoid using high risk procedures (nebulization, bronchoscopy, humidified O2).<br>• Pregnant employees or those at high risk for complications from influenza are assigned to non-influenza cohort areas.<br>• Staff assigned to cohort areas do not float to non-cohort areas.<br>• Staff assigned to cohort areas maintains a daily fever and symptom journal.<br>• Implement staff surveillance: all staff will self-monitor for fever of >38°C (>100.4°F), cough/sneeze, and fatigue. If these symptoms occur, report to Occupational Health.<br>o Fit-to-work procedure is implemented. Ill employees who become asymptomatic wait one incubation period (currently 4 to 6 days) and report to Occupational Health for an exam and declaration for "fit-to-work."<br>o Implement furlough status for symptomatic employees: These employees remain home for the duration of the illness.<br>o Staff who fully recovers from pandemic illness may be assigned to care for patients with active novel influenza and/or may care for patients at high risk for complications from novel influenza.<br>• Transition to droplet precautions pending virus identification and transmissibility.<br>• Review CDC and Region/MTF/Hospital/Clinic Web sites for updated information regarding novel influenza and update infection plans and procedures as needed.<br>• Managers on each unit allocate supplies. Reusable items (i.e., non-disposable N-95) and consumable products for hand hygiene, facial tissues are signed out by the employee. |
| Pandemic Period:<br>Phase 6<br><br>*Increased, sustained transmission in the general public*<br><br>Triggers:<br>1) 10 Cases admitted to Region/MTF/ Hospital/Clinic | **Employ safeguards as stated in Phases 1 through 5; PLUS**<br><br><u>Hospital and Clinics</u>:<br>• Maintain cohort principles until the pandemic wave is declared over.<br>• Prioritize medical/surgical acute care admissions.<br>• Quarantine will be implemented as directed by public health agencies. The quarantine period extends for one incubation period. The incubation period differs for each pathogen. A typical incubation period for influenza is 4 to 6 days.<br><br><u>Staff-related actions</u>:<br>• Shelter-in-place may be implemented for employees assigned to the influenza cohort areas, if staffing reaches a critical level.<br><br>**HAND HYGIENE MAY BE THE ONLY PREVENTATIVE METHOD AVAILABLE IF SUPPLIES BECOME UNAVAILABLE** |
| Post Pandemic Period:<br>Phase 7 | • Return to basic infection control measures.<br>• Review enhanced novel influenza infection control measures and modify, if needed. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phase | Activity (Communication & Education)<br>Preventive Medicine/Staff Education and Training/Public Affairs Officer |
|---|---|
| Interpandemic Period<br>Phases 1 and 2 | • None |
| Pandemic Alert Period:<br>Phase 3 | **Preventive Medicine**<br><br>• Develop an influenza prevention educational campaign targeted to internal audiences (e.g., Region/Medical Treatment Facility (MTF)/Hospital/Clinic staff, primary care patients, etc.). Produce and distribute communications materials (brochures, posters) and/or a flu prevention kit, (e.g. information on hand washing, hygiene, covering up coughs, self-diagnosis, when to seek medical attention, etc.). Utilize available resources for distribution of information.<br>• Test expansion of influenza prevention educational campaign to external audiences (i.e., general public). Develop and run advertisements with an offer of flu prevention information (or a free kit) from the Region/MTF/Hospital/Clinic. Requests for the information would be made online at the Region/MTF/Hospital/Clinic Web site.<br>• Identify Region/MTF/Hospital/Clinic subject matter experts on influenza pandemic. Provide media training, as needed.<br>• Develop emergency/crisis intranet Web site, with content to include emergency procedures, hospital/clinic operating status, etc.<br>• Consult with state and local health departments on plans for coordinating or facilitating communication among health care facilities in the event of an influenza pandemic.<br>• Determine the types of Region/MTF/Hospital/Clinic-specific communications that might be needed (i.e., news releases, fact sheets, etc.). Develop templates for all materials.<br><br>**Staff Education and Training**<br><br>• Develop an ongoing plan for distribution of influenza prevention educational materials to hospital staff, military, dependents, patients, and visitors. Reinforce good hygiene behaviors throughout the Region/MTF/Hospital/Clinic. Provide all necessary information.<br>• Identify educational resources for clinicians (e.g., Federally sponsored teleconferences, state and local health department programs, Web-based training, Center for Disease Control and Prevention (CDC) satellite broadcasts, etc.). Inform clinicians about these resources.<br>• Add influenza prevention training to new employee orientation sessions.<br>• Add continuing education training in PI.<br><br>**Public Affairs Officer**<br><br>• Identify clinical spokespersons. Provide media training, as needed.<br>• Identify all key points of contact with external information sources (e.g., outside agencies, hospitals, etc.).<br>• Determine how communications between local and regional health care facilities will be handled in the event of an influenza pandemic. Assign responsibility within the Region/MTF/Hospital/Clinic for communication with other health care facilities. |

| WHO Pandemic Phase | Activity (Communication & Education)<br>Preventive Medicine/Staff Education and Training/Public Affairs Officer (Continued) |
|---|---|
| Pandemic Alert Period:<br>Phase 4 | **Preventive Medicine**<br><br>• Notify all internal personnel of the change in pandemic status via e-mail notice, staff intranet site, and voicemail broadcast messages as well as through interpersonal means (from managers/supervisors). Inform staff of the health systems preparedness should the phase escalate.<br>• Finalize and distribute influenza pandemic educational materials for internal and external audiences. Emphasize hygiene, social distancing, and emergency supplies needed.<br>• Activate emergency/crisis intranet site; fill in all relevant content; and maintain throughout the crisis period.<br><br>**Staff Education and Training**<br><br>• Provide training to personnel on dealing with anxiety and stress as a result of emergency situations.<br>• Provide separate training to mental health service providers (i.e., psychologists, psychiatrists, social workers, and nurses) to provide psychological support for staff and patients during an influenza pandemic. Topics may include: signs of distress, traumatic grief, stress management, coping skills, etc.<br><br>**Public Affairs Officer**<br><br>• Train hospital operators; customer service representatives, Public Affairs and Patient Relations phone staff, and any other points of entry for callers on how to handle an influx of calls. Topics include where to direct calls from patients families, the media, people looking for loved ones, along with other key messages.<br>• Inform personnel and their families about protective measures being taken by the Region/MTF/Hospital/Clinic. |
| Pandemic Alert Period:<br>Phase 5 | **Preventive Medicine**<br><br>• Notify all internal personnel of the change in pandemic status via e-mail notice, staff intranet site, voicemail broadcast messages, and through interpersonal means (from managers/supervisors). Provide information about and foster the health systems preparedness should the phase escalate.<br><br>**Public Affairs Officer**<br><br>• Ensure availability of the Region/MTF/Hospital/Clinic subject matter experts to respond to media inquiries. Notify all media spokespersons to be on alert. Respond to all media inquiries; maintain communications 24/7. |
| Pandemic Period:<br>Phase 6 | **Preventive Medicine**<br><br>• Notify all internal personnel of the pandemic status through all functional automated systems (all hands e-mail, text messages, pagers, Intranet site, etc.).<br><br>**Public Affairs Officer**<br><br>• Notify all media spokespersons to be on alert. Respond to all media inquiries; maintain communications 24/7.<br>• Gather information about events; verify facts.<br>• Establish location for media briefings and press conferences. |

| WHO Pandemic Phase | Activity (Communication & Education) Preventive Medicine/Staff Education and Training/Public Affairs Officer (Continued) |
|---|---|
| Post Pandemic Period: Phase 7 | **Preventive Medicine**<br><br>• Conduct an internal Lessons Learned session with all health system personnel involved in pandemic communications. Determine what processes, if any, in the Communication and Education Plan should be changed. Modify planning document.<br>• Provide information on internal pandemic outcomes to staff, media, the general public, and public health officials.<br>• Develop and add messages and content to intranet emergency site regarding dealing with grief and post-traumatic stress. Provide links to appropriate internal and external resources.<br><br>**Staff Education and Training**<br><br>• Offer training sessions for staff in critical stress management. |

# Pandemic Influenza Trigger Table

| WHO Pandemic Phase | Activity (Critical Infrastructure and Utilities) Department Head, Information Management (TELECOM), Facilities Management |
|---|---|
| Interpandemic Period: Phases 1 and 2 | • The Pandemic Influenza Planning Committee (PIPC), Information Management, and Telecommunications services develop department specific policies and procedures regarding critical utilities and systems. |
| Pandemic Alert Period: Phase 3 | • Review critical utility emergency plans and update, if needed. |
| Pandemic Alert Period: Phase 4 | • Review critical utility emergency plans and update, if needed.<br>• Prepare plans to provide critical utilities to potential surge locations. |
| Pandemic Alert Period: Phase 5 | • Alert Staff.<br>• Verify all Staff has been fit tested for Personal Protective Equipment (PPE).<br>• Ensure emergency supplies/material inventory is at 100 percent. |
| Pandemic Period: Phase 6 | • Assign Staff specific duties per critical functions list, as developed by individual department plans.<br>• Complete tasks as assigned by the Emergency Operations Center (EOC). |
| Post Pandemic Period: Phase 7 | • Return to normal operations.<br>• Develop and implement a plan to catch up on any deferred maintenance or repairs.<br>• Ensure infrastructure is back to normal operations. |

# COMMUNICATION AND EDUCATION PLAN

1. Overview. The overall goal of the Communication and Education Plan is to provide clear and accurate education and information to audiences and stakeholders during all pandemic phases.

2. Critical Roles and Responsibilities. In the event of an influenza pandemic, many departments involved in communications and training will have several highly critical functions to perform.

3. Plan of Action and Tasks

a. Phase 3 (Pandemic Alert Period, limited human-to-human transmission worldwide, and no cases in the United States (U.S.)).

(1) Identify members of an Education and Training group that would develop and revise Influenza Training material for staff members including Reservists.

(2) Develop training briefs for staff. There should be separate training briefs for medical providers, administrative, and ancillary support staff.

(a) Training briefs must be attached to your plan for the following categories of staff: medical provider, non-medical provider, and non-provider (e.g., housekeeping, food operations); these presentations can take the form of power point or some other media.

(b) Language and reading-level appropriate materials on pandemic influenza (e.g., available through state and Federal public health agencies and professional organizations) appropriate for professional, allied, and support personnel have been identified and a plan is in place for obtaining these materials at: www.cdc.gov/flu/professionals/patiented.htm.

(c) Readability and grade level will be determined for all handouts and every effort will be made to ensure they are at 60 percent readability (at a minimum) and 8$^{th}$ grade reading level. The materials provided will be based on the population specific to the Navy Medicine Region's and Medical Treatment Facilities (MTFs) geographic location (i.e., for Southwest populations, materials in English, Spanish, and Tagalog would be appropriate). Examples of handouts and educational materials that will be used are available at: http://www.cdc.gov/flu/language.htm.

(3) Generate information pamphlets for eligible beneficiaries. Language specific pamphlets need to be generated to help ensure maximum coverage amongst beneficiaries.

(4) Develop a training plan for the staff. Specific plan items are to include: training locations, means of delivery, and documentation of the receipt of training of staff members.

(a) Training Locations: Will be determined by the Navy Medical Regions and/or MTFs.

(b) Means of Delivery: Web-based Training. Hard copy and handouts will be provided on a case-by-case basis (personnel without access to work center computers (i.e., housekeeping and Food Operations Staff)).

(c) Documentation of Training

1. Defense Medical Human Resources System – internet (DMHRSi) for Web-based training;

2. Documentation in Training Records by Training Officers, as necessary, for non-Web-based training.

(d) Identify online Web sites or local education and training opportunities for clinicians.

b. Phase 4 (Pandemic Alert Period: increased human-to-human transmission; OR human cases identified in the U.S., but not locally). Continue the Phase 3 actions above, and implement any or all of the following additional actions:

(1) If necessary, update training briefs to reflect the latest information on the epidemiology of the Pan Flu strain outbreak, protective measures, occupational health guidelines, and infection control measures. The three training briefs are designed for the following categories: 1) medical providers, 2) non-medical providers, and 3) non-providers.

(2) Initiate the command training plan utilizing educational briefs. Ensure the following staff members have been trained and that the training has been documented:

Note: In Table 2 below, a medical provider is identified by the letter "M," a non-medical provider is represented by the letter "N," and a non-provider support staff is represented by the letter "S" (housekeeping, food service, and security). An asterisk (*) indicates a category with dual designation. Perform the appropriate level of training, as directed by the Training Officer.

Table 2
STAFF CATEGORIES

| | | | |
|---|---|---|---|
| M | Attending Physicians | M/N | Laboratory Staff |
| M | Emergency Department Staff | N | Nursing Staff |
| S | Engineering and Facilities Maintenance Personnel | S | Food Operations Staff |
| S | Environmental Services Personnel | M/N | Outpatient Personnel |
| S | Housekeeping and Janitorial Staff | M/N | Preventive Medicine Personnel |
| M/N | Infection Control Staff* | S | Security Personnel |

c. Phase 5 (Pandemic Alert Period, Evidence of significant human-to-human transmission, OR human cases identified in the U.S., but not locally).

(1) Ensure all remaining staff have been trained using the appropriate training brief.

(a) Live training updates will be provided at regularly scheduled intervals to leadership and staff on the changing Pandemic Phase and level of response by a variety of methods (e.g., Internet and CDs, as necessary).

(2) Navy Medicine Regional Commanders via their MTF Commanders shall ensure all personnel are familiar with the roles and responsibilities when the Hospital Incident Command System (HICS) is activated.

d. Phase 6 (Pandemic Period; OR human cases identified locally). Continue the actions above, and implement any or all of the following:

(1) Update command leadership and staff on the latest developments concerning the outbreak, protective measures, and occupational health and infection control issues.

(2) Train incoming staff (military and civilian volunteers) using the appropriate training briefs. Also, ensure that newly incoming personnel are trained about the locations of various departments and the services available.

(3) Live training updates will be provided at regularly scheduled intervals to staff (including Branch Medical Clinics) on the changing Pandemic Phase and level of response by a variety of methods (e.g., VBRICK, Internet, and CDs, as necessary).

(4) Ensure all staff members have been periodically updated on the latest developments and command policies. Continue to document the receipt of any and all training updates.

4. Actions and Trigger. The World Health Organization (WHO) defines 7 phases for a pandemic. When the status changes, the phase-triggered actions identified in this instruction will be implemented. The Navy Medicine Region Commanders will direct, and the local MTF Commander will monitor completion of phase-triggered actions listed in this instruction, when phase 4 is initiated.

## ACRONYMS

| | |
|---|---|
| AFHSC | Armed Forces Health Surveillance Center |
| AOR | Areas of Responsibility |
| ARDS | Acute Respiratory Distress Syndrome |
| BEQ | Bachelor Enlisted Quarters |
| BSO | Budget Submitting Office |
| BUMED | Bureau of Medicine and Surgery |
| $C^3$ | Command and Control and Communications |
| CC | Chain-of-Command |
| CCPH | Clinical Care and Public Health |
| CDC | Centers for Disease Control and Prevention |
| CNIC | Commander, Navy Installations Command |
| CO | Commanding Officer |
| CONPLAN | Concept of Operations |
| COOP | Continuity of Operations |
| DCDC | Division of Communicable Disease Control |
| DMLSS | Defense Medical Logistics Standard Support System |
| DMHRSi | Defense Medical Human Resources System - internet |
| DoD | Department of Defense |
| ED | Emergency Department |
| EM | Emergency Manager |
| EMWG | Emergency Management Working Group |
| EOC | Emergency Operations Center |
| EPI | Emergency Public Information |
| ESSENCE | Electronic Surveillance System for Early Notification of Community Based Epidemics |
| FAQ | Frequently Asked Questions |
| FCC | Federal Coordinating Center |
| HCC | Hospital Command Center |
| HHS | Health and Human Services |
| HICS | Hospital Incident Command System |
| ICS | Incident Command System |
| ICU | Intensive Care Unit |
| ILI | Influenza-Like Illness |
| IM/IT | Information Management/Information Technology |
| LRN | Laboratory Response Network |
| MAA | Mutual Aid Agreements |
| MEM | MTF Emergency Manager |
| MERS | Medical Events Reporting System |
| MISC | Medical Installation Support Center |
| MOC | Medical Operations Center |
| MOU | Memorandum of Understanding |
| MRCC | Medical Regional Command Center |

| | |
|---|---|
| MTF | Medical Treatment Facility |
| NAVHOSP | Naval Hospital |
| NDMS | National Disaster Medical System |
| NDRSi | Navy Disease Reporting System - internet |
| NEPMU | Navy Environmental Preventive Medicine Units |
| NMCSD | Naval Medical Center, San Diego |
| NMCPHC | Navy and Marine Corps Public Health Center |
| OIC | Officer in Charge |
| OSHA | Occupational Safety and Health Administration |
| PAO | Public Affairs Officer |
| PAPR | Powered Air-Purifying Respirator |
| PanFlu | Pandemic Influenza |
| PCR | Polymerase Chain Reaction |
| PHEO | Public Health Emergency Officer |
| PI | Pandemic Influenza |
| PIPC | Pandemic Influenza Planning Committee |
| PIWG | Pandemic Influenza Working Group |
| POD | Point of Distribution |
| PPE | Personal Protective Equipment |
| SNS | Strategic National Stockpile |
| SOP | Standard Operating Procedure |
| U.S. | United States |
| USFF | United States Fleet Forces |
| WHO | World Health Organization |
| 24/7 | 24 Hours a Day/7 Days a Week |