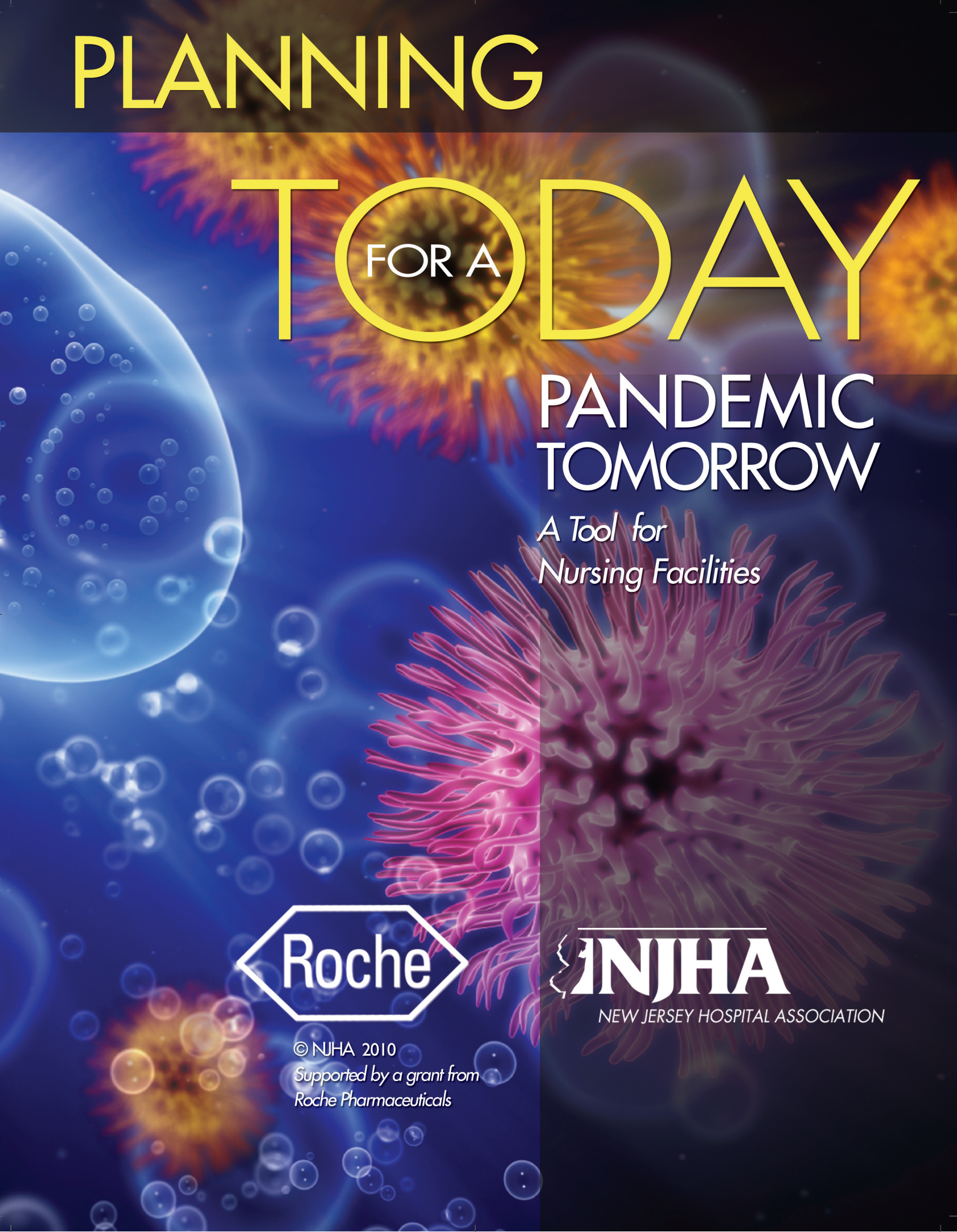
PLANNING FOR A TODAY FOR A PANDEMIC TOMORROW

A Tool for Nursing Facilities



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NEW JERSEY HOSPITAL ASSOCIATION

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TABLE OF CONTENTS

Acknowledgements

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Introduction

World health experts have long said that a global influenza pandemic is not a matter of "if," but a matter of "when." Is your nursing home ready?

The impact of a novel virus, to which the general population would have little or no immunity, is not possible to predict. The effects of a pandemic could range from moderate to severe. In a moderate pandemic, nursing homes may need to implement restricted visitation or manage a shortage of personal protective equipment, like N95 respirators, and struggle with the challenges of just-in-time fit testing for staff. In a severe pandemic, a facility will struggle with these and more difficult issues that may threaten the facility's ability to remain operational. In a severe pandemic, nursing homes may be faced with a sharp demand for increased services while attempting to manage their own staffing[1] and supply shortages caused by multiple healthcare facilities sharing the same need for supplies. As your own residents become acutely ill, hospitals already implementing their own surge plans may deny requests for transfers from your facility. In fact, nursing homes may be asked to accept transfers *from* acute care and be tasked with providing care for individuals with much higher acuity than those cared for in the regular resident census.

To be sure, pandemic influenza will present different challenges than the seasonal flu:

How Seasonal Flu Differs from Pandemic Flu[2]

Seasonal Flu	Pandemic Flu
Outbreaks follow predictable seasonal patterns; occurs annually, usually in winter, in temperate climates	Occurs rarely (three times in 20th century)
Usually some immunity built up from previous exposure	No previous exposure; little or no pre-existing immunity
Healthy adults usually not at risk for serious complications; the very young, the elderly and those with certain underlying health conditions at increased risk for serious complications	Healthy people may be at increased risk for serious complications
Health systems can usually meet public and patient needs	Health systems may be overwhelmed
Vaccine developed based on known flu strains and available for annual flu season	Vaccine probably would not be available in the early stages of a pandemic
Adequate supplies of antivirals are usually available	Effective antivirals may be in limited supply

[1] The Centers for Disease Control (CDC) estimate that illness rates during a pandemic are likely to be 2-3 times higher than in a typical influenza season.

[2] U.S. Department of Health & Human Services. *How Does Seasonal Flu Differ From Pandemic Flu?* Retrieved Dec. 3, 2010, from http://www.flu.gov/season_or_pandemic.html

Seasonal Flu	Pandemic Flu
Average U.S. deaths approximately 36,000/yr	Number of deaths could be quite high (e.g., U.S. 1918 death toll approximately 675,000)
Symptoms: fever, cough, runny nose, muscle pain. Deaths often caused by complications, such as pneumonia.	Symptoms may be more severe and complications more frequent
Generally causes modest impact on society (e.g., some school closing, encouragement of people who are sick to stay home)	May cause major impact on society (e.g., widespread restrictions on travel, closings of schools and businesses, cancellation of large public gatherings)
Manageable impact on domestic and world economy	Potential for severe impact on domestic and world economy

The information contained in this toolkit is designed to support your planning efforts, so that nursing homes are well-prepared to protect residents and staff through continuous operations throughout even the most challenging pandemic scenario.

Using a detailed assessment and planning tool, nursing homes can:

- Review existing policies and procedures
- Identify gaps
- Develop new policies and procedures; and
- Generate a pandemic influenza plan that will facilitate a more effective response during a crisis.

How to Use These Modules

The toolkit is comprised of the following modules, representative of areas identified as critical to pandemic planning:

Clinical Care
Communications
Operations
Supplies, Logistics and Support Services
Psycho-Social
Ethics
Leadership
Human Resources
Finance
Legal

These modules are to be used as a guide to facilitate discussion and to ensure that key points related to a specific topic, such as human resources, are identified and addressed in the planning process. Sample policies and procedures provided are not all-inclusive, and nursing

homes should not interpret the sample policies ready to be adopted as-is. Sample policies are provided to assist in developing a policy that is consistent with the culture and values of the individual organization, and do not reflect a standard of care. The information included in this toolkit is intended to be used as a fluid and flexible resource in dealing with the issues associated with a pandemic influenza outbreak. It is based on the best information available at the time of publication. Therefore, facilities should routinely review their plans to ensure new information is incorporated into policies and procedures as necessary.

Where Do I Begin?

1. *Form a pandemic planning committee and address one module at a time.*
   Printing the entire toolkit and addressing all modules simultaneously may prove overwhelming. As you work through the first module, assign specific planning tasks to individuals as appropriate.
2. *Reach out and establish collaborative relationships* with local and state government resources and other healthcare providers.
3. *Ensure your nursing home's pandemic plan is developed as an annex to the existing facility disaster plan and updated regularly.*
   Pandemic/disaster planning is an ongoing process.

Forming a pandemic planning committee

Nursing homes should consider forming a pandemic planning committee and, when possible, interdisciplinary work teams focused on specific areas, to develop policies and procedures relating to each of the critical areas. Diverse perspectives will help ensure that all issues or concerns that may occur during a pandemic can be considered during the planning process. All committee members should be educated on state and federal regulations applicable to a pandemic.

Suggested pandemic planning committee members include:

- Administrator
- Medical director
- Director of nursing
- Director of finance
- Infection control professional
- Pharmacy providers and/or pharmacy consultant
- Department managers[3]
- Social workers/ mental health staff[4]
- Human resources
- Union/Collective bargaining representatives, if applicable
- Other members as appropriate[5]

[3] Departments may include maintenance, housekeeping, food service, rehabilitation and recreation therapy.
[4] For tasks noted in the Psychosocial Module, facilities may want to consider inviting their county mental health administrator and representatives from local mental health centers to collaborate in planning efforts.
[5] For example: clergy, community representatives, resident and family representatives, risk managers, quality improvement, direct care staff, collective bargaining agreement union representatives. Adapted from *Long-term Care and Other Residential Facilities Pandemic Influenza Planning Checklist*. (May 1, 2006). Retrieved September 8, 2010, from http://www.flu.gov/professional/pdf/longtermcare.pdf

Communicating with local/state government resources and other healthcare providers

It is imperative that the committee ensures ongoing communication with local and state government and private entities. For New Jersey facilities, these would include:

- Local Office of Emergency Management (OEM)
- Local NJ Local Information Network and Communication System (LINCS)agency
- NJ Department of Health and Senior Services (DHSS)
    - DHSS-Health Facilities Evaluation and Licensing (HFEL)
    - DHSS-Division of Public Health Infrastructure, Laboratories, and Emergency Preparedness (PHILEP)
- Other healthcare providers
- Local Medical Coordination Center (MCC)

In communicating with other healthcare providers, identify common issues of concern and develop strategies to address these concerns. It is important to obtain information about their scope of services and planned responses related to:

- Managing surge capacity[6]
- Developing a regional plan to share resources with neighboring facilities, if necessary
- Establishing an emergency operations center (EOC).[7]

Be aware of what your state department of health expects of your facility during a pandemic and how it will support your operations. Facilities should communicate plans with local, county and state agencies to integrate planning efforts. Consider contacting community and local government leaders to discuss your facility's plan and to gather information on how community providers plan to prepare and respond. Meet with local emergency health agencies, such as the Red Cross and Salvation Army, to share pandemic plans. Facilities should strive to coordinate with local emergency officials, agencies and healthcare providers to ensure a community-wide coordinated response.

Important Information on Stockpiling Medications

While stockpiling medications may be an option for acute care facilities, nursing homes may face significant challenges in this regard as long-term care facilities are generally not permitted to stockpile medications. In New Jersey, nursing homes are not permitted to stock anti-viral medications and can only purchase them when a physician provides an order for a resident. Doctors do not routinely go to a nursing home, and while there may be a physician associated with the long term care facility, he/she is not on the premises to write orders on a daily basis.

[6] Surge capacity refers to the facility's ability to rapidly expand beyond normal services to meet the increased demand for qualified personnel and medical care in the event of bioterrorism or other large-scale public health emergency or disaster.

[7] In addition to other healthcare facilities, it is important to maintain contact names and phone numbers for other key EOCs in the area, including local and regional offices of emergency management (OEMs), state health department, key suppliers/ vendors/ contractors, police, fire, EMS and funeral directors.

These types of circumstances present significant challenges and are only exacerbated if/when the nursing home is asked to accept admissions from a hospital. Since state regulations prohibit the hospital from sending medication with the patient to the nursing home, the nursing home would be expected to provide medications but have inadequate pharmaceutical resources to do so. The New Jersey Hospital Association is committed to working collaboratively with state regulators to address these and other important issues critical to supporting the state's healthcare continuum.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
CLINICAL MODULE						
A. Assessing Surge Capacity						
1	Identify clinical services and programs[8] that will be affected during a pandemic to reassign space[9]. Consider how reducing or eliminating services will affect: • Vulnerable populations • Staff and physicians • Community • Financial viability • Legal liability.					
2	Identify areas that can be used in an emergency for surge. • Review existing policies that address cohorting residents with similar diagnoses to ensure these policies can be implemented in an emergency. • Consider cohorting symptomatic residents, placing symptomatic residents together in one area or restricting residents to a particular area, regardless of symptoms. [10]					
3	Develop appropriate signage to route residents, ambulances, visitors, staff and vendors/contractors when access to facility is limited. • Include signs for holding areas, triage areas, resident beds and signs describing limited visitation policies.					

[8] Clinical services and programs may include Alzheimer's unit, dementia unit, ventilator dependent, medical clinic, etc.

[9] During a pandemic, LTC facilities may have to suspend/modify clinical services or programs. For example, the facility's dementia unit may need to accommodate a surge.

[10] From *Disaster Preparedness Plan Template for Long Term Care Facilities*, Missouri Department of Health and Senior Services, Jan. 18, 2007. NOTE: This will require an NJDHSS waiver as well as permission from the resident/family; should be considered a last resort surge action that the facility is prepared to implement when necessary. A federal waiver may also be required since federal regulations specify the minimum square footage required per resident in multiple resident bedrooms. These regulations may be found at the Centers for Medicare and Medicaid Services (CMS) Long-term Care Conditions of Participation at 42 CFR § 483.70 (d)(1) at http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=42&PART=483&SECTION=70&YEAR=2001&TYPE=PDF.

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4	Identify: a. Where resources will be obtained (working in conjunction with vendors and County OEM) b. The process for requesting the resources needed.					
5	In each surge area, identify an area that can serve the purposes of a: • Central nursing area (with IT access) • Medication access control room/cart • Pantry • Clean/dirty utility area.					
6	Develop procedures for increasing oxygen tank/ wall oxygen/ medical air supplies and other equipment needed in surge areas.					
7	Ensure communication with local healthcare providers to obtain information about their scope of services and responses to surge.					
B. Surge Staffing						
1	Identify strategies to staff surge areas. Consider minimum number of staff needed. • Identify non-clinical or management level staff that can be reassigned to clinical areas. • Address training issues related to reassigned staff, either through pre-event cross training or predesigned, just-in-time training. • Develop just-in-time training for basic palliative care for all direct care staff not already trained.					

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2	Develop policies and procedures[11] to utilize volunteers or members of government-sponsored programs during a pandemic. *See Surge Staffing Resource List under Resources.*					
3	Determine if surge staff will be granted access to equipment storage units (i.e., Pyxis, locked medication carts, medication rooms, etc.) and if so, how that will be accomplished. If not, how will this affect resident care?					
4	Develop policies on utilizing family members to augment resident care during a staffing shortage, including what tasks family members will be allowed to perform.[12]					
C.	**Modified Infection Control Practices**					
1	Develop family visitation policies for use during a pandemic.[13] Consider how you will keep staff and family members from contracting influenza in the facility. Consider if you would allow children to visit.					
2	Evaluate the minimum safe amount of separation between residents that will be allowed (three to six feet is recommended) and identify procedures to be implemented to separate individuals without adequate personal protective equipment.					
3	Develop policies addressing allowable personal and business travel for staff during different pandemic phases.					

[11] These policies and procedures should address specific requirements, e.g. primary source verification of credentials, scope of practice, medical clearance, etc.

[12] For example, family members may be permitted to perform simple tasks such as bathing or hygiene or more complex tasks such as ventilating the resident with an AMBU bag if there were no ventilators available and insufficient staff available to perform this task. This may also be subject to a state/federal waiver.

[13] See November 2009 NJHA memo: *H1N1 Visitation Guidelines for Healthcare Facilities*.

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4	Consider screening staff for illness prior to entry into facility. This policy should address: • Acceptable normal temperature range. • How to handle elevated temperature in someone who feels well and is showing no other signs or symptoms. • How to handle normal temperature reading in someone who appears ill and/or is showing other signs of illness.					
5	Develop policy to protect people during face-to-face meetings during a pandemic, including severely limiting all non-essential face-to-face meetings. For those interactions where individuals will be in close proximity, adequate personal protective equipment must be supplied.					
6	Ensure procedures are in place to educate staff, residents and visitors on proper hand washing, sneeze/cough etiquette and the basics of influenza prevention. • Compare procedures to current CDC guidelines.					
7	Review policies regarding the use of waterless hand sanitizers and determine the viability of stockpiling a supply. [14] • Hand sanitizer and dispensers should be included in plans for non-traditional care areas.					

[14] Consider implementing this policy now to reduce facility-acquired infections and rotate hand-sanitizer stock throughout the facility.

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8	Ensure the maintenance department has a process in place to modify the schedule of changing HVAC air filters based on updated infection control recommendations.					
9	Develop process to manage residents requiring respiratory isolation.					
10	Develop infection control plan[15] to handle excess contaminated equipment. • Develop a plan to obtain increased amount of sterilization gas as needed during 6-8 week resident surge. • Determine the feasibility of establishing a process where pre-identified single-use essential supplies are sent out for sterilization and reused.					
11	Develop process to continually monitor and evaluate infection control recommendations from government authorities (e.g., CDC). • Develop process to quickly update staff on accepted changes in infection control recommendations from government authorities. • Develop process to quickly implement approved changes and ensure compliance throughout facility.					
D. Clinical Systems and Documentation						
If charting systems are electronic:						
1	Determine process to grant access to surge staff to critical clinical IT systems (e.g., computer charting					

[15] For CDC resources on sterilization and disinfection in healthcare settings, see http://www.cdc.gov/ncidod/dhqp/sterile.html.

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	systems, lab results, PACS, etc.) • Develop just-in-time training on clinical systems for surge staff.					
2	Identify surge care areas for clinical IT systems so that residents in these areas can be tracked and clinical/ dietary orders and test results can be entered and transmitted. • Test these systems periodically to ensure that rarely used surge areas are recognized in the clinical, dietary, admission and other critical systems. • Ensure adequate IT resources will be available. • Evaluate outsourced areas such as pharmacy, lab and radiology and communicate any concerns to vendors.					
If charting systems are paper-based:						
3	Determine process for surge staff to access charts. • Develop just-in-time training for surge staff. • Stockpile sufficient quantity of charts to cover expected surge. • Test the charting system in surge areas.					
E. Crisis Standards of Care						
1	Develop policies (including triggers) related to changes in resident care practices during a pandemic. These may include changes in: • Staffing ratios • Documentation expectations • Housekeeping expectations • Who can deliver treatment • Medication administration practices • Nursing practices.					
2	Develop a policy concerning palliative care during a pandemic. This should include:					

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	• Stages and triggers • Conditions for which palliative care would be considered. It is important to include both influenza and non-influenza conditions in this policy as a severe staffing shortage plus surge would affect all resident care.					
3	Discuss changes in resident care practices with the legal and regulatory experts, as well as ethics professionals.					
4	Consider the collective bargaining implications of these changes (if applicable.)					
5	Develop a process to quickly and efficiently communicate any changes in acceptable resident care practices to all staff.					
6	Develop a process to facilitate feedback to leadership on new resident care practices as they are developed and implemented.					
7	Review all anticipated changes that will be needed during a pandemic and identify applicable regulations that govern each change.					
8	Discuss with appropriate authorities, waiving or relaxing regulations that would be in conflict with modified resident care practices. • Identify who has the authority to request regulations be waived or relaxed and triggers for such a request. • Maintain list of 24-hour contact numbers for regulatory entities so that requests can be communicated as needed.					

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9	Develop a procedure to document changes in resident care as a result of supply, equipment, staff shortages, etc., in all resident charts.[16]					
F. Admission Criteria						
1	Develop a process to adjust admission criteria during a pandemic, including trigger points. • Identify what supplies and equipment would be needed to implement modified admission processes. • Ensure modified admission policies and procedures are tested.					
2	Develop a process to communicate changes in admission criteria to both facility and community practitioners. This should include: • Long term acute-care hospitals • Rehabilitation hospitals • Other skilled nursing facilities • Home health agencies • Assisted living facilities • Hospice agencies • Any other referring facilities • Community practitioners. If community plans include the establishment of alternate care sites, then these facilities must be included in this communication as well.					
3	Collaborate with referring entities to ensure that modified admission criteria will be adhered to during a pandemic crisis.					

[16] For example, notes made in the resident record may refer to unavoidable shortages in supplies, equipment, medication or personnel.

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G.	**Discharge Criteria**					
1	Develop a process to adjust potential discharge criteria during a pandemic. • Identify what supplies and equipment would be needed to implement modified discharge processes. • Ensure legal, regulatory and ethics professionals are included in the design of this process. • Ensure modified discharge policies and procedures are tested.					
2	Develop a process to communicate changes in discharge criteria to both hospital and community practitioners. This should include: • Other skilled nursing facilities • Long term acute-care hospitals • Home health agencies • Assisted living facilities • Hospice agencies • Other facilities • Community practitioners.					
3	Ensure processes are in place to facilitate appropriate resident follow-up.					
H.	**Alternate Care Sites**[17]					
1	Work with local OEM to identify potential alternate care sites and collaborate with community planners to integrate facility plans with community plans.					
2	Develop alternate care site policies and procedures to determine:					

[17] Alternative care sites (ACS) may be established by hospitals overwhelmed by an influx of patients. Most likely, nursing homes would not establish alternate care sites themselves. However, under the conditions of an extreme pandemic, nursing homes may need to make use of such sites as established by hospitals. Use of an ACS will require an NJDHSS waiver.

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	• Criteria for transfer to the alternate care site • Criteria for transfer from the alternate care site • The process for transfer, including transfer of the medical record • How family members will be informed of resident transfers. Consider legal/regulatory issues and ensure adequate continuity of care.					
I. Antiviral Prophylaxis and Treatment						
1	Contact the state health department for information related to the state antiviral stockpile.					
2	If an antiviral program is established, ensure the facility has: • An educational program to educate employees on antiviral medication use, benefits and side effects. • Educational materials for residents and families on antiviral medication use, benefits and side effects. • Stages and triggers for medication release, including a process to evaluate whether medication should be pre-distributed or stored centrally until a specific trigger occurs. • A screening program in place to screen for contraindications. • A process to maintain security around the medications. Ensure local public health is included in antiviral medication program development.					

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J.	**Vaccine Deployment**					
1	Develop policy regarding the use of any new pandemic vaccines (e.g., facility will not consider the use of any new vaccine unless it is endorsed by the CDC.)					
2	Develop process to safely and efficiently administer vaccine to staff and others in accordance with public health guidelines.					
3	Develop process to track which employees have been vaccinated to: • Facilitate reassignment of resident care responsibilities. • Monitor side effects or complications.					

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COMMUNICATION MODULE						
A. Creating a Crisis Communication Team						
1	Designate a committee or "communication team" to craft messages and manage media relations.					
2	Ensure communication team has representatives from several departments. Consider the following: • Administration[18] • Nursing • Safety Officer/Emergency Management Coordinator • Infection Control • Business Office • Information Technology (IT), if applicable • Admissions/Community Relations • Social Work • Resident Council.					
3	Develop a procedure to mobilize crisis communications team on short notice, day or night. • Notification system should include multiple notification methods (e.g., phone tree, e-mails, text messages) and central meeting points for immediate next steps (e.g., secure conference call or designated meeting room.)					
4	Develop a communication plan that clearly identifies team members to assume the following roles: • Crisis communication team leader • Public Information Officer (PIO) • Internal communications coordinator (residents, visitors, staff) • External communications coordinator/ media spokesperson[19] • Medical advisor • Legal counsel • Outside marketing or public relations firm (if applicable) • Communications team support					

[18] If Administration is not represented, ensure channels for the ongoing approval and execution of the communication plan.

[19] Identify the necessary skill set and training for anyone designated as a spokesperson. Consider individuals with differing specialties to best handle information requests (e.g., PR person to handle general media/announcements, physician for medical information, etc.)

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	• Web site and other IT support (if applicable) • Record keeper/historian.					
5	Ensure the communication team leader and spokespeople have appropriate ICS training[20] to function effectively within a multi-agency community response.					
6	Ensure committee's awareness of local emergency planning committee activities.					
B.	**Audience Identification**					
1	Ensure key audiences are identified and important contact information is stored for each audience. Audiences may include: • Residents/families/visitors[21] • Volunteers/ Clergy • Board members/Trustees • Attending physicians • Unions • Other healthcare facilities/ agencies[22] • Regulatory groups or agencies (e.g. CMS, DHHS) • Managed care organizations • Media • Community groups • Elected officials • Police/Fire/EMS • Funeral directors • Contractors • Vendors.					
2	Develop and maintain a contact list of: • Media outlets (e.g., print, radio, television, online), assessing which outlets reach target audiences most effectively • Public health officials					

[20] For more information on ICS training, see http://training.fema.gov/EMIWeb/IS/is200HCa.asp, IS-200.HCa, *Applying ICS to Healthcare Organizations.*

[21] Consider communication strategies for residents with cognitive impairments, especially in the absence of a proxy or guardian. Develop a plan to communicate with limited English proficient individuals. Identify the diverse cultures that exist within your facility and ensure messages are tailored to reach all groups.

[22] See the NJ Department of Health and Senior Services listing of licensed healthcare providers at http://nj.gov/health/healthfacilities/search.shtml. Reach out to other healthcare providers to streamline information sharing, report status, facilitate requests, coordinate media inquiries, etc

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	• Community leaders • Government representatives • Healthcare provider associations, e.g. New Jersey Hospital Association, other state nursing home associations. Include day and after-hours contact information and update bi-annually.					
C.	**Communication Methods and Technology**					
1	Identify communications methods. These may include: phone; fax; bulletin boards; hotline phone number; Internet/ intranet; facility Web site; mail; personal visits; e-mail; and voicemail. • Consider communication methods that would be open to the public and those that would be restricted.[23] • Consider communication methods for residents with cognitive impairments or individuals with limited English proficiency.					
2	Identify technology that could be used for communications. This may include: BlackBerry/ smartphone; e-mail distribution list; automated notification system; group pages; and Web sites. • Train team members on use of identified technology (e.g., how to generate group voicemail, activate automatic notification system, update facility Web site, etc.) • If applicable, ensure internal or vendor IT staff is available 24/7 to update Web site and handle any technical difficulties during a crisis.					
D.	**Policies and Procedures**					
1	Ensure policies are in place for general staff approached by the media[24] and that all staff members know how to direct the media to spokespeople, as appropriate.					
2	Ensure policies are in place to guide general staff on the release of resident information.[25]					

[23] For example, staff information may be placed in a password protected section of the Web site.
[24] See Appendix: *Sample Policy for Staff Contacted by the Media*
[25] See Appendix: *For the Release of Information on Patient Conditions to the Media*

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3	Identify areas that may receive a high volume of incoming calls (e.g., switchboard, administration, nursing units) and ensure department staff is advised of how to direct calls regarding the crisis. • Prepare a script for staff. • Prepare a pre-recorded message for automated phone system.					
4	Ensure media policies and procedures address the following: • Establishment of onsite and online media centers. • Frequency of media contact with spokespersons. • Clear limits of media access to residents, families, staff. • Methods for making media requests[26] and expected timeframes for responses. • Required identification/credentials needed by media while onsite. • Entrances/exits for media use and check-in procedures. • Anticipated schedule for releasing news updates (be aware of media deadlines). • Policies on cell phone usage within the facility.					
5	Ensure communications policies address continuity of operations for key communications, especially IT components (e.g., phones, computers, Web site) and staff critical to managing crisis communications.					
6	Create list of emergency contact numbers for critical communications service providers (e.g., Internet Service Provider (ISP), telephone, paging service, satellite telephone provider, etc.) • Identify backup communication service providers to be contacted if primary providers are unavailable. Connect with alternate providers to understand procedures, costs, and other administrative needs to activate services, if needed. • Identify vulnerabilities of each communications service provider and alternate providers. Ask providers for their pandemic preparedness plans and 24-hour contact					

[26] See Appendix: *Media Inquiry Form*

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	information.					
7	Ensure policies include regularly scheduled testing of primary and alternative communication systems.					
8	Maintain easily accessible telecommunications infrastructure documents, including circuit numbers, diagrams, and any assigned Telecommunications Services Priority (TSP), Government Emergency Telecommunications Service (GETS) and Wireless Priority Service (WPS) program codes.[27]					
9	Ensure communications systems are included in security plans.					
E. Crisis Communication Trigger Points						
1	Review facility hazard vulnerability analysis[28] and develop a list of events that would trigger an increase in internal and external communication needs.					
2	Identify triggers that would activate the communications plan. Triggers may include: • First case of novel influenza in the facility • First case of novel influenza in the county/ state/ country • Concerns of novel influenza pandemic outside the U.S. • Information from local health alert network, e.g. LINCS[29] • Information from the CDC.					
3	Identify key issues for ongoing communication with internal[30] and external audiences. These may include: staffing; bed capacity; durable and consumable medical equipment and device needs; influenza vaccine and antiviral drugs supplies; and a surge of influenza admissions.					

[27] For more information and to register for these vital programs, see http://tsp.ncs.gov/, http://gets.ncs.gov/ and http://wps.ncs.gov/.

[28] The hazard vulnerability analysis (HVA) identifies hazards that may negatively impact your facility. The risks associated with each hazard are analyzed to prioritize emergency preparedness activities. For a sample HVA, see *Kaiser Permanente Hazards Vulnerability Analysis* at http://www.njha.com/ep/pdf/627200834041PM.pdf.

[29] All NJ healthcare facilities are strongly encouraged to register with the NJ Local Information Network and Communication System (NJ LINCS). To register, go to http://www.njlincs.net/home.aspx.

[30] As resources for your use, see Appendices: *Facility Status Update Form*, *Hospital Incident Command System (HICS) Facility System Status Report Form* and *Nursing Home Incident Command System (NHICS) Report Form*.

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F.	**Communication/ Press Materials**					
1	Prepare to coordinate all information releases with local health department and local/state government to ensure messaging is consistent.[31] • Consult with local/ state public health officials regarding the facility's role in communicating news with the media and the public.					
2	Gather accurate information from authorized resources (e.g., state health department, Centers for Disease Control, etc.)					
3	Develop rumor control strategy by providing accurate information internally and externally on a pre-determined schedule (e.g., provide updates every 24 hours).					
4	Designate team members to craft messages/materials for pre-defined audiences. • Determine appropriate format (e.g., memo, press release, voicemail, web page, etc.) and draft skeleton materials in advance of crisis.[32] • Review messages and materials to ensure brevity and relevance.[33] Materials should offer positive action steps. • Produce messages in appropriate languages, as needed.					
5	Review the *Pandemic Influenza Pre-Event Message Maps* and customize applicable messages based on target audiences. • Ensure messages are translated into languages other than English, as appropriate.					
6	Review messages/materials approval process (i.e., who needs to approve materials before they are distributed – legal, administration, etc.) and how this process may be streamlined in a crisis.					
7	Create a frequently asked questions (FAQ) document[34] and a fact sheet containing all known details, based on information from local health, state and federal agencies.					

[31] See Appendix: *Communication Vehicle Worksheet*
[32] See Appendices: *Sample Pre-Event* and *Event Messages*
[33] See Appendix: *Tips for Press Messages/ Materials Creation in a Crisis Environment*
[34] See Appendix: *Questions Frequently Asked by Journalists and the Public During Disease Outbreak*

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	• Ensure these documents are reviewed with respect to the public's right to know, as well as privacy and security issues.					
8	Determine anticipated timeframes for routine information releases including location, method of release, and intended audience. • Implement strategies for internal communication.					
G. Post-Event Communication						
1	Hold "lessons learned" meeting with communication team members to determine: • What responses were effective? • What messages did not resonate? Why? • What worked well? • Where did any problems occur? Why? What can be done differently for next time? • Were spokespeople effective in communicating key messages? • How effective was coordination with outside audiences (especially government agencies)? • What audiences were not properly considered?					
2	Ensure relevant event follow-up information is shared, as appropriate.					
3	Send sympathy letters to: • Impacted staff • Impacted residents and visitors.					
4	Send thank you letters to: • Staff • Helpful agencies, other healthcare partners • Others who went "above and beyond" during the event.					

ASSIGNMENT		COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
OPERATIONS MODULE						
A. Creating an Emergency Management Plan						
1	Develop an emergency management plan (EMP) compliant with the National Incident Management System (NIMS)[35].					
2	Ensure the EMP includes the following. • Implementation triggers, which may include: ○ First case of novel influenza in the facility ○ First case of novel influenza in the county/ state/ country ○ Concerns of novel influenza pandemic outside the U.S. ○ Information from local health alert network, e.g. LINCS[36] ○ Information from the CDC. • The process for implementing the EMP, including: ○ Who has authority to activate[37] ○ Who gets notified and how ○ Initial steps to be taken. • An implementation matrix detailing triggers and associated key actions to be taken by departments across the facility.[38] • Activation of the Incident Command System (ICS)[39] or Nursing Home Incident Command System (NHICS).[40] • Activation of the emergency operations center (EOC).					
3	Ensure the facility exercises its EMP as required by established standards within the healthcare community. Consider the following: • NJ Department of Health and Senior Services (NJ DHSS)[41] • National Fire Protection Association (NFPA) • The Joint Commission (TJC).					

[35] See *NIMS: Frequently Asked Questions* at http://www.fema.gov/pdf/emergency/nims/NIMSFAQs.pdf. See also *Summary of NIMS Implementation Activities for Hospitals and Healthcare Systems* at http://www.fema.gov/pdf/emergency/nims/imp_act_hos.pdf.

[36] All NJ healthcare facilities are strongly encouraged to register with the NJ Local Information Network and Communication System (NJ LINCS). To register, go to http://www.njlincs.net/home.aspx.

[37] See *NHICS Job Action Sheets*, provided by the California Association of Health Facilities at http://cahfdisasterprep.com/NHICS/JobActionSheets.aspx.

[38] For an example, see Appendix: *Implementation Matrix*

[39] For more information on ICS, see http://www.fema.gov/emergency/nims/IncidentCommandSystem.shtm

[40] For more information on NHICS, see *Nursing Home Incident Command System (NHICS),* provided by the California Association of Health Facilities at http://www.cahfdownload.com/cahf/dpp/1-Guidebook%2010109.pdf.

[41] See NJ DHSS licensing regulations at http://www.state.nj.us/publicadvocate/home/reports/pdfs/NursingHomeRegs.pdf.

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4	Ensure the plan has explicit policies/procedures for communicating with residents, families, physicians, staff, etc. so that these individuals understand the facility's pandemic plan and are committed to plan compliance.					
5	Ensure the plan is reviewed at least every six months to update information, regulations and standards.					
B.	**Establishing an Emergency Operations Center (EOC)**					
1	Identify primary and secondary locations for your EOC, for example, administrator's office, security department, conference room, an off-site location, etc.					
2	If possible, consider the following to equip the EOC: • Multiple phone and fax lines • Computer and printer • E-mail capability, internet access • Radio communication devices • Cell phone service • Office supplies to sustain a prolonged operation, for example: pens, pads, toner, printer cartridges, copy paper, etc.					
3	Consider if the EOC could be operated on emergency power.					
4	Develop specific triggers identifying when to open your EOC.					
5	Develop processes for standing up the EOC, including: • Who has the authority to open the EOC • How to set up the room • How to set up required equipment • Whom to notify when the EOC is opened.					
6	Establish positions within the EOC (e.g., public information officer, safety officer, etc.) consistent with ICS or NHICS. Ensure: • Individuals filling the positions have had adequate training • Responsibilities for each position are reflected in corresponding job action sheets[42] • Key positions have backup staff assigned.					
7	Develop system to document and communicate all EOC decisions, processes and pathways[43], including:					

[42] See *NHICS Job Action Sheets*, provided by the California Association of Health Facilities at http://cahfdisasterprep.com/NHICS/JobActionSheets.aspx.

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	• Sharing information with management, staff, residents, visitors, media, outside agencies • Staff practice exercises of ICS/ NHICS • Operational briefings and change of command exercises.					
8	Develop processes to set-up a virtual EOC[44] when face-to-face meetings are not allowed due to social distancing. Include: • Identification of required technology and equipment • Protocols on how to conduct virtual meetings • Practice exercises for virtual EOC operation.					
9	Maintain contact names and phone numbers for key EOCs in the area, including: • Other healthcare facilities/ agencies (e.g., hospice, home health, other nursing facilities, acute care, clinics) • Local and regional offices of emergency management (OEMs) • State health department • Key suppliers/ vendors/ contractors • Police/Fire/EMS • Funeral directors.					
10	Develop arrangements/memoranda of understanding (MOUs) to share staff and supplies with other facility EOCs.					
11	Develop procedures to provide support to EOC staff for prolonged periods of time (e.g., food, sleeping areas, bathroom, shower facilities, etc.)					
12	Develop procedures for de-escalation and shutting down the EOC.					
C.	**Adopting a NIMS-Compliant Incident Management System**					
1	Ensure your incident management system is National Incident Management System (NIMS)-compliant[45] and includes: • Adoption of a formalized ICS or NHICS for use in managing a pandemic. • Training for all staff to the level required by NIMS. • Pre-identification of command staff and section chief positions with individuals identified as backups.					

[43] See *NHICS forms,* provided by the California Association of Health Facilities at http://cahfdisasterprep.com/NHICS/GuidesForms.aspx.
[44] Consider addressing phone, email and web conferencing needs.
[45] For more information on NIMS, see http://www.fema.gov/emergency/nims/.

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	• Development of job action sheets or checklists for all positions within the EOC. • Development of a plan to internally exercise the incident management system at least twice a year. • Development of a plan to externally exercise the incident management system with community partners (e.g. local public health department, OEM) at least once a year. This includes the concept of unified command.[46]					
2	Cross-train staff to assume command and general staff positions.					
3	Ensure staff knows how to integrate the facility ICS/ NHICS structure into the city/county/state structure.					
4	Ensure command structures and roles are discussed with community partners (e.g. local public health department, OEM[47]). Roles should be identified and agreed upon.					
D.	**Risk Assessment and Business Impact Analysis**					
1	Ensure pandemic flu is addressed in the facility's hazard vulnerability analysis (HVA).					

2	Develop and perform a business impact analysis (BIA) to identify the most critical processes and resources[48] that will be maintained during a pandemic.
	• Consider the following definition of "essential functions" as provided by FEMA:
	  ○ Functions that must be continued in all circumstances.
	  ○ Functions that cannot suffer an interruption of more than 12 hours.					

3	Ensure that information technology (IT) systems are addressed. Develop recovery time objectives (RTOs)[49] and recovery point objectives (RPOs)[50] for critical clinical systems, processes and data.					

[46] Unified Command allows agencies with different legal, geographic and functional authorities and responsibilities to work together effectively without affecting individual agency authority, responsibility or accountability. ICS Management Characteristics. Retrieved Sept. 8, 2010, from http://www.fema.gov/emergency/nims/ICSpopup.htm#item11

[47] N.J.A.C. 8:39-31.6 (f), *Standards for Licensure of Long-term Care Facilities*, requires that all N.J. licensed long-term care facilities develop a written comprehensive emergency operations plan in coordination with their local office of emergency management. N.J.A.C. 8:39-31.6 (i) 1 requires the facility to meet with county and municipal emergency management coordinators at least once a year to review and update the written comprehensive evacuation plan.

[48] See *Utility Failure Operational Impact Chart* and *Consumable Supply Operational Impact Chart*.

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E.	**Community Planning & Integration**					
1	Ensure facility participates in community planning efforts to integrate facility plans with community plans: • Participate in local emergency planning committee (LEPC) activities. • Participate in local/county/state government and regional public health planning activities. • Coordinate with local law enforcement to develop plans for increased security, noting police resources that may be available to meet those needs.[51]					
F.	**Resource Sharing**					
1	Develop an inventory of resources that could be shared with other health care organizations during a pandemic.					
2	Develop process and associated policies for sharing resources with other health care facilities in the region.					
3	Ensure resource sharing policies address: • Methods for sharing, including how shared equipment is returned • Training[52] on the safe use of shared resources • Liability issues for shared equipment (e.g., if someone is injured by equipment, who assumes responsibility – the sending or receiving facility?) • Insurance concerns (e.g., will coverage or warranties apply if equipment or other resources/supplies are utilized by a different facility at their location?)					

[49] A Recovery Time Objective (RTO), also known as the maximum allowable downtime, is the maximum amount of time that a critical function may be suspended before causing a severe impact to your facility's operations.

[50] A Recovery Point Objective (RPO) is the point in time in which systems and data must be recovered after an outage. The RPO helps you decide how often you should back up your data. For example, if your RPO is one week, your data should be backed up once a week so that the maximum amount of data you would lose is all data since backup.

[51] For example, increased security needs may result from agitated family members, stressed staff members, shortages of critical supplies, etc. Keep in mind that community law enforcement resources may be stretched thin by absenteeism and other pressing community needs.

[52] Consider both internal training for incoming items and external training for recipients of your resources.

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	• Care and upkeep of shared equipment • Financial considerations for shared equipment (e.g., will a fee be charged for the use of borrowed equipment; if items are destroyed or lost, what is the reimbursement policy, etc.)					
G. Stockpile Development						

1	Assess the needs and develop plan for personal protective equipment (PPE), including:
	• Identify which PPE would be in high demand for your facility and estimate what that demand would be[53]. Consider: masks, respirators (N-95, PAPRs, etc.), gloves, gowns, goggles and face shields.
	• Based on PPE availability, develop a process for just-in-time fit testing.
	• Determine if your facility will stockpile PPE.
	  ○ Develop procedures for rotation and maintenance of the stockpile.
	  ○ Maintain a current inventory of the stockpiled PPE.
	• Through local health department and OEMs, identify local stockpiles.
	  ○ Obtain contact name and phone/ email for local stockpiles.
	• Identify alternate/backup PPE suppliers.
	• Ensure discussion of emergency response plans with PPE vendors and pre-submission of emergency orders with suppliers.
	• For anti-viral medications, contact local LINCS agency and self-identify as a "fixed facility"[54].					

2	Ensure facility develops plans to augment the supply of surge-					

[53] See Kimberly-Clark's online PPE Stock Pile Calculator and PPE Demand Analysis Tool at http://www.kchealthcare.com/pandemicflu/PPE%20Demand%20Calculator.asp.

[54] New Jersey's Fixed Facility Plan includes the following organization types: private industry with at least 100 employees; local/county/federal facilities; service sector (public utilities, water, electric, etc); correctional facilities; residential facilities; colleges and universities; and physician practices. The Fixed Facility Plan is a medication distribution system in which LINCS agencies coordinate with OEM and local health departments to develop a mass prophylaxis plan to dispense medications to the employees of fixed facilities and their families. See *Responding to Public Health Emergencies: New Jersey's Strategy.* (2010). New Jersey Department of Health and Senior Services, Division of Health Infrastructure Preparedness.

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	related supplies, including: • Linens • Cots • Charts, forms, documents • Admission kits • Disposable plates, cups, utensils • Oxygen tank/ wall oxygen/ medical air supplies and other equipment • Body bags for the deceased.					
H.	**Securing the Facility**					
1	Assess security needs in the event of surge resulting from pandemic. Ensure all security policies are: • Shared with staff • Authorized by facility administration, owner and/or board of directors.					
2	Address facility lockdown issues, including: • Limiting access to main building/ specific areas • Identifying specific triggers for different stages of limited access • Determining who will be permitted access during different stages of limited access. Consider: residents, families, regular staff, surge staff,[55] vendors and contractors. • Determining specific procedures to implement the different stages of limited access • Training and drilling staff in controlled access policies.					
3	Determine how facility will augment its security staff should there be gaps. This may be accomplished through: • Utilizing outside security guards • Agreements with local police • Deputizing staff members • Engaging community groups.					
4	Collaborate with local law enforcement to refine the procedures used to request additional resources and to gain a better					

[55] Consider how access will be granted to surge staff.

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	understanding of what law enforcement resources may be available.					
I.	**Environment of Care Practices**					
1	Identify the level of housekeeping services that can be provided during staffing shortages.[56] • Consider what cleaning can be performed by non-environmental service staff and/or residents' family members. • Ensure changes are discussed with the infection control professional.					
2	Develop policies and procedures outlining how medical waste will be handled during a staffing shortage. This includes red bags, sharps and any other waste requiring special handling (e.g. radioactive waste).[57]					
3	Develop plans to ensure building maintenance continues to monitor critical areas.					
4	To the greatest extent possible, examine all environment critical functions to ensure they are maintained during the pandemic, including: • Safety management • Hazardous materials and waste management • Fire safety • Medical equipment management • Utilities management.					
J.	**Mass Fatality Management**					
1	Communicate with your local health department, local OEM, coroner's office and local mortuary service for a copy of any mass fatality plans and adjust your procedures to the plan.					

[56] Consider that the need for housekeeping functions may increase significantly.
[57] This will require an NJDHSS waiver.

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2	Identify procedures that may be needed/changed/waived regarding death registration. Ensure changes are reflected in policy and that authorized personnel and procedures have been discussed with all responsible agencies.					
3	Develop policies and procedures to manage the disposition of deceased residents when routine funeral services become overwhelmed. • Contact local Office of Emergency Management (OEM) for information on regional plans and resources. • Communicate with local funeral homes and county/ state coroners and identify emergency procedures to remove deceased from facility, including 24/7 contact information. • Develop procedures to obtain death certificates 24/7 once stock is exhausted. • Determine the minimum documentation required by the coroner's office during a mass fatality crisis. • Design infection control procedures into the facility's mass fatality plan to protect staff, residents and the community.					
4	Develop policies and procedures to manage post mortem care of bodies if routine funeral services are delayed or unavailable. • Identify areas within the facility that could be used to store bodies.[58] • Identify temporary morgue facilities outside the facility (e.g., ice rinks, air conditioned warehouse areas, refrigerator trucks.) • Consider the development of emergency embalming procedures.[59]					
5	Develop protocols for safe handling of bodies that respect the					

[58] Consider appropriate temperature, humidity levels, infection control and insect/rodent control. Bodies may need to be stored for a prolonged period of time, possibly months.

[59] In the event the deceased's remains cannot be removed from the facility in a timely fashion, place the body in the body bag and carry it to the temporary morgue. Cover the body entirely with salt and lime and close the bag. The salt and lime will embalm the remains, kill bacteria, mold and viruses within the body, reduce bloating, lessen odors and absorb body fluids to some degree. Tag the bag including enough information to clearly identify whose remains are stored there. While this is far from an ideal, it is certainly preferable to not being prepared and confronted with this challenge. Adapted from the California Association of Health Facilities (August 2007) *Pandemic Influenza Workbook for Long Term Care Providers, 2009*

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	cultural and religious beliefs of families and the community. • Work with local religious organizations and community groups to ensure cultural and religious needs of families are addressed. • Consider developing a process to hold memorial services for the deceased as traditional funeral services are unlikely to be immediately available.					
K.	**Post-pandemic Recovery**					

1	Perform facility capabilities assessment when pandemic wave has passed:
	• Develop plan and process to allow pandemic activities de-escalation and move to post-pandemic wave operations. This includes:
	  ○ Restarting clinical services and programs that were suspended
	  ○ Restoring administrative functions that were suspended
	  ○ Addressing outstanding human resources issues
	  ○ Replenishing supplies and equipment
	  ○ Planning for the next pandemic wave.					

2	Develop a plan to address financial recovery: • Billing for services rendered • Obtaining reimbursement from relevant government entities, e.g. state government, the Federal Emergency Management Agency (FEMA), HHS, DHS, etc. • Resolving wage and benefit issues (union and non-union) • Resolving workers compensation issues.					
3	Develop a records management policy to limit legal exposure.					
4	Develop a process to clean and recover areas used for surge to return them to their previous function (e.g., cafeterias, conference rooms, offices, etc.)					

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SUPPLIES MODULE						
A. Influenza-related Medical Supplies						
1	Perform an assessment of influenza-related medical supplies.[60] Note quantities of each item needed for a 6-8 week crisis.					
2	Perform an inventory of influenza-related medical supplies across the facility.					
3	Identify primary and secondary vendors of influenza-related medical supplies. • Perform an assessment of expected supply levels from vendors based on previous ordering patterns and/or other vendor criteria. Understand vendors' plans for fulfilling orders during a product shortage.[61] • Identity 2-3 secondary vendors[62] for each influenza-related medical supply item, obtaining credit approval and entering vendors into purchasing and accounts payable systems. • Obtain 24-hour emergency contact information for all vendors.[63]					
4	Develop plans with primary and secondary vendors to pick up product in the event of a trucking shortage and/or delivery difficulties (e.g., utilization of facility vehicles to pick up supplies from distribution centers or warehouses.)					
5	Develop a process for emergency purchase orders that can be implemented quickly. Determine who has the authority to implement emergency orders and trigger points.[64] • Identify inventory triggers, i.e. recommendations based on normal usage and anticipated increase.					

[60] See Appendix: *Influenza Specific Supplies*

[61] See Appendix: *Seeking Information from Vendors*

[62] Secondary vendors should be physically located 50-100 miles away from the facility. Consider non-traditional healthcare facility vendors, e.g. Lowe's, Home Depot, True Value, etc.

[63] See Appendix: *24-Hour Emergency Contact Form*

[64] Trigger points are pre-identified conditions that would activate all or part of a plan. Specific actions should be tied to each trigger point. Most organizations use the World Health Organization (WHO) or U.S. Government pandemic phases. The WHO system relates to the global situation and the U.S. Government system focuses on the pandemic situation in the United States.

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	• Perform an evaluation of the facility's current medical supply tracking system to determine whether it can detect and respond to rapid consumption.					
6	Develop a plan with local Office of Emergency Management (OEM) and local LINCS agency to request needed supplies from local, state and federal stockpiles should the normal supply chain be interrupted.[65]					
7	Consider a storage plan for 6-8 weeks worth of influenza-related and other medical supplies. Include procedures to enable quick access to supplies. • Consider the possibility of off-site storage.					
8	Develop a plan to optimize management of medical supply distribution in the event of a workforce reduction, including cross training and/or "just-in-time" training for staff (e.g., inventory functions, ordering functions, nursing unit replenishment, par level assessment, product receipt and storage, etc.)					
9	Develop a plan to address how supplies would be distributed throughout the facility during a severe staffing shortage.					
10	Address the increased risk of theft or diversion of critical medical supplies if a shortage occurs (e.g., hoarding, increased supply costs, potential black market situation.)					
11	Identify alternate but functionally equivalent items to fill in shortages that may occur (e.g., triangular bandages used in place of Kling bandage, industrial garbage bags used in place of body bags.)					
12	Develop written protocols to safely extend the use of disposable medical supplies (e.g., dressings changed less frequently.)[66]					
13	Develop policy to address ethical and legal issues related to the allocation of scarce resources. • Ensure legal, regulatory and ethics professionals are included in the design of this process.					
14	Develop regional plan to share resources with neighboring facilities, if necessary.					

[65] See Appendix: *Government Assistance with Supplies*
[66] See Appendix: *Consumable Materials Considerations*

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B.	**Pharmaceuticals**					
1	If applicable, work with your institutional pharmacy to identify therapeutically equivalent, non-formulary medications in the event formulary medications are not available. Consider alternate medications for supply shortages.					
2	Identify primary and secondary vendors[67] for both formulary and non-formulary medications. • Obtain 24-hour emergency contact information for vendors.[68] • Ensure credit approval is obtained for secondary vendors and that their information is entered into purchasing and accounts payable systems. • Develop plans with primary and secondary vendors to pick up pharmaceuticals in case of delivery difficulties. Plans should include both controlled and non-controlled substances and should specify who has authority to implement the plan.					
3	Develop set of emergency purchase orders to expedite purchasing of critical medications should normal purchasing procedures be interrupted or delayed. Determine who has the authority to implement emergency procedures and trigger points.					
4	Communicate with pharmaceutical vendors to determine whether high-demand medications will be allocated based on past ordering patterns and/or other vendor criteria. Understand vendors' plans for fulfilling orders during a product shortage.[69]					
5	Develop a plan with local Office of Emergency Management (OEM) to request needed medications from the government's Strategic National Stockpile (SNS)[70] should the normal supply chain be interrupted.					

[67] See Appendix: *Seeking Information from Vendors*

[68] See Appendix: *24-Hour Emergency Contact Form*

[69] As each resident has his/her own medication orders provided by the physician, a shortage will require involvement of the physician to either change medications or revise the dosage/time of the medication.

[70] The CDC's Strategic National Stockpile (SNS) has large quantities of medicine and medical supplies that can be delivered to any state within 12 hours. For more information on the CDC's SNS see http://www.bt.cdc.gov/stockpile/.

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C.	**Resident Comfort Supplies**					
1	Consider creating modified admission kits. • Identify alternate sources for kit components (e.g., Wal-Mart, Home Depot, etc.) and have agreements in place with retailers. • Develop instruction sheets for rapid assembly of resident kits and design a "just-in-time" training module.					
2	Develop policy for utilizing comfort supplies provided by residents and families (e.g., blankets, pillows, linens, basins from home).					
3	Develop infection control policy to limit or prevent the spread of influenza from use of comfort supplies provided by residents/family.					
D.	**Laundry**					
1	Determine current average pounds of laundry used per resident per day.					
2	Develop policy to significantly reduce linen use during a surge (i.e., modify how often linen is changed, use disposable linen when possible).					
3	Develop plan to assure the continued availability of linen and other items from laundry in the event of a workforce shortage. • Develop plans to obtain linens and other laundry supplies from local retailers or big-box stores (e.g., Wal-Mart, Costco, etc.); have agreements in place with retailers.					
4	Perform an assessment of vendors' pandemic preparation plans.[71] Identify secondary vendors. • Develop plans with primary and secondary vendors to pick up and deliver laundry in the event of a trucking shortage and/or delivery difficulties (e.g., utilization of vehicles, etc.) • Develop plan to utilize community resources to clean laundry and obtain agreements in the event outside vendors have service difficulties.					

[71] See Appendix: *Seeking Information from Vendors*

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E.	**Food Service**					
1	Perform an inventory of average amount of food on hand across facility.					
2	Identify groups to be fed during a pandemic crisis. Consider residents, families, visitors, staff and staff families.					
3	Develop easy-to-prepare menu templates, considering that non-food service staff may be involved in food preparation. Consider the use of packaged foods and foods that minimize the need for refrigeration.					
4	Develop infection control plan to minimize or prevent the spread of influenza during food distribution in private rooms and self-service environments. For example, replacing open bins of utensils with prepackaged utensils, using disposable plates and bowls.[72]					
5	Identify primary food suppliers and obtain 24-hour emergency contact numbers.[73] • Identify secondary vendors who normally supply venues not accessed by the facility (e.g., restaurants, diners, etc.) Develop agreements with vendors to provide food, if needed. • Identify alternate sources of food and service items in the community (e.g., supermarket chains, Costco, Wal-Mart, etc.) and obtain agreements to acquire items during a pandemic crisis. • Develop a process for emergency purchase orders that can be implemented quickly and file with food vendors. Determine who has the authority to implement emergency orders and trigger points. These orders should emphasize non-perishable items. • Ensure understanding of food service vendor plans for obtaining foodstuffs during a pandemic crisis, including vendors' ability to reallocate food from less critical venues (e.g., school cafeterias, sports venues, etc.) to support your facility.					

[72] Consider increasing supplies of disposable utensils to accommodate large volumes as indicated.

[73] See Appendix: *24-Hour Emergency Contact Form*

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
6	Perform an assessment of potable water needs. • Identify alternate sources of potable water should municipal supply become unavailable. • Develop agreements with vendors who can provide water, ice and dry ice. Ensure emergency purchase orders are in place and identify trigger points.					
7	Identify storage areas for food stockpiles that are secure and temperature controlled.					
8	Develop plan for utilizing non-food service workers in food service should there be a workforce reduction. • Develop plan to enable an in-house food service should the external vendor become unable to provide service. Develop a "just-in-time" training program for staff from other departments.					
9	Develop plan for safe transport and delivery of food to residents in isolation.					
10	Develop policy to facilitate the use and cleaning of plates and utensils provided by residents and their families.					
F. Housekeeping						
1	Develop minimal basic set of housekeeping tasks for a 6-8 week pandemic crisis, taking into consideration areas may be ignored or greatly reduced in service.					
2	Develop a template for housekeeping tasks to be performed at various staffing levels. • Determine the amount of housekeeping supplies needed for each staffing level.					
3	Develop an infection control plan to limit or prevent the spread of influenza during housekeeping tasks. Develop a "just-in-time" training program to train non-housekeeping employees.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
4	Identify primary and 2-3 secondary vendors[74] of housekeeping supplies. • Obtain credit approval for all vendors and enter vendors into purchasing and accounts payable systems. • Obtain 24-hour emergency contact information for all vendors.[75]					
5	Develop a process for emergency purchase orders that can be implemented quickly and file with food vendors. Determine who has the authority to implement emergency orders and trigger points.					
6	Develop plan to increase number of available sharps containers deployed in facility, including all unconventional and surge areas.					
7	Develop plan to increase number of medical waste disposal cans/bags deployed in facility, including all unconventional and surge areas.					
8	Develop infection control and storage plan to handle medical waste and sharps should the facility be unable to dispose of these items for a prolonged period.					
G. Mass Fatality Management						
1	Develop a plan to easily wrap and tag bodies using alternate supplies when normal supplies are exhausted. • Identify list of alternative morgue supplies and identify local retailers to provide supplies (e.g., local hardware stores, Wal-Mart or Home Depot for large industrial garbage bags to replace body bags) and have supply agreements in place with selected retailers.					
2	Develop a process for emergency purchase orders that can be implemented quickly. Determine who has the authority to implement emergency orders and trigger points.					

[74] See Appendix: *Seeking Information from Vendors*

[75] See Appendix: *24-Hour Emergency Contact Form*

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
H.	**Transportation Services**					
1	Perform an inventory of all facility vehicles including department assignment for each vehicle, individuals in possession of keys for each vehicle and emergency contact information for each key holder.					
2	Develop an agreement with local repair shop for emergency repairs during a pandemic.					
3	Identify several sources for gasoline and diesel; develop agreements to assure adequate fuel supply.					
4	Develop policies addressing who is permitted to drive facility vehicles during a crisis. Check insurance coverage and policies.					
5	Develop a policy assigning all vehicles to the incident commander during a crisis. The incident commander will be responsible for vehicle assignments.					
6	Develop plans for the safe and legal transport of dead bodies, supplies, pharmaceuticals (controlled and non-controlled), lab samples, food, other items and staff. • Determine items that will require police escort or additional security and have those agreements, permits/documents in place.					
7	Develop infection control policies to minimize or prevent the spread of influenza during the transport of infectious materials or personnel.					
8	Develop plan for cleaning contaminated vehicles. Obtain cleaning supplies and solutions to meet expected need.					
I.	**Laboratory**					
1	Ensure understanding of primary vendor's pandemic influenza plan.[76]					

[76] See Appendix: *Seeking Information from Vendors*

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
2	Develop plan to obtain secondary laboratory vendor services, if needed (e.g., local private labs, neighboring facilities, national labs.) • Obtain 24-hour emergency contact information for all vendors.[77]					
3	Perform assessment of essential laboratory functions to be maintained during a 6-8 week pandemic crisis. • Determine which laboratory services may experience increased volume; develop plan to ensure timely service delivery.					
J. Radiology						
1	Ensure understanding of primary vendor's pandemic influenza plan.[78]					
2	Develop plan to obtain secondary radiology vendor services, if needed. Consider teleradiology or Picture Archiving and Communication Systems (PACS). • Obtain 24-hour emergency contact information for all vendors.[79]					
3	Perform assessment of essential radiology functions to be maintained during a 6-8 week pandemic crisis. • Determine which radiology services may experience increased volume; develop plan to ensure timely service delivery.					
K. Respiratory Therapy and Care						
1	Ensure understanding of primary vendor's pandemic influenza plan.[80] • Obtain secondary vendors, obtain credit approval and enter vendors into purchasing and accounts payable systems.					

[77] See Appendix: *24-Hour Emergency Contact Form*
[78] See Appendix: *Seeking Information from Vendors*
[79] See Appendix: *24-Hour Emergency Contact Form*
[80] See Appendix: *Seeking Information from Vendors*

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Obtain 24-hour emergency contact information for all vendors.[81]					
2	Determine which respiratory care functions will be maintained during a 6-8 week pandemic crisis; develop plan to ensure service continuity should there be a workforce reduction.					
3	Develop plan to facilitate non-traditional worker or family ventilatory support in case of severe workforce reduction/ equipment shortages. Include "just-in-time" training and detailed instructions for layperson use in common local languages.					
4	Develop infection control plan to : • Limit or prevent the spread of influenza in mass care setting during respiratory procedures. • Facilitate the cleaning and rapid service return of ventilators and other respiratory support equipment.					
5	Perform an inventory of respiratory therapy supplies on hand including portable oxygen, ventilators and tubing.					
6	Develop plan with local Office of Emergency Management (OEM) to request needed supplies/equipment, including ventilators, from state and federal Strategic National Stockpiles (SNS), or alternate vendors.[82] • Ensure OEM is familiar with what type of ventilatory equipment your facility will request.					
L. Waste Removal						
1	Perform assessment of cubic yards of waste (medical and non-medical) that would be generated during a 6-8 week pandemic crisis.					

[81] See Appendix: *24-Hour Emergency Contact Form*

[82] In many locales, the same companies are used by multiple area healthcare facilities to rent ventilators. This has the potential of creating a severe shortage of ventilators during a pandemic. The federal government and some state governments have a stockpile of ventilators that may be accessed during a shortage. Facilities should discuss this scenario with their OEM and local health department to ascertain access procedures for additional ventilators.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
2	Develop plan to increase medical and non-medical waste storage and removal during a trucking shortage, including review of regulatory and legal issues. • Identify space that is safe and secure to house dumpsters and excess waste. • Identify safe, secure space to store excess filled sharps containers. • Develop plan to screen excess medical waste for radiological contamination. • Develop infection control plan to allow safe handling of excess waste.					
3	Identify 2-3 large dumpster vendors. Develop agreements to allow for dumpster delivery on short notice, obtain credit approval and enter vendors into purchasing and accounts payable systems. • Obtain 24-hour emergency contact information for all vendors.					
4	Identify primary and secondary incinerator service vendors. • Obtain 24-hour emergency contact information for all vendors.					
5	Develop a process for emergency purchase orders that can be implemented quickly. Determine who has the authority to implement emergency orders and trigger points.					
6	Develop plan with local OEM and regulators to address medical waste transportation issues, including the use of licensed and unlicensed vehicles.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
PSYCHO-SOCIAL MODULE						
A. General Preparedness						
1	Obtain a copy of your local/county/state[83] pandemic influenza plans and review what mental health services will be provided (e.g., statewide crisis counselors or training for disaster counselors.) • Ensure knowledge of how to access these resources. • Collaborate with local, county and state agencies to ensure integration into the planning process.					
2	Obtain information and brochures on existing hotlines (e.g., 211 for information and referral; mental health helpline 877-294-HELP). Explore if call lines can be used for reverse 911.					
3	Consider developing emergency kits for mental health needs. Contents might include: • Recreational items such as pens/pencils, notepads and books. • If appropriate, religious items such as rosary beads, prayer books or bibles. • Other items that provide comfort to adults and the elderly. Collaborate with community agencies to facilitate distribution.					
B. Provider and Community Collaboration						
1	Secure Memoranda of Understanding (MOU)[84] with local rehabilitation agencies, behavioral health agencies, outpatient centers, etc. for use of their services and/or staff during a pandemic.					
2	Ensure facility has placement protocols for community-based and other behavioral health organizations specializing in at-risk resident needs.					

[83] The State of New Jersey Pandemic Influenza Plan can be accessed at http://www.state.nj.us/health/flu/panflu_plan.shtml.

[84] For sample MOU, see Appendix: *Model Memorandum of Understanding Regarding Sharing of Personnel During a Disaster*

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
C.	**Staff Education and Training**					
1	Ensure staff is trained on personal and family preparedness. Provide tools and resources to help staff develop personal preparedness plans.[85]					
2	Develop a staff mental health program that provides targeted education about resident and staff mental health needs during a pandemic.[86] • Provide risk reduction strategies and infection control practices. • Educate staff about psychological first aid provider care.[87] ○ Create mechanisms to answer real-time questions, e.g., staff hotline, dedicated e-mail address, etc. • Plan to provide continuing education annually and develop a mechanism for ongoing education as issues/topics are identified.					
3	Determine the availability of employee assistance services for staff support.					
4	Identify staff with crisis, screening management or grief support experience and consider using staff trainers: • To educate employees regarding pandemic • For critical incident stress debriefing.					
5	Counsel staff on factors such as age, religious beliefs, native languages (verbal and body language/gestures) and cultural norms when assisting someone who is in grief.[88]					
6	For families and the community, prepare resources identifying traumatic stress management techniques,[89] such as: • Getting timely, accurate information from credible sources. • Maintaining a normal daily routine as much as possible • Limiting exposure to graphic news stories and images • Talking and sharing thoughts and feelings with others					

[85] Consider the following resources: http://www.pandemicflu.gov/individualfamily/individuals.pdf, http://www.ready.gov/ and http://www.nj211.org/.

[86] For more information and resources, see *Coping with Stress Related to H1N1 and Health Emergencies at http://www.state.nj.us/humanservices/dmhs/disaster/h1n1dtb.html.*

[87] See *Psychological First Aid: Field Operations Guide for Nursing Homes* at http://amhd.cbcs.usf.edu/pfanh.pdf. For additional psychological first aid resources, see http://www.samhsa.gov/Disaster/resources.aspx.

[88] See U.S. Department of Health and Human Services. *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations.* http://www.hhs.gov/od/documents/CulturalCompetence_FINALwithcovers.pdf.

[89] See *Tips for Survivors of a Traumatic Event: Managing Your Stress* at http://www.samhsa.gov/MentalHealth/Tips_Survivors_Managing_Your_Stress.pdf.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Identifying personally effective coping skills from other extremely stressful life situations • Staying connected to family, friends and supporters, as much as possible • Drawing upon spirituality or personal beliefs for comfort • Expression through writing, drawing and other art forms.					
D. Resident Care						
1	Recognize any emotional stress that may have been caused to residents as the result of infection control measures, including: • Restricted visitation • Cohorting or restricting residents to a particular area.					
2	Ensure continuity of care for residents already receiving mental health services, including medication access.					
3	Due to restricted social interaction during a pandemic, prepare to assist residents experiencing interruption in support systems/programs offered by facility. Consider conducting on-line meetings or free conference calls.					
4	Identify members of pastoral staff and faith-based community who may assist in providing spiritual support.					
5	As best possible, establish an environment for grieving so that families may have privacy if they so desire.					
6	Ensure availability of pamphlets or papers on grief to distribute to families who may need assistance.					
E. Post Pandemic Recovery						
1	Identify at-risk employees for continued stress or PTSD during recovery, as well as employees who may be in need of more intense post-pandemic attention. • Recognize and address emotional needs of employees that lost friends, family or co-workers.					
2	Recognize that employees will encounter co-workers, residents and friends that will seek their support and guidance during and following the pandemic. Consider providing psychological first aid					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	training to employees without mental health experience.					
3	Review existing employee programs and determine if they will be effective in addressing employee needs following a pandemic.					
4	Provide opportunity for staff to discuss feelings and concerns related to their experiences during and following the pandemic.					
5	Provide support to employees that may harbor negative feelings toward co-workers that chose not to work. In turn, provide support to employees that chose not to work, or were told not to work, as they try to re-establish their work routine.					

In identifying resources, consider the following:

Mental Health Services • State • County (e.g., county mental health administrator; trauma/loss coalition) • Local • Private • Colleges and universities	***Social Services*** • County health departments[90] • County department of human services • County board of social services • Broad community resources • Acute care hospitals
Faith-Based Resources • Pastoral care – internal/external • Community resources	***Contract Services*** • Suicide Hotline/ EAP • Ancillary services • Staffing services • Specific department services

[90] For a list of New Jersey County Mental Health Administrators, see the Psychosocial Considerations section of the New Jersey Pandemic Influenza Plan at http://www.state.nj.us/health/flu/documents/plan/psy_app_7.pdf.

ETHICS MODULE

When the next influenza pandemic strikes, healthcare providers and leaders will face a wide range of difficult decisions that will affect how we, as a society, cope with the medical consequences of a pandemic. Individual healthcare workers will be forced to decide what level of personal risk they are willing to take, and employers will be forced to decide what protections they will provide for employees and their families. Insufficient or strained resources will have a significant impact on medical decisions and resource allocation. Ethics can provide a moral compass to guide the difficult decisions that must be made during a pandemic.

The need for a clearly understood and widely accepted ethical approach to dealing with serious communicable diseases was underscored during the outbreak of Severe Acute Respiratory Distress (SARS) in early 2003. The SARS outbreak highlighted that healthcare systems had generally not prepared themselves to deal with immediate and tough ethical choices. Research done in the aftermath of the outbreak showed that people are more likely to accept difficult and complex decisions if the decision-making processes are reasonable; open and transparent; inclusive of all concerned parties; and responsive to the concerns of healthcare workers and the community.[91] This transparency extends to residents, caregivers and the general public. The results of not having an ethical framework in place included loss of trust, low morale, fear and misinformation. This module will help guide healthcare facilities with understanding and incorporating accepted ethical principles into pandemic planning.

The sections that follow contain a series of planning/policy tasks broken down by essential ethics expertise areas and begin with a "primer" to lay the foundation for the *process* of making ethical decisions. As always, the planning/policy tasks are discretionary and are representative of the issues that *should* be considered. Associated with each section are appendices and suggestions to refer to other toolkit modules that offer additional details, tips and further explanation of important considerations for each task. Careful planning in these areas will assure that ethical decisions run smoothly under the extreme conditions of a pandemic.

[91] *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/mceguide.pdf

How to Use This Module[92]

Regardless of whether a facility has a formal ethics committee or simply convenes key staff when ethical issues arise, the reality is a pandemic will create ethical challenges that healthcare providers have not been faced with in any other crisis. The critical directive of this section is to think through anticipated ethical challenges/issues to determine how the facility will respond in advance of a pandemic.

When giving consideration to these ethical decisions, it can be easier to think in terms of "buckets" (see next page for illustration). A number and variety of decisions will fall within these buckets that are reflective of a facility's *core values (*the values of the facility that drive day-to-day operations). In other words, the buckets will include examples of specific values that are associated with:

- The process by which decisions will be made;
- What is in the best interest of the organization/facility;
- What is in the best interest of the community; and
- What is in the best interest of the individual.

The core values reflected by the buckets do not reflect any order of importance as it is up to each individual organization to determine the priority of one value over another. For example, one facility may determine that the good of the community should take priority over the good of the individual during a pandemic, while others may believe that focusing on the good of the facility should be the main concern. Since determining the priority of a facility's core values is of utmost importance, the process of determining these core values must always be transparent to those served by the facility (e.g., the community, employees, residents, caregivers), to avoid negative public perception or misunderstood intent.

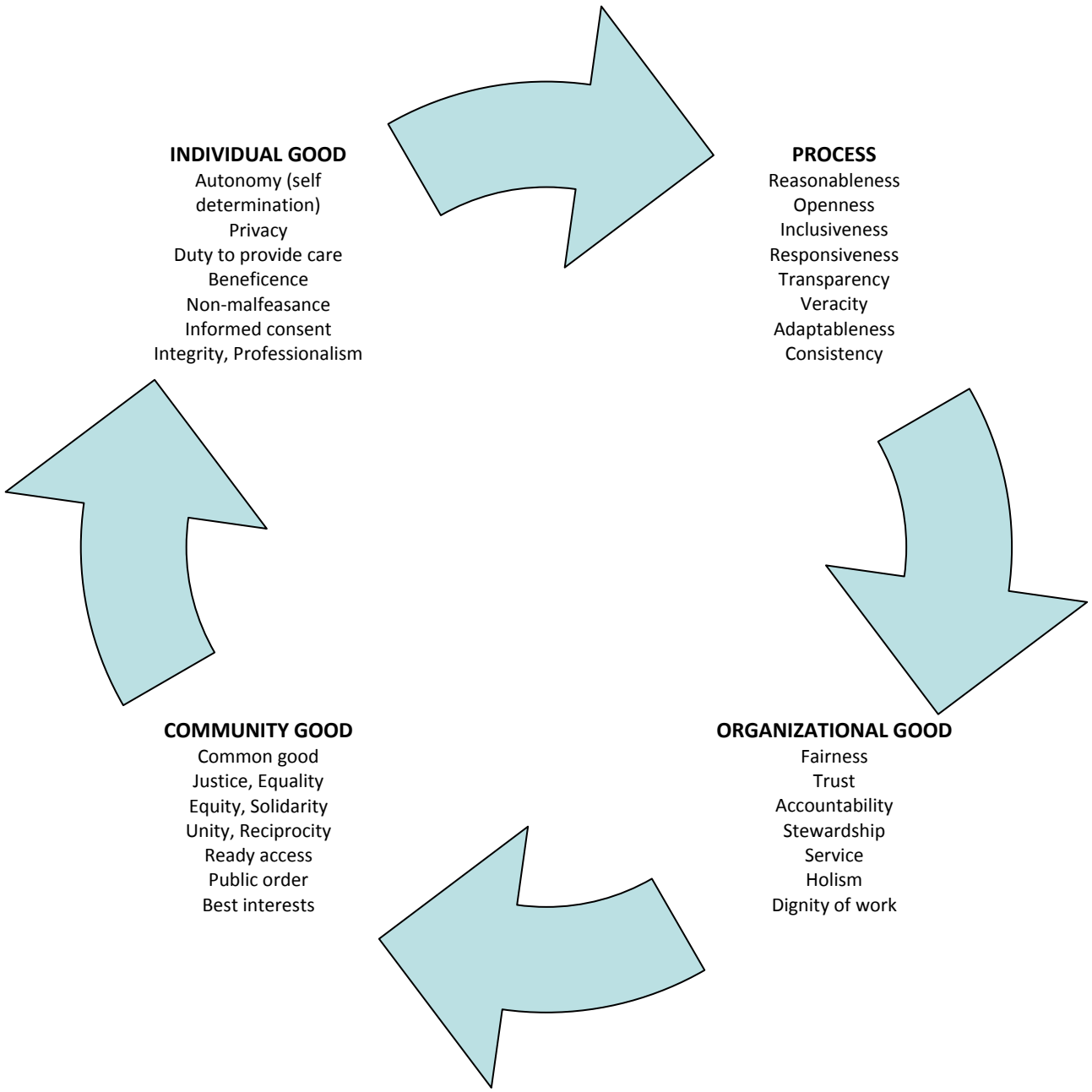
Reflected within each bucket are examples of different values that may be considered when developing policies on behalf of the facility. They are by no means all-inclusive, but may be used to facilitate discussion and to ensure that the values are considered before determining if they will be reflected in policy. For example, when developing policy regarding a healthcare worker's responsibility to provide care, should the decision be left to the individual worker or should the worker be informed that the facility believes he/she has a duty to provide care? Considering these values can assist in the decision-making process and should result in consensus-based, clearly understood agreements.

[92] The information reflected in this module is based in large part on the model developed by the Catholic Health Association; however, there are many and varied models that may serve as a guide to ethical decision-making. In addition, the ethical considerations discussed are in relation to a facility's scope of authority. Other entities, such as insurers, faith-based organizations, etc., should be engaged in their own ethical determinations since these organizations will be interrelated with the facility during a pandemic. Given that each organization will adopt its own values, conflicts that add complexity to the ethical decision-making process should be expected.

Core Values

Consider these core values as the values that drive your facility's daily operations:

- Process
- Organizational Good
- Community Good
- Individual Good



Framework for Decision Making[93]

Providers and staff at every level of the facility must understand the ethical decision-making process and comprehend the consequences of those decisions. There must also be an assurance that the facility is understanding and supportive of its employees when they are faced with ethical dilemmas. If these critical elements are not addressed, staff's ability to function effectively will be diminished.

This module provides a framework for decision making as well as the assessment tool. This resource will support the facility in evaluating its decision-making process in advance of a pandemic. While the decisions may be challenging, the process can be more easily understood by following a structure that reflects the context of the situation being addressed – in this case, a pandemic. The determined and understood values of the facility are guides – not answers – to the challenges of concrete circumstances during a pandemic outbreak and should be considered when decision alternatives are identified. Of course, these values should also be an extension of the facility's clearly delineated goals.

- **STEP ONE**
  Determine:
  - Who should be heard?
  - Who should be "at the table?"
  - Who makes the final decision?

    ***For example**: As a containment strategy and to protect residents and staff, it may become necessary to restrict visitation.*

- **STEP TWO**
  Gather information:
  - Who, what, where, when, why and how
  - Key stakeholders
  - Relevant social, economic, legal and religious considerations.

    ***For example**: Discuss with clinical staff, resident council and state department of health to communicate facility's rationale and plan for restricted visitation.*

- **STEP THREE**
  Identify the specific issue and determine:
  - What are the values that may be in conflict (e.g., protecting the health of all residents and staff vs. protecting the rights of the individual resident?)
  - What is creating a conflict with the facility's values?

    ***For example**: The facility recognized and promotes the rights of each resident to receive visitors. However, due to the infectious nature of the novel flu, visitors may introduce increased risk to the health of all residents and staff.*

[93] Process outline based on *A Process for Ethical Decision Making*, Catholic Health Association of the United States.

Framework for Decision Making (continued)

- **STEP FOUR**
  Review core commitments
  - What core values may need to change in the context of a pandemic?
  - Is there a clear and justifiable reason for modifying the facility's values?
  - Do values need to be reprioritized?
    ***For example**: While the facility strives to protect all resident rights, the health of all residents and staff must take priority.*

- **STEP FIVE**
  Identify alternatives
  - Are there alternative options that can be utilized to address the situation/problem?
  - Have the negative and positive consequences (both short-term and long-term) been identified?
  - Do the facility's core values determine which alternatives, if any, are unacceptable?
  - Are the consequences of the decision(s) acceptable?
    ***For example**: The restricted visitation policy may be temporary or for a pre-determined period of time.*

- **STEP SIX**
  Make a decision
  - Choose one of the alternatives
  - Ensure the ability to justify the chosen alternative, as well as the process used to eliminate other alternatives
  - Determine how the decision will be communicated; ensure a process is in place to allow for discussion of concerns.
    ***For example**: The restricted visitation policy will be implemented immediately and re-evaluated in three months. The policy will be posted and communicated to residents, visitors and staff.*

- **STEP SEVEN**
  Evaluate:
  - The impact the decision has had on the facility's core values
  - If the chosen alternative is not appropriate, determine if other alternatives exist.
    ***For example**: The rationale and need for restricted visitation is explained to all residents and family. The impact of the revised visitation policy and feedback from residents/families will be solicited and discussed in resident council and by facility leadership.*

The goals of creating and implementing a formalized standard process for ethical thinking are to provide a consistent set of guidelines and directions for leaders who will be forced to make difficult decisions during a pandemic and to provide an organized way of presenting situations and cases for discussion.

The process for ethical decision making includes the following three broad phases: **Preparation, Decision Making and Follow Through**. While there are several processes used in ethical decision making, the basic elements are presented below.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
A. Process for Ethical Decision Making						
	PREPARATION					
1	Create a formal ethical decision-making process that is clearly delineated in layperson language.					
2	Create a process by which an issue or question is brought forward in a succinct written statement.					
3	Create a process to identify the stakeholders who will be affected by the decision. • Agreement should be reached by those developing policies to acknowledge stakeholders' interests when reaching a decision.					
4	Create process to gather relevant key facts about the issue or question: • Identify legal and regulatory issues • Identify system-wide regulations (i.e. ethical and/or religious directives) • Clarify the resident's perspective by examining religious beliefs and cultural or philosophical values • Determine if a resident-based model is appropriate vs. another model (e.g., community-based decision-making model) • Identify financial constraints • Determine essential ethical principles • Identify treatment alternatives.					
DECISION MAKING						
5	Determine what is in the best interest of all involved parties:					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Allow input and/or acknowledge all perspectives • Integrate public health policies into the decision-making process • Bring stakeholder groups into the decision-making process.					
6	Create process to make timely decisions when the decision is difficult morally or ethically.					
7	Train several people in the ethical decision-making process and empower them to guide others in making difficult decisions.					
8	Confirm the committee has a process to document deliberative process used to reach decision points.					
9	Create policies based on the final decision, as well as process to implement the new policies.					
10	Create plan to communicate how decisions are made. • Include what values played a role in the decision. • Address how stakeholder impact was factored into the decision. • Create a complaint/appeal process.					
FOLLOW THROUGH						
11	Ensure flexibility to change decisions when new information becomes available or unanticipated results occur.					
12	Review the implementation of committee decisions and new policies using collected data.					
13	Monitor and report measurable outcomes.					

B. Ethical Values and Processes

PRIVACY PLANNING CONSIDERATIONS

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Consider individual right-to-privacy issues. During a pandemic or surge, it may be necessary to override this right to protect the public from harm. When examining individual good issues, consider the following: • Autonomy (self determination) • Privacy • Duty to provide care • Beneficence • Non-malfeasance • Informed consent • Integrity • Professionalism.					
2	Determine how, when, to whom and what medical information will be released to protect the public good.					
DUTY TO PROVIDE CARE CONSIDERATIONS						
3	Weigh duty to provide care against competing obligations to staff's own health, family/friends' needs, etc.					
4	Confirm medical, nursing and human resources staff (and other professional groups) have devised and ratified a code of ethical behavior that will govern professional duties during a pandemic. Include language on: • Difficult decisions related to resource allocation • Scope of practice • Professional liability • Workplace conditions.					
EQUITY CONSIDERATIONS						
5	During a pandemic, equal claims to clinical services[94] may be curtailed or suspended. Create process to determine which services may be suspended and how residents requiring these					

[94] Clinical service lines may include the following types of services: ventilator dependent, Alzheimer's unit, dementia unit, medical clinic, etc.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	services will be handled.					
6	When examining community good issues, consider the following: • Common good • Justice • Equality • Equity • Solidarity • Unity • Reciprocity • Ready access • Public order • Best interests.					
FAIRNESS						
7	Design processes and procedures to deliver palliative care to those who cannot receive life-saving measures (e.g., lack of sufficient anti-viral medications, lack of ventilators, etc.)					
TRUST						
8	Recognize that, during a pandemic, facility leaders will have the difficult challenge of maintaining stakeholder trust while simultaneously implementing unpopular or unproven measures.					
9	Create open, transparent process when making difficult decisions that have moral implications.					
10	Include various stakeholder groups in the decision-making process.					
SOLIDARITY						
11	Prepare services and professional staff to set aside traditional values of self-interest and territoriality in order to present solidarity to stakeholders.					
12	Implement policies for facility departments that will eliminate conflict during a public health crisis (e.g., which departments must maintain operations/services within the facility vs. which					

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	departments can function with employees working remotely.)					
REASONABLENESS						
13	Ensure that decisions made during a pandemic are based on evidence, principles and values (i.e., reasons) that stakeholder groups agree are relevant to the crisis health needs. When undertaking ethical decision making, consider the following process values: • Reasonableness • Openness • Inclusiveness • Responsiveness • Transparency • Veracity • Adaptiveness • Consistency.					
14	Ensure that decisions are rational, not arbitrary, and can be justified and applied consistently.					
15	Ensure that decisions are based on appropriate evidence available at the time of the decision (e.g., effectiveness of ventilators for specific age groups.)					
POLICY DECISION/ INFORMATION						
16	Ensure decisions are result of appropriate process that takes into account how quickly a decision must be made (e.g., two people with same health status each requiring a ventilator when only one is available.)					
OPENESS AND TRANSPARENCY						
17	Confirm that ethics decisions are open to scrutiny by various stakeholders, are well documented, and the basis upon which these decisions are made is publicly accessible.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
18	Confirm decision-making process follows a pre-established pathway and uses a pre-established framework.					
INCLUSIVENESS						
19	Engage as many stakeholder groups as possible in decision-making process to confirm final decisions are made with stakeholder views in mind.					
20	Consider process to assure unrepresented stakeholder groups have their views represented during the decision-making process.					
RESPONSIVENESS						
21	Create opportunities to revisit and revise decisions as new information emerges and/or as complaints/disputes arise.					
22	Create mechanism to address disputes/complaints.					
23	Plan to revisit and revise decisions based on new information, clinical data or epidemiological knowledge.					
ACCOUNTABILITY						
24	Ensure process for accountability related to ethical actions and inactions.					
25	Formally document decision-making process for all morally and ethically challenging decisions to provide for legal defense and to create “lessons learned” document for future pandemics.					
BENEFICENCE AND NON-MALFEASANCE						
26	Remind staff of their duty to promote and engage in positive effect activities with residents while refraining from any activity that may					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	cause harm.					
27	Ensure decisions are made with the goal of promoting the best public health outcome during a pandemic (e.g., certain employees work from home to reduce risk of exposure.)					
UNITY/ RECIPROCITY						
28	Support staff pandemic needs and plan to show generosity toward workers who assume a higher risk during a pandemic.					
29	Create process to minimize or evenly distribute burdens placed on employees who choose to take on increased pandemic risk.					
STEWARDSHIP						
30	Ensure facility leaders are guided by trust and ethical behavior in making their decisions to achieve the best possible public health outcomes.					
31	Provide education/training program for staff that may be called upon to assume leadership roles in the ethical decision-making process. Ensure they are able and willing to provide appropriate information to all employees upon request.					
C. Ethical Conflicts						
DUTY TO PROVIDE CARE CONSIDERATIONS						
1	Develop codes or statements of ethical conduct in high risk situations for all staff (e.g., physicians, nurses, clinical staff, non-clinical staff.)					
2	Address reciprocity and solidarity issues: • Acknowledge that work is dangerous					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Help workers cope with high stress of pandemic care • Provide for health and safety of workers • Care for those who become ill at work or as a result of work • Provide health and disability insurance and/or death benefits for those who become ill or die.					
RESTRICTION OF PERSONAL LIBERTIES IN THE INTEREST OF PUBLIC HEALTH						
4	Create policy to implement work quarantine if directed to do so by public health authorities.					
5	Create policy to handle workers who ignore work quarantine guidelines.					
6	Prepare a policy to handle staff that refuses mandatory vaccination.					
7	Prepare a policy to handle staff who are arrested or imprisoned for failing to follow public health requirements during a pandemic (e.g., if someone is arrested and/or quarantined for refusing mandatory vaccination, will they be fired.)					
PRIORITY SETTING—ALLOCATION OF SCARCE RESOURCES						
8	Guarantee that scarce resource allocations are reasonable, transparent, inclusive, responsive, accountable and fair.					
9	Create a policy regarding how scarce resources will be distributed and utilized, taking into account: • How will short-supply vaccine candidates be prioritized if clear guidance is not available from local health department or the CDC? • Who will decide how resources are prioritized and distributed? • Who will be eligible recipients of various goods and services?					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
10	Allocate available healthcare professionals to answer the following questions: • How will procedures and interventions be delegated (e.g., physician tasks done by nurses; nursing tasks done by aides, etc?) • What percentage of healthcare professional time will be allocated to pandemic care, non-pandemic care, time-sensitive critical research, animal care, etc.?					
SUSPENSION OF ORDINARY MORAL RULES						
11	Determine procedure to suspend ordinary moral rules that are commonly used to guide behavior, disciplinary committees/actions and decision-making processes. • Under what conditions would such suspensions occur? • Who is authorized to suspend such rule?					
EMPLOYER OBLIGATIONS TO HEALTHCARE WORKERS						
12	Recognize duty to minimize workers' risk of exposure to pandemic influenza by providing some or all of the following: • Ethical decision framework training • Infection control equipment supply and training • Antiviral medications and vaccines supply (if available) • Access to health insurance, disability insurance, death benefits with waived waiting periods (to be negotiated with insurance companies, if possible) • Liability protection that provides care beyond facility's scope of practice (if within limits of the law). • Institutional or community guidelines that could be cited as legal standard of care.					
OBLIGATIONS OF HEALTHCARE WORKERS TO EMPLOYER						

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
13	Establish guidelines for sanctions and incentives: • If sanctions are applied, application must be consistent across similar situations/contexts; they should be limited to usual sanctions; and a formal appeals process must be in place. • Consider incentives to encourage workers to assume increased risk.					
OTHER ISSUES						
14	Establish procedure to handle moral dilemmas when staff members are asked to do something with which they disagree.					
15	Establish procedure to handle situation where a physician recommends an appropriate course of treatment, but the resident requests a different, non-conventional (but approved) treatment or therapy.					
16	Determine what sanctions, if any, will be implemented if a physician refuses to abide by the adopted decision-making process (e.g., a population-based triage decision-making policy rather than individual-based.)					
D. Resident Issues						
INFORMED CONSENT ISSUES						
1	Ensure residents are aware of proposed medical interventions and available alternatives during a pandemic.					
2	Create process to document the informed consent process.					
3	Create consent process for when there is no ability to obtain informed consent in these populations: • Unconscious adult • Adult with altered mental status					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Language barrier • Insufficient mental ability to understand					
INTERVENTION ISSUES						
4	Follow public health policy to address mandated interventions when a resident refuses treatment (e.g., mandated flu vaccine.)					
5	Create policy to address medically futile treatment issues, if requested by resident or family.					
6	Create policy that addresses giving treatments to individuals in a priority group while withholding treatment from others.					
7	Create policy that addresses withdrawing treatment from one group to give it to another group (e.g., removing an elderly person from a ventilator to provide service to a 20-year-old.)					
8	Create policy that addresses residents in persistent vegetative states that are using scarce resources (e.g., ventilators.)					
9	Confirm decisions on how clinical staff will respond to codes (cardio-pulmonary arrests.)					
RIGHT-TO-DIE ISSUES						
10	Create policy that addresses a resident's request to withhold treatment.					
11	Create policy that addresses how to handle DO NOT RESUSCITATE (DNR) requests.					
12	Create policy that addresses withholding treatment in special circumstances such as: • If the resident is 20-years-old and was previously healthy. • If the resident is elderly and does not want to use a ventilator that could benefit someone else.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
LEADERSHIP MODULE						
A. Creating a Culture of Preparedness						
1	Establish disaster/pandemic planning as a priority for your facility (e.g., include updates/reports at every management meeting; present periodic updates to Board of Trustees/ownership). • Ensure all leaders understand that disaster/pandemic planning is an ongoing process. • Discuss benefits of pandemic flu planning with senior staff, incorporating pandemic planning efforts into "all hazards" approach to facility disaster planning.					
2	Assign specific pandemic planning issues to management as appropriate to ensure planning modules are completed and submitted for review.					
3	Ensure management understands that accountability for completion of tasks will be a priority for the administrator. Request quarterly pandemic planning progress updates from designated staff.					
4	Ensure plan development includes a diverse and representative group of employees (e.g., employee representatives from unions, dietary workers etc.)					
5	Engage in proactive discussion and negotiation with external parties (e.g. physicians, payers, referring facilities, contracted physician groups or staff, suppliers, etc.) to define and agree upon responsibilities. • Create second- and third-level plans in the event an external group, business or entity violates negotiated/contracted terms.					
B. Role of Board of Trustees/Ownership						
1	Educate Board of Trustees/owners about pandemic influenza, its potential impact on operations and the need for effective planning.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
2	Discuss clearly delineated board leadership/ownership responsibilities prior to a pandemic. • Ensure board members/ owners have been educated on and trained in ICS[95] or NHICS[96]. • Empower ICS leadership with significant authority so they can complete all objectives with necessary speed.					
3	Share impact analysis, operational and financial projections with the board/ownership.					
4	Ensure board/ ownership has an understanding of local, state and federal authority during a pandemic (e.g., the state commandeering the facility to be used for quarantine or isolation.)					
5	Define what specific issues/problems the board/ owners may need to address (e.g., administrator's illness and reassignment of his/her responsibilities.)					
6	Board/ owners should be educated on community impact policies (e.g., restricting or prohibiting visitors; distribution of scare resources.)					
7	Discuss pandemic flu policies that may have legal or ethical implications, such as altered standards of care or withdrawal of care.					
8	Determine what issues can be addressed by senior staff and issues that must be brought to the board/ownership. • Identify board members/ owners who will be kept apprised of facility operations on a frequent basis and what information they will be given. • Determine frequency of communication with full board/ ownership (e.g., daily, every other day, etc.)					
9	Determine if board/ ownership meetings can be conducted remotely or through telecommunications and what will determine the need for alternate methods.					

[95] For more information on the Incident Command System (ICS), see http://www.fema.gov/emergency/nims/IncidentCommandSystem.shtm and http://www.emsa.ca.gov/HICS/default.asp.

[96] For more information on Nursing Home Incident Command System (NHICS), see *Nursing Home Incident Command System (NHICS),* provided by the California Association of Health Facilities at http://www.cahfdownload.com/cahf/dpp/1-Guidebook%2010109.pdf.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
10	Describe prioritization for medical countermeasures receipt and explain why certain board members/ owners will not be prioritized to the top of the list.					
11	Provide Board of Trustees/ owners with final pandemic plan. • Provide detailed information/education regarding specific policies/procedures including or affecting members of the board/ owners.					
C. Continuity of Operations Planning (COOP)						
SUCCESSION PLANNING/DELGATIONS OF AUTHORITY						
1	Review facility's current Continuity of Operations Plan to identify necessary changes when responding to a pandemic.					
2	Review facility's current leadership succession plan.[97] • Identify backup individuals who would be able to succeed the current leadership. • Review list of critical staff leaders and ensure that the succession plan includes alternate individuals for each position. • Inform, and seek approval from, the Board of Trustees/ ownership of your succession plan and authority delegations. • Develop and share expectations for each critical position to achieve smooth transitions. • Determine whether successors could work remotely and have the resources available to do so (e.g., multiple phone lines, fax, Internet accessibility.) • Ensure each member of the executive team identifies critical areas/services and creates a succession plan for those services.					
3	Develop procedure for reinstatement of a former leader who is healthy enough to return to work.					
4	Consider compensation for the incapacitated as well as those stepping into higher positions of authority.					

[97] The Center for Nonprofit Advancement has developed the *Emergency Succession Plan Template* which can be accessed at www.nonprofitadvancement.org. You may also access a copy of the document, distributed by the New Jersey Hospital Association by permission, at http://www.njha.com/paninf/Pdf/leadershipmodulefinal.pdf

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
5	Review Orders of Succession and Delegations of Authority to ensure the following: • Management and direction of personnel • Access and safety of vital records • Access and distribution of supplies • Continued operation of equipment and systems and supplies delivery.					
6	Ensure Orders of Succession have specific information regarding the conditions under which succession will take place (e.g., defining incapacitation.)					
7	Ensure Delegations of Authority: • State the title of the person to whom authority is being assigned. • Provide enough power to the appointed individual to successfully complete position objectives.					
	OVERSIGHT AND AUTHORIZATION					
8	Develop, implement and communicate oversight and authorization policies and procedures. Determine who will have authorization to: • Activate emergency plans • Communicate with staff, residents and community • Modify shift hours or rotations • Implement employee isolation and quarantine • Assess mental and physical fitness of employees, if necessary • Restrict visitation to residents, including facility lockdown if necessary • Implement changes in resident care protocols • Engage in discussions with local, county and state government officials. Decision making should be consistent with provisions in the facility's pandemic plan.					
	D. Post-Event Recovery					
1	Require an after-event review involving all departments and staff.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
2	Quantify expenses associated with pandemic response and explore avenues for recovering those costs.					
3	Meet with insurers to assess the impact on health, death and workers compensation benefits.					
4	Develop an After-Event Report and distribute to appropriate audiences. Consider if audiences include external organizations (e.g., government agencies, suppliers, etc.)					

HUMAN RESOURCES MODULE

During a pandemic, short supply of resources and supplies to meet residents' needs may seem to be of first concern. However, it is actually the limited number of available employees that will have the most significant and immediate impact on your facility operations. Given the high likelihood of a workforce shortage, it is imperative that healthcare facilities plan for this problem.

This module focuses on several human resources (HR) pandemic-preparedness strategies including:

- Protecting your workforce during a pandemic.
- Minimizing staff absenteeism and its impact on your operations.
- Minimizing administrative chaos when managing HR problems, with greatly diminished HR staff.

Isolation and Quarantine

All states have laws that provide authority and guidance for declared states of emergency. For example, in September 2005, the New Jersey Legislature signed into law the amended Emergency Health Powers Act[98], which provides the governor with express authority to declare a public health emergency, as well as granting the state commissioner of health and senior services wide ranging authority to detect, prevent, prepare for and respond to public health emergencies. Part of this broad authority pertains to isolation and quarantine of the general population during a declared emergency.

Through New Jersey law, the Department of Health and Senior Services (DHSS) and local boards of health are given the power to identify and determine specific diseases that may be addressed under the Emergency Health Powers Act. Specifically, DHSS can declare what diseases are communicable, when a communicable disease has become a perceived epidemic and require the reporting of certain communicable diseases. If there is a declared epidemic, the state will have the authority to maintain and enforce quarantine. Actions by DHSS can include removal of any person infected with a communicable disease to a suitable place, disinfecting premises when necessary and removal of all articles and items that, in the opinion of DHSS, could have been infected with the disease.

In simplest definitions:

- *Isolation* refers to persons who are known to be ill with a contagious disease.
- *Quarantine* refers to persons who have been exposed to a contagious disease but who may or may not become ill.[99]

The policies and procedures reflected on the following pages are drawn from experiences with infectious disease outbreaks including the SARS outbreaks in 2003 in Singapore and Toronto, where different strategies for implementation of quarantine were identified.

Careful planning in all of the following areas will assure that HR runs smoothly – and workforce shortage is minimized – under the extreme conditions of a pandemic.

[98] The New Jersey *Emergency Health Powers Act* can be accessed electronically at http://www.state.nj.us/health/flu/documents/plan/comm_app_5.pdf.

[99] These definitions were referenced from the Centers for Disease Control Web site at http://www.bt.cdc.gov/preparedness/quarantine/.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
A.	**Initial Planning**					
1	Review existing policies to see if they address: • Anti-viral prophylaxis • Attendance • Changes to job descriptions • Critical staff shortages • Cross-training • Education/training specific to pandemic flu • Incident command system training • Issues subject to collective bargaining • Resident/nurse ratios • Reassignment • Staff availability • Vaccine protection.					
2	Create an outline of immediate facility concern issues. Ensure this includes: • Compensation and benefits (e.g., sick time or paid time off (PTO) benefits; return to work policies; family leave/FMLA policies; death/bereavement policies; workers compensation, liability exposure.) • Independent contractor expectations (including financial implications for performance or lack of performance; changes in work rules; protection offered to independent contractors, such as anti-viral medications, masks.) • Labor and employee relations (e.g., waiving of work rule change procedures; grievance procedures; hazard pay, appeals for work reassignment; staffing ratios; shift lengths.) • Occupational health and safety (including strategies to maintain a safe work environment during a pandemic; social distancing; infection control practices.) • Organizational resiliency and resistance (e.g., practices to support employee attendance such as child care, elder care, pet care, assistance with family chores.)					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Recruitment, staffing and reassignment (e.g., using hotel maids as housekeepers; cafeteria/restaurant workers as food service employees; recalling retired staff; reassigning clinical staff in non-clinical jobs to resident care; managers to line worker positions.) • Regulatory and state requirements (including strategies to determine which regulations would be waived; a method to ask for waivers; procedures to comply with regulations during the changing conditions of a pandemic.) • Training, education and compliance (e.g., general awareness training; just-in-time training for new job assignments or new equipment; methods for assuring competency in new situations.)					
3	Determine which policies may differ based on union vs. non-union employees: • Attendance • Compensation • Cross-training • Grievances • Reassignment • Staff shortages • Work hours.					
4	Determine which policies and procedures may change based on the use of independent contractors for specific services.					
5	Establish/update employee contact information – update at least annually.					
B. Attendance						
	PLANNING					
1	Establish an expected rate of absenteeism and include as a planning consideration. • To calculate, use historical data and divide the average number of days lost due to unscheduled absence per employee by the					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	average number of work days per employee per month.[100] • Consider using "FluWorkLoss" software available through CDC.[101]					
2	Address insurance/ liability issues when determining emergency staffing alternatives to sustain critical operations. Consider the following: disability coverage, workers compensation, stop loss insurance and death benefits.					
3	Consider that the state department of health may place facility employees in isolation or quarantine. Plan for how this would be managed and what resources would be required to support staff.					
4	Explore any legal liability associated with imposing "working" quarantine policies. If such action poses too great a risk to the facility, explore alternative strategies.					
	POLICIES FOR CONSIDERATION					
5	Develop policy to address employee attendance expectations during a pandemic. Note policy exceptions such as ADA, FMLA or other state regulations. • Example: Employees are required to report to work with the exceptions of personal illness or required care of ill family members. Failure to do so may result in discipline, up to and including termination.[102]					
6	Develop policy to address "call-out" protocol. • Example: Employees must report absenteeism according to established protocol. Failure to do so may result in disciplinary action, up to and including termination.					
7	Develop policy to address pandemic shift length. • Example: Employees will not work a shift that exceeds 16 hours.[103]					

[100] This calculation can be expanded to address rates of absenteeism for individual departments and the facility as a whole.
[101] http://www.cdc.gov/flu/tools/fluworkloss/
[102] See the U.S. Department of Labor *Employment Law Guide* at http://www.dol.gov/compliance/guide/fmla.htm.
[103] See the New Jersey *Mandatory Overtime Restrictions for Health Care Facilities* booklet at http://lwd.dol.state.nj.us/labor/forms_pdfs/lsse/MW-379.pdf.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
8	Develop policy to address utilization of vacation, personal days and holiday time. • Example: Employees who do not report to work may be required to utilize vacation, personal days or unused holiday time unless otherwise on an approved leave. If there is no accrued time available for a non-exempt staff member, the time away from work may be leave without pay. • Example: Employees may have all vacation, personal time and any other planned absences, including staff holidays, suspended pending a return to normal operations. • Example: Employees that have experienced a death in their immediate families may request and be eligible for the facility's established bereavement leave; however, any existing bereavement leave may be subject to change.					
9	Develop policy to address issues regarding employees that have more than one job. • Example: Employees with multiple jobs may be required to sign a form indicating their commitment to (Name of Facility) in exchange for a commitment to provide employees with a specific number of hours not less than the total hours usually worked across multiple positions and/or provision of available medical countermeasures to employee and their family.					
10	Develop policy to address additional compensation or benefits to employees that work during a pandemic. • Example: Employees that work during a declared pandemic may receive additional compensation, e.g., bonus salary, extra vacation time, etc.					
11	Develop policy to address employee assistance during a pandemic. • Example: (Name of Facility) will have resources to assist employees with child care, elder care, general errands, pet care, etc.					
12	Develop policy to address staffing shortages.[104] • Example: (Name of Facility) may utilize resident family members and/or volunteers (through ESAR-VHP/MRC programs) for supportive clinical care.					

[104] For sample MOU, see Appendix: *Model Memorandum of Understanding Regarding Sharing of Personnel During a Disaster*

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
13	Develop policy to address staff that may be permitted to work remotely or at home. • Example: Pre-identified employees may be permitted to work from a remote location assuming workers compensation can be secured.[105]					
C.	**Work Schedules**					
PLANNING						
1	Identify <u>minimum</u> staffing requirements needed throughout the facility during a pandemic.					
2	Identify staff to be responsible for developing staffing plans (e.g., department director).					
3	Review pandemic staffing plans annually.					
4	Ensure consideration is given to individual religious beliefs, as it relates to work availability.					
5	Examine regulations regarding mandatory overtime. Exceptions should be identified. Seek a waiver of regulations regarding staffing and other regulations that affect staffing, if necessary.[106]					
6	Identify respite space for staff working overtime.					
POLICIES FOR CONSIDERATION						
7	Develop policy to address mandatory overtime. • Example: Employees will not be expected to work more than 16 hours in a 24-hour period, even during a declared state of emergency.					
8	Develop policy to address shift definitions in the event of a pandemic. • Check state and federal wage laws and acts, e.g., FFLA, the NJ Wage and Hour Act.					

[105] Sample telecommuting policies may be accessed electronically at http://www.employmentlawadvisors.com/resources/policies/telecommutingpolicy.html. *This information is copyrighted 2007 and used by NJHA with permission. All rights reserved. The Employer Advisors Network, Inc.*

[106] See the New Jersey *Mandatory Overtime Restrictions for Health Care Facilities* booklet at http://lwd.dol.state.nj.us/labor/forms_pdfs/lsse/MW-379.pdf

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Example: The facility may redefine a work day, work week and/or overtime in response to a public health emergency, in accordance with applicable state and federal wage laws.					
9	Develop policy to minimize staff exhaustion. • Examples: Outline a rotation cycle to minimize staff exhaustion; employees working extended hours will be provided respite time and areas to sleep, bathe and contact family members.					
D. Prophylaxis						
PLANNING						
1	Develop a priority strategy for the distribution of flu vaccine to facility employees.					
2	Evaluate the feasibility of providing flu vaccine to employees' household members, in accordance with public health policy.					
3	Develop a rapid delivery system to administer flu vaccine to facility employees and residents.					
POLICIES FOR CONSIDERATION						
7	Develop policy to address prophylaxis reception requirements. Examples: • If and when available, flu vaccine shall be provided to employees and employees' household members at the direction of public health authorities. • If and when available, flu vaccine will be provided only to employees that: ○ Have direct resident care responsibilities; and/or ○ Are part of an established high-risk group (e.g., immunodeficient, pregnant, etc.)					
8	Develop policy to address employees that refuse provided prophylaxis. Example: • An employee's refusal to accept a flu vaccine may result in reassignment, reduction in pay and/or unpaid leave if residents					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	and/or other employees are put at risk from contact with the employee. Exceptions will be made for employees where medication administration is contraindicated.					
E. Staff Assignment/ Reassignment						
PLANNING						
1	Conduct employee skill sets inventory for reassignment consideration. Update annually.					
2	Identify staff responsible for establishing job descriptions and responsibilities (e.g., department supervisors.)					
3	Identify and compile contact information for non-clinical staff that could receive just-in-time cross-training in supportive clinical functions.					
4	Develop bulleted job responsibility sheets for categories of workers (e.g. nurses, dieticians, etc.)					
5	Develop a priority list for reassignment and recruitment of employees/volunteers.					
PLANNING- Procedural Considerations						
6	Develop a process for rapidly credentialing newly recruited employees/volunteers, if appropriate.					
7	Establish mutual aid agreements and memoranda of understanding agreements with other facilities or corporations that have agreed to share their staff, as needed. [107]					
8	Review the Emergency Health Powers Act (P.L. 2005) to determine and address issues related to healthcare employees with out-of-state licenses.[108]					

[107] See sample Mutual Assistance Agreement at http://www.njha.com/ep/pdf/921201044621PM.pdf. *This document is used with the permission of the North Dakota Healthcare Association.*

[108] The New Jersey *Emergency Health Powers Act* can be accessed electronically at http://www.state.nj.us/health/flu/documents/plan/comm_app_5.pdf.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
9	Identify and address issues regarding application of workers' compensation and liability protection for individuals not employed by the facility. Any limitations in either protection under workers' compensation or liability should be communicated to the employee prior to assuming responsibilities. Review protections provided through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and Medical Reserve Corps (MRC) programs and understand the extent of those protections.					
	POLICIES FOR CONSIDERATION					
10	Develop policy to address employee reassignment. Examples: • Employees may be subject to reassignment to new positions, if necessary. • Employees in positions that are curtailed or stopped due to the pandemic may be reassigned to assist with other staffing shortages. • Continuity of facility operations will require staff to be flexible and redeployed based on need; this may require night shift or weekend work. Every attempt should be made to distribute shifts equitably. • Employees reassigned to other units will identify any skill deficiencies they may have to an appropriate person in charge. The staff member may receive just-in-time training or may be required to provide services based on their skill level.					
11	Develop policy to address reassignment of high-risk staff. • Example: Employees that have been identified as being members of a high-risk group (for example, employees that are immunocompromised or pregnant, among other conditions) will be given consideration, prior to reassignment. High-risk staff may include personnel that have a contraindication to medical countermeasures such as anti-viral medications or vaccine, are unable to safely wear a mask or respirator, or have some other medical condition that puts them at higher risk.					
12	Develop policy to address how reassignment requests are made. • Example: Priority will be given to direct resident care requirements, then to specific administrative requirements.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
13	Develop policy to address payroll issues for reassigned staff. • Example: Reassigned employees will continue to have their salaries charged to their home cost center during a pandemic, regardless of actual assignment during the crisis.					
F. Incident Command Training						
PLANNING						
1	• Identify employees who will function in leadership roles during a pandemic (e.g., administrators, emergency operations center staff, departmental directors, managers, etc.) Selected staff will require extensive Incident Command System (ICS) training.[109]					
2	• Incorporate ICS 100 and 700 training into new hire orientation for all new employees.					
3	• Implement ICS 100 and 700 training for all non-leadership staff.					
POLICY FOR CONSIDERATION						
4	Develop policy to address incident command training requirements. • Example: Pandemic leadership employees will complete ICS 100, 200, 700 and 800 training. All existing and newly hired staff will be required to complete ICS 100 and 200 training.					
G. Unions/Collective Bargaining						
PLANNING						
1	Review pandemic plans with unions, particularly with regard to operational considerations in relation to collective agreements, related legislative requirements and regulations.					

[109] For more information on ICS, including training, see http://www.fema.gov/emergency/nims/IncidentCommandSystem.shtm

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
2	Review policies that will differ for each union, due to the fact that they will need to be addressed in the union contract. Include attendance, work hours, reassignment, cross-training and compensation.					
3	Address concerns that unionized employees may be subject to different policies as they relate to reassignment.					
4	Prepare for involvement of unions in the facility's overall pandemic planning activities.					
5	Prepare for union expectations of "hazard pay." Consider the expectations of non-union employees if hazard pay is agreed upon for union members.					
6	Review and be prepared to continue to function within the terms and conditions of your existing union contracts. Careful planning will minimize the need to make decisions in the midst of the pandemic which may have union contract implications post-crisis.					
7	Prepare to respond to an increased number of grievances and workload complaints.					
8	Develop process to increase union communications throughout the pandemic.					
POLICIES FOR CONSIDERATION						
9	Develop policy to address disaster waiver clauses. • Example: During a declared state of emergency, the terms and conditions of a union contract will be suspended (with the exception of salary provisions) pending termination of the declaration. • Example: During a declared state of emergency, policies regarding attendance, work hours, reassignment, etc., will be subject to the policies reflected in the facility pandemic flu preparedness and response plan.					
10	Develop policy to address union inclusion in planning process. • Example: Each union will be permitted to designate one representative to serve on the facility's pandemic planning committee.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
11	Develop policy to address salary, wage and benefits concerns. • Example: Policies regarding salaries, wages and benefits will be determined and addressed in the facility's pandemic flu plan and will be applied uniformly to union and non-union employees.					
12	Develop policy to address facility expectations of unions. • Example: Union contracts should include policies that suspend the specific terms and conditions reflected in the contract and require compliance with policies and procedures developed specifically for pandemic flu.					
13	Develop policy to ensure communication during a pandemic. • Example: A designated union representative will be permitted to attend daily briefings within the facility's ICS. Union representatives can and are encouraged to communicate with their members with the assurance that the information communicated is consistent with the information provided at the daily briefing.					
H. Isolation and Quarantine						
PLANNING						
1	Educate employees to fully understand the purpose of the following quarantine options, as well as who has mandate authority: • *General quarantine* - People who have been exposed to an identified infectious disease will be housed in a specific area for a defined period of time. • *Home quarantine* - The purpose of home quarantine is to contain the spread of a communicable disease, as well as to facilitate the monitoring of people who have been in contact					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	with the disease. • *Work Quarantine* - Work quarantine allows some healthcare workers to continue to work at the facility where they were exposed as long as they remain well.[110]					
2	Provide employees with definitions[111] of the relevant terms related to isolation and quarantine, including: • Home isolation and quarantine • Facility isolation • Special isolation and quarantine facilities • Voluntary isolation and quarantine • Ordered isolation and quarantine • Detention (locked and guarded) isolation and quarantine.					
3	Determine how quarantine may be implemented in your area and at your facility**.** • Ask your public health officer for information regarding the circumstances under which voluntary or involuntary isolation and quarantine would be implemented.					
4	Develop policies and procedures to implement quarantine should it be ordered by the county commissioner of health.					
5	Identify and communicate to employees what services, if any, will be provided to employees whose movements have been restricted (e.g., food, medicine, etc.)					
6	Identify how to communicate information related to instructions and services to quarantined or isolated individuals.					
7	Develop contingency plan for the rapid isolation of individuals that become symptomatic at work.					
8	Develop checklists to assess active monitoring and return-to-work procedures.					

[110] Developed as a strategy to ensure continuity of services during the SARS outbreak, work quarantine restricts healthcare workers' travel between work and home only. Those subject to work quarantine must eliminate contact with the public, other than those they may come in contact with at the facility and those residing at home. This approach requires special considerations for the protection and care of family members at home who come into contact with the healthcare worker.

[111] See *Issues to Consider: Isolation & Quarantine*, National Association of County and City Health Officials, January 2006, which can be accessed electronically at http://biotech.law.lsu.edu/cases/pp/naccho-quarantine.pdf.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
9	Develop a template for employees on home quarantine to self-report their clinical condition.					
POLICIES FOR CONSIDERATION: Home Quarantine						
10	Develop policy to address necessary precautions/other requirements of healthcare workers under home quarantine. Example: Healthcare workers placed under home quarantine must follow the following guidelines: • Eat, drink, sleep and stay in a separate room in the house away from other household members during the whole period of quarantine. • Minimize direct contact with other household members. Wash hands thoroughly and use a facial mask if contact with other household members cannot be completely avoided (surgical masks will suffice, or simply a handkerchief). • Use separate eating utensils and dishes for meals, which should then be washed and immersed separately from other household members' utensils/dishes, using hot water with detergent. Similarly, wash clothes separately to avoid potential cross-contamination. • Do not share personal items, such as towels. • Take your temperature twice a day. If elevated or if flu-like symptoms appear, contact the employee health service immediately. • Force fluids, even if asymptomatic. • Remain in quarantine for the full required time or until released by health official.					
11	Develop policy to address compensation issues surrounding employees that are under home quarantine or isolation. • Example: <u>(Name of facility)</u> may provide some compensation and other financial support for employees unable to return to work because of an isolation/ quarantine order. Additionally, <u>(name of facility)</u> may provide temporary lodging, meals or reimbursement for other incidental expenses for employees that are quarantined.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
12	Develop policy to address reporting requirements. • Example: An employee placed in quarantine must report the status of his/her health condition on a daily basis and may not return to work until given clearance to do so.					
13	Develop process to monitor quarantined employees' conditions on a regular basis (e.g., daily phone calls).					
POLICIES FOR CONSIDERATION: Work Quarantine						
14	If work quarantine is imposed, ensure consideration is given to the following: • Facilities must be prepared to provide support for daily functional living, including providing food and other personal goods, if necessary. Recognizing that travel is restricted (travel is permitted between the facility and home), ensure availability of resources, such as fuel, to ensure employees can commute to and from work. • Ensure financial support is available to employees that are restricted from traveling to a bank. • Provide mental health support services to employees that experience anxiety, stress and fear, among other emotions. • Recognize the stigma that may be associated with individuals subject to work quarantine, or even to employees providing care to residents infected with the flu.					
15	Screen employees via health questionnaire and/or by taking body temperatures prior to the start of each shift to minimize inadvertent exposures.					
16	Consider providing employee commuter transportation to minimize interactions. Identify volunteers that may be willing to provide transportation service.					
17	Develop policy to educate healthcare workers under work quarantine. Example: Healthcare workers under work quarantine must follow the following guidelines: • When not at work, follow rules of home quarantine. • High-risk workers must wear N95 mask at all times while					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	at work. Proper hand hygiene also is critical. • Commute to work alone in a private vehicle, if possible. If riding with others, the quarantined healthcare worker should wear an N95 or surgical mask.[112] • Enter/exit the facility through a designated site; do not use public entrances or normal employee entrance. • Health monitoring for fever and other symptoms should take place before employees are allowed to enter the facility. Body temperatures should be monitored twice a day. [113]					
18	• Quarantined healthcare providers with offices in the community may be allowed to see residents in the facility under the following conditions: • They wear an N95 or surgical mask at all times while at the facility; and • They are diligent with proper hand hygiene.					
I. Employee Health						
PLANNING						
1	Consult with infection control department when developing training content and materials for staff.					
2	Establish training/education schedule for clinical staff. Utilize infection control updates and meetings, and other education opportunities for flu pandemic training.					

[112] Refer to CDC mask guidance for further information and ensure compliance with OSHA guidelines at www.osha.gov/SLTC/respiratoryprotection/index.html.
[113] The facility must determine appropriate person to facilitate such monitoring, e.g., public health or facility clinical staff.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
3	Implement and communicate basic hygiene[114] and social distancing precautions to all employees, volunteers and visitors, including: • Sick or symptomatic employees should be instructed to stay at home. • Employees must wash their hands frequently with soap and water, or use hand sanitizer if there is no soap or water available. Also, encourage your employees to avoid touching their noses, mouths and eyes. • Employees must cover their coughs and sneezes with a tissue, or cough and sneeze into their upper sleeves if tissues are not available. All employees must wash their hands or use a hand sanitizer after each cough, sneeze or nose blowing. • Employees should avoid close contact with their coworkers, residents and visitors, maintaining a separation of at least 6 feet. They should avoid shaking hands, and always wash their hands after contact with others. Even if employees wear gloves, they should wash their hands upon removal of the gloves in case their hand(s) became contaminated during the removal process. • Provide tissues and trash receptacles throughout the facility, as well as several places to wash or disinfect hands.					
PLANNING: Employee Return to Work Following Flu Diagnosis						
4	Consider if employees who recover from the pandemic flu strain should be preferentially assigned to work with current flu residents since they are likely immune. (Note: this may be difficult to determine in the midst of a pandemic as viral typing may not be readily available.)					
POLICY FOR CONSIDERATION: Employee Return to Work Following Flu Diagnosis						
5	Develop policy to allow employees to return to work. • Example: Employee must be asymptomatic for XX days prior to return to work. Additionally, employee must produce a					

[114] See http://www.cdc.gov/flu/protect/stopgerms.htm.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	doctor's clearance note or documentation from the employee health department to return to work.[115] • Example: In the event physicians or employee health staff are not available, employee may be subject to medical review upon returning to the facility. However, this is contingent on employee monitoring and reporting health status on a daily basis.					
	PLANNING: Employee Protection Issues Protecting employees is critical in sustaining clinical operations during a pandemic that will last for several months, particularly as staff's availability will depend on their belief that they are safe and that the organization considers their safety and well-being as a top priority. Toward this end, the Occupational Safety and Health Administration (OSHA) has developed extensive information and guidelines regarding Personal Protective Equipment (PPE) and respirators.					
6	• *Personal Protective Equipment (PPE)* – In addition to administrative and engineering controls and proper work practices, the use of PPE may also be indicated during certain exposures. Examples of PPE are gloves, goggles, face shields, N95 and surgical masks. It is important that PPE be: ○ Selected based on the hazard to the employee. ○ Properly fitted and periodically refitted (e.g., respirators). ○ Conscientiously and properly worn. ○ Regularly maintained and replaced, as necessary. ○ Properly removed and disposed of to avoid contamination of self, others or the environment. Monitor www.pandemicflu.gov for the latest guidance regarding PPE recommended for flu pandemic. The types of PPE recommended will be based on the risk of contracting flu while working and the availability of PPE.					
7	• *Respirators* – Respirators are designed to reduce an employee's exposure to airborne contaminants and are designed to fit the face and to provide a tight seal between the respirator's edge and the face. Suggested guidelines include: ○ Respirators must be used in the context of a comprehensive respiratory protection program.[116] ○ Medically evaluate employees to assure that they can					

[115] These policies may not be practical given the challenges posed by a pandemic; however, develop the policy and recognize that it may not be implemented or utilized if the state of emergency does not allow for such protocols.

[116] See OSHA standard 29 CFR 1910.134, or www.osha.gov/SLTC/respiratoryprotection/index.html.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	perform work tasks while wearing a respirator. Medical evaluation can be as simple as a questionnaire (found in Appendix C of OSHA's Respiratory Protection Standard, 29 CFR 1910.134). ○ Employers who have not previously considered a respiratory protection plan should note that it can take time to choose a respirator, arrange for a qualified trainer and provide use training, fit testing and medical evaluation for their employees. If employers wait until a pandemic actually arrives, they may be unable to provide an adequate respiratory protection program.[117]					
8	Develop a comprehensive PPE/respirators fit testing plan that includes emergency fit testing.					
9	Consider rest periods for mask-wearing staff. As it is harder to breathe while wearing an N95 mask, recognize that most employees will not be able to tolerate wearing one for their entire shift.					
POLICY FOR CONSIDERATION: Employee Protection Issues						
10	Develop policy to address employees that cannot utilize a respirator. • Example: Employees that are unable to utilize a respirator for legitimate reasons will be assigned to areas of the facility that have the least risk.					

[117] See *Guidance on Preparing Workplaces for an Influenza Pandemic,* OSHA 3327-02N, 2007 at http://www.osha.gov/Publications/OSHA3327pandemic.pdf.

FINANCE MODULE

An outbreak of pandemic influenza may result in a serious disruption in cash flow for all healthcare providers and health care-associated entities. It is crucial that facilities review existing financial policies and procedures and make appropriate adjustments in advance of such a crisis to ensure financial stability as a lack of financial resources would result in an inability to pay employees and vendors, making it difficult to sustain critical operations. Advance planning is the most effective way a facility can be confident in its ability to sustain operations both during and after a pandemic.

There are areas related to finance that are beyond the control of any one facility. For example, federal policies and procedures for processing claims and continuing payments will be implemented by the Centers for Medicare and Medicaid Services. A facility's financial crisis plan should address potential federal and state level payment disruptions.

Areas of strategic focus for effective financial planning should include:
- Cash-on-hand analysis
- Claims processing requirements
- Services reimbursement
- Payment from federal and state agencies
- Billing operations continuity
- Vendors' payments
- Lines of credit
- Payroll processing
- Recording of costs associated with a pandemic
- Current bond rating and potential bond rating following a pandemic.

In the sections that follow, a series of planning/policy tasks are broken down by essential financial expertise areas. They are discretionary and are representative of the issues that should be considered. These tasks include:
A. Operations – Internal
B. Operations – Federal/State Agencies
C. Operations – Health Plans
D. Billing and Claims Processing
E. Financial Institutions.

Careful planning in these areas will help minimize the financial burden facilities will experience under the extreme conditions of a pandemic.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
A.	**Operations- Internal**					
1	Determine operating costs on a daily, weekly and monthly basis for the prior 12-month period. Use data as a base to determine revenue that must be available for continuity of operations.					
2	Tabulate cash-on-hand. Determine how long operations can be sustained during a pandemic based on existing financial resources.					
3	Identify all current sources of income and consider how they may be affected (e.g., if medical record documentation is compromised and claims are submitted with less information than required by payers, reimbursement may be reduced.)					
4	Review all labor/union contracts to identify clauses that have financial implications during a declared emergency (e.g., bonus pay for hazardous work.)					
5	Obtain and review any Continuity of Operations Plans (COOP) from any group with which there is a service contract.					
6	Establish salary payments as a financial priority for the facility.					
7	Establish a policy to reduce employees' financial liability by lowering copayments when accessing non-network healthcare services.					
8	Develop continuity plan for payroll functions. Plan should address the following: • Will the usual process for approving time sheets be modified in the event a supervisor is not available? • Who will have access to payroll systems in the event primary staff are unavailable? • Will/can payroll be conducted from a remote site? • Have various methods for distributing payroll been considered? For example, employees may not be able to access bank direct deposits; will optional cash salary payments be available? • Will backup staff be able to print checks in the event primary staff are unavailable? • How will paper checks be distributed? Will department managers					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	collect and distribute to staff, or will they be distributed from a central location? • Should all employees be required to accept direct deposit? Is this possible?					
9	Develop a Web-based time and attendance system to allow employees and supervisors to record / approve time worked for payroll processing purposes.					
10	Contract in advance with an outside payroll vendor to ensure the ability to process payroll in the event the "in house" payroll system should become disabled. Utilize direct deposit whenever possible to eliminate the need for paper checks.					
11	Contact vendors about payment issues that may arise during a pandemic. Discuss possible remedies including: • Deferred payment • Partial payments • Credit.					
12	Contact the facility's insurance agent and review policies related to external events (e.g., rioting) that may occur and cause damage to the facility.					
13	Review the facility's insurance policies regarding coverage for the following: • Loss of income • Disability coverage for sick employees • Coverage for family members of employees • Death benefits • Legal liability for alternate standards of care • Legal liability for volunteers administering • Change in scope of practice.					
14	Monitor changes and waivers of requirements in the following government programs: • Medicare • Medicaid • SCHIP • HIPAA • EMTALA • Medicare certification of facilities • State licensure of facilities.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
15	Create and have readily available a mechanism to track used resources so that disaster relief funding may be requested immediately post-event.					
B.	**Operations- Federal/ State Agencies**					
1	Monitor UM and claims changes, waivers related to enrollment for public assistance and rules modifications for the following: • Medicare • Medicaid • HIPAA • Medicare certification of facilities.					
2	Identify methodology for communicating federal and state policy changes to remote billing/claims department(s).					
C.	**Operations- Health Plans**					
1	Review payer contracts to see if they include clauses that address utilization management and claims processing during emergencies. Determine which areas need to be suspended to address operations during a pandemic.					
2	Review expected reimbursement with payers to determine whether payment for services during a pandemic will be subject to a case rate, per diem, periodic interim payment or other reimbursement methodology and whether reimbursement will be based on severity. Agree on coding parameters.					
D.	**Billing and Claims Processing**					
1	Prioritize claim submissions. Consider submitting high-dollar claims first, or those that do not require extensive documentation.					
2	Reconcile existing periodic interim payment with the number of claims submitted and paid – or submitted and denied – to ensure accurate PIP payments during a pandemic.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
3	Determine availability of periodic interim payments from other payers to ensure continued cash flow in the event claims cannot be submitted.					
4	Review expected reimbursement with payers to determine whether payment for services during a pandemic will be subject to a case rate, per diem, periodic interim payment or other reimbursement methodology and whether reimbursement will be based on severity and include stop-loss provisions. Agree on coding parameters.					
E. Financial Institutions						
1	Identify all investments to determine amount of liquidity that could be accessed on short notice. Understand possible penalties for accessing the investment early.					
2	Contact banking agency about keeping a signature block and extra checks at its location.					
3	Develop plan for banking functions to be taken over by a remote bank office. • Consider whether bank is capable and prepared to take such action. If not, develop alternatives. • Know which bank location would take over and which staff at that location are responsible for working with you. Regularly verify 24/7 contact information. • Test the transfer of responsibilities as often as possible.					
4	Establish a line of credit with local banks, possibly with deferred payment, to temporarily provide cash flow if claims processing and billing is delayed. Complete and continuously update a loan application that could be executed on very short notice. Lines of credit should be accessible by both Web and telephone to access funds as needed.					
5	Keep a readily accessible file of all bond and rating agencies.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
6	Review bond covenants to determine consequences of default, such as an increase in interest rate. Determine the impact of potential consequences on facility's finances.					
7	Ensure the ability to access any "long term" investments and convert them to cash on short notice. Establish the ability to do so by Web and telephone as well.					
8	Ensure overdraft protection with banks along with the ability to transfer funds within accounts easily.					

LEGAL MODULE

Traditionally, when healthcare facilities engage in preparedness activities, they focus on operational preparedness; however, because the complex legal and regulatory framework in which healthcare facilities and providers operate will not "disappear" during a pandemic, it also is critical to focus on the requirements of these laws and regulations. Indeed, experiences with SARS and Hurricanes Katrina and Rita demonstrate that, while some laws and regulations are likely to be suspended or waived during a large scale disaster, the majority of legal and regulatory requirements are expected to remain in full force and effect. In addition, during a pandemic, facilities will have to comply with a host of additional state and federal laws and regulations. Therefore, "legal preparedness" is an essential component of an organization's overall pandemic preparedness activities.

Legal preparedness begins with risk mitigation. It is now widely accepted that healthcare facilities have a duty to prepare for disasters, including influenza pandemic. The failure to develop implementable plans, based on realistic assumptions, is likely to be a breach of this duty and expose healthcare facilities to liability. A key component of an implementable plan is compliance with all applicable laws and regulations. In addition to the myriad of laws with which they are already familiar, facilities also must understand the requirements and contours of the Public Readiness and Emergency Preparedness (PREP) Act; the Pandemic and All Hazards Act; the Federal Volunteer Protection Act; state emergency services laws; emergency health powers acts; quarantine and isolation laws; and Good Samaritan laws. This legal module has been designed to help readers understand not only which laws should be examined, but also the complexities and issues that these laws present for planning efforts.

In the sections that follow, a series of numbered planning tasks are broken down by type of legal issue and operational preparedness activity. The planning tasks walk the reader through the analysis of the relevant law and methods for complying with the law. The planning tasks are discretionary and are representative of the legal issues that should be considered by healthcare facilities.

These legal issues and operational preparedness activities include:

A. EMERGENCY HEALTH POWERS ACT

- Initial Planning
- Commandeering and Closure
- Healthcare Workers Issues
- Quarantine and Isolation

B. EMERGENCY SERVICES LAW

- Initial Planning
- Control, Use and Closure
- Providing Care and Volunteers

C. FACILITY LICENSURE AND REGULATORY ISSUES

- Initial Planning
- Surge Considerations: Licensure
- Surge Considerations: Certificate of Need Requirements
- Medicare Conditions of Participation
- Treatment and Disposition of the Dead

D. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- Initial Planning
- Specific Exceptions and Applications

E. STAFFING ISSUES

- Initial Planning
- Healthcare Provider Licensing Statutes and Regulations – Maximizing Delegable Duties
  - Unlicensed Personnel Performing Clinical Duties
  - Scope of Practice Issues Involving Licensed Healthcare Practitioners
- Provision of Scarce Countermeasures to Healthcare Facility Personnel
- Employee Screening By Healthcare Facilities
- Legal Considerations Related To Contractors
- Infrastructure for Decision Making During Disasters

F. CONTRACT ISSUES

- Initial Planning
- Supply Vendors
- Utilities
- Third Party Reimbursement Statutory and Regulatory Issues
- Third Party Reimbursement Payer Contract Issues

G. VOLUNTEERS

- Initial Planning
- Good Samaritan and Other Volunteer Protections
- EMAC and Other Mutual Aid Agreements

Where applicable, footnotes reference New Jersey law related to the planning task. This information is intended to serve as a helpful resource for counsel to review when advising a New Jersey nursing home on its legal preparedness. Counsel for nursing homes outside of New Jersey should substitute their own analysis of the applicable state's statutes and regulations when advising their clients.

This module is not offered as legal advice, and should not be viewed as a substitute for a facility consulting with legal counsel experienced in emergency and disaster law since each healthcare facility's situation is unique.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
A.	**Emergency Health Powers Act- *Initial Planning***					
	Most states have a set of statutes that govern preparedness, response and recovery for public health emergencies. In many of these statutes, the governor or state health officer (SHO) will be granted authority to declare a public health emergency and will be vested with certain powers as a result of the declaration. These statutes also may contain provisions related to the quarantine and isolation of contagious individuals. In some states, these statutes are collectively referred to as the Emergency Health Powers Act. In other states, these statutes do not have a specific title.					
	Emergency Declaration					
1	Review the state's Emergency Health Powers Act.[118]					
2	Identify if a pandemic can be declared a "public health emergency" under the Emergency Health Powers Act. [119]					
3	Identify who, under state law, has the authority to declare a public health emergency:[120] • Governor					

[118] The New Jersey Emergency Health Powers Act is located at N.J.S.A. § 26:13-1 et seq. (2008) and may be accessed electronically at http://www.state.nj.us/health/flu/documents/plan/comm_app_5.pdf. See also the *New Jersey Influenza Pandemic Plan* (June 2008), which summarizes the state's legal authorities during a pandemic in Section II. "Authorities" and Section IV. "Planning Assumptions," addressing in part how those powers will be used, available at http://www.state.nj.us/health/flu/panflu_plan.shtml.

[119] In New Jersey, a "public health emergency" is, among other things, caused by the appearance of a novel biological agent and poses a high probability of a large number of deaths, illness or injuries in the affected population (N.J.S.A. § 26:13-2 (2008)). A "biological agent" includes a virus that is naturally occurring. A pandemic caused by the influenza virus can be a public health emergency under New Jersey's Emergency Health Powers Act. Various provisions of the New Jersey Emergency Health Powers Act switch between use of the term "declared public health emergency" and "state of public health emergency." It is unclear whether this distinction has any significance, but healthcare facilities should consider seeking clarification from the Department of Health and Senior Services or the attorney general's office.

[120] Pursuant to New Jersey's Emergency Health Powers Act, the governor, in consultation with the commissioner of Health and Senior Services and the director of the State Office of Emergency Management, may declare a public health emergency. The governor must issue an order that specifies the nature of the public health emergency; the geographic area subject to the declaration; the conditions that have brought about the public health emergency; and the expected duration of the state of public health emergency (see N.J.S.A. § 26:13-3 (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• State health officer • Other					
4	Identify how a public health emergency is declared and whether legislative ratification is necessary.					
5	Identify what, if any, limitations are imposed on this authority (e.g., duration, geographic boundaries.)					
6	Determine how the healthcare facility will know that a declaration has been issued.					
7	Determine how the healthcare facility will obtain a copy of the declaration once it is issued.					
Emergency Powers and Rights						
8	Identify all provisions of the Emergency Health Powers Act that may impact the healthcare facility.					
9	Identify the scope of the SHO's preparedness power under the Emergency Health Powers Act.[121]					
10	Identify how these powers might impact a healthcare facility. Consider possible commandeering of the healthcare facility, seizure of medicines or medical supplies, etc.					
11	Ensure familiarity with the scope of all additional rights and powers granted to the governor, SHO or other governmental officials that are associated with the declaration of a public health emergency.					
12	Ensure an understanding of the healthcare facility's appeal rights to challenge specific governmental actions or orders granted under a public health emergency.					
Suspension of Laws and Regulations						

[121] Under the New Jersey Emergency Health Powers Act, if the governor declares an emergency in accordance with the Civilian Defense Act and Disaster Control Act (N.J.S.A. § App.A:9-33 et seq. (2008)), the governor is then authorized to exercise the powers granted to the commissioner pursuant to the Emergency Health Powers Act. To the extent that an influenza pandemic is both a declared public health emergency and a declared emergency under N.J.S.A. § App.A:9-33 (2008), it is unclear exactly who will be exercising the powers granted in the Emergency Health Powers Act – the governor or the commissioner.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
13	Identify if the Emergency Health Powers Act gives the SHO the authority to suspend state laws or regulations.[122]					
14	Identify what state laws or regulations the healthcare facility would have difficulty complying with during a pandemic, and whether they can be suspended, waived or otherwise modified.					
15	Develop procedures to enable the healthcare facility to immediately and appropriately respond to a request from the SHO or governor to identify laws or regulations hindering the healthcare facility's response efforts in case the government wishes to suspend them.					
16	Determine if other persons or agencies within the state government are granted additional rights and powers as a result of the declaration of a public health emergency.					
17	Identify how the rights and powers granted others could impact the healthcare facility.					
Interaction with Other Laws						
18	Identify how the Emergency Health Powers Act will interact with the Emergency Services Act, if applicable. [123]					
19	Identify how quarantine and isolation laws interact with the Emergency Health Powers Act, if applicable.					

A. Emergency Health Powers Act- *Commandeering and Closure*

The State Emergency Health Powers Act may authorize the government to commandeer or close healthcare facilities, as well as confiscate medicines, supplies and equipment. Healthcare facilities should carefully understand the processes for how such decisions will be made; how to appeal such orders; procedures for re-opening the facility; and how to seek appropriate compensation for governmental use or taking of property. Healthcare facilities must also develop strategies, such as securing business interruption insurance, to mitigate the effects of a closure or confiscation.

[122] The New Jersey Emergency Health Powers Act does not give the commissioner the explicit authority to suspend state laws or regulations, but it does direct him/her to "confer with the Commissioner of Banking and Insurance to request that the Department of Banking and Insurance waive regulations requiring compliance by a healthcare provider or healthcare facility with a managed care plan's administrative protocols, including but not limited to, prior authorization and pre-certification" (N.J.S.A. § 26:13-9(b)(5) (2008)). As a result, during a public health emergency it will be important for healthcare facilities to monitor the orders issued by the commissioner of NJDHSS and the commissioner of Banking and Insurance. In New Jersey, the commissioner of Banking and Insurance may have the ability to waive certain administrative regulations related to managed care plans (N.J.S.A. § 26:13-9(b)(5) (2008)).

[123] In New Jersey, the commissioner's response to a public health emergency is coordinated with the State Office of Emergency Management and in accordance with the State Emergency Operations Plan (N.J.S.A. § 26:13-3 (2008)). New Jersey nursing homes should be familiar with the Emergency Health Powers Act as well as the State Emergency Operations Plan.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
Closure of Facilities						
1	Identify who is permitted to close a healthcare facility under the Emergency Health Powers Act[124]: • Governor • State health officer • Local health officer • Other					
2	Identify if there is a process to appeal closure under the Act and, if so, the process for appeal. [125]					
3	Identify if an appeal will allow for a stay in the order to close.[126]					
Control of Facilities						
4	Identify who is permitted to take control of a healthcare facility under the Emergency Health Powers Act[127]: • Governor • State health officer • Local health officer • Other					
5	Identify if there is a process to appeal a governmental decision to assume control of a healthcare facility under the Act. If so, identify the process for appeal.[128]					

[124] In New Jersey, N.J.S.A. § 26:13-8 (2008) gives the commissioner the ability to close, direct and compel the evacuation of, or to cause to be decontaminated, any facility for "which there is reasonable cause to believe that it may endanger the public health." Within 24 hours of closure of the healthcare facility, the commissioner must provide the healthcare facility with a written order specifying the details of the closure.

[125] New Jersey nursing homes subject to a closure order may request a hearing in the Superior Court to contest the order. The Superior Court must hold the hearing within 72 hours of the request, excluding Saturdays, Sundays and legal holidays.

[126] It is unclear whether filing to contest the order stays the order. This is a point that should be clarified and understood by all healthcare facilities.

[127] In New Jersey, N.J.S.A. § 26:13-9 (2008) gives the commissioner the ability to take control of a New Jersey healthcare facility. The commissioner may require a healthcare facility to provide services or to use its facilities to respond to the public health emergency, "as a condition of licensure, authorization or the ability to continue doing business in the state as a healthcare facility."

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
6	Identify if an appeal will allow for a stay in the governmental order assuming control of a healthcare facility.					
7	Clarify who is responsible for continued operation post-seizure — the healthcare facility's current management or the government.[129]					
8	Clarify that, upon governmental seizure of the healthcare facility, the organization has no further liability for acts that occur during the period of seizure.					
Confiscate Supplies, Equipment or Medicines						
9	Identify who is permitted to confiscate a healthcare facility's supplies, equipment or medication under the Emergency Health Powers Act[130]: • Governor • State health officer • Local health officer • Other					
10	Determine if an appeal will allow for a stay in the governmental order to confiscate a healthcare facility's supplies, equipment or medication.					
Control of Persons						
11	Determine if the SHO has the authority to require licensed medical professionals to report for work.[131]					
Mitigation and Compensation						

[128] In New Jersey, the nursing home subject to an order to transfer management and supervision may request a hearing in the Superior Court to contest the order. The Superior Court must hold the hearing within 72 hours of the request, excluding Saturdays, Sundays and legal holidays.

[129] In New Jersey, the commissioner, after consultation with the management of the healthcare facility, may also transfer the management and supervision of the healthcare facility to the commissioner. In the event of such transfer, the commissioner must use the existing management of the healthcare facility.

[130] In New Jersey, N.J.S.A. § 26:13-11 (2008) gives the commissioner the power to purchase, obtain, store, distribute, or "take for priority redistribution" any vaccines, antibiotics, or other pharmaceutical agents or medical supplies "as may be reasonable and necessary to respond to the public health emergency." Moreover, even if the commissioner does not take possession of the supplies, the commissioner has the ability to issue and enforce orders to ration and allocate supplies to respond to a shortage or threatened shortage of the supply. In making these rationing decisions, the commissioner may give "preference to healthcare providers; disaster response personnel; mortuary staff; and such other persons as the commissioner deems appropriate in order to respond to the public health emergency."

[131] In New Jersey, N.J.S.A. § 26:13-18 addresses the emergency powers of the commissioner over healthcare personnel.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
12	Determine if there is any mechanism for compensation if the state closes or commandeers a healthcare facility.					
13	Determine if the healthcare facility has business interruption insurance.					
14	Determine the process for regaining control or re-opening the healthcare facility after a pandemic.					
15	If the SHO has the ability to commandeer the healthcare facilities and/or its supplies, or can require people to report to work, identify the compensation that is available to the healthcare facility and/or employees.[132]					

A. Emergency Health Powers Act- *Healthcare Worker Issues*

Healthcare workers are a critical resource during public health emergencies. The State Emergency Health Powers Act gives government the right to require that healthcare workers in the state assist in the response to a public health emergency. Healthcare workers are compelled to assist and are given liability protections in return for their activities planning for and responding to a public health emergency. Healthcare volunteers are another critical resource available to states to help meet surging demands for medical services during an emergency. Healthcare facilities should familiarize themselves with the rights and duties of workers during a declared public health emergency.

Duty to Report to Work

1	Identify if the Emergency Health Powers Act gives the SHO the authority to require licensed medical professionals to report to work.[133]					
2	Identify if the Emergency Health Powers Act authorizes license revocations, fines or detention for healthcare providers who disobey public health officials' orders to work during a pandemic.[134]					
3	Evaluate the impact of any collective bargaining agreements on the SHO's authority to require licensed medical professionals to report to work. See HR module.					

[132] In New Jersey, if the commissioner invokes these powers, the nursing home will be entitled to the payment of reasonable costs from the State Public Health Emergency Claim Reimbursement Board in accordance with N.J.S.A. § 26:13-24, 25 (2008). The specifics of how "reasonable costs" are calculated are not clear.

[133] In New Jersey, N.J.S.A. § 26:13-18 (2008) gives the commissioner the ability to "require in-state healthcare providers to assist in the performance of vaccination, treatment, examination or testing of any individual" during a public health emergency. Pursuant to the same statute, an in-state provider who is required by the commissioner to assist in the response to the public health emergency will not be liable for any civil damages arising out of the care provided in good faith.

[134] The New Jersey Emergency Health Powers Act does not appear to impose sanctions on those providers who refuse to work during a public health emergency.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
Providing Care in a Healthcare Facility Setting						
4	Determine if the Emergency Health Powers Act provides any liability protection or immunity for persons providing care in a healthcare facility setting during a pandemic.[135]					
5	Identify the parameters and limitations of any protections offered under the Emergency Health Powers Act to persons providing care in a healthcare facility setting.					
6	Identify if protections offered under the Emergency Health Powers Act to persons providing care is limited to volunteers or also covers persons who are paid for their services.					
7	Identify if the protections offered are limited to those persons licensed to deliver the type of care they are providing during an emergency.					
Use of Volunteers						
8	Identify if the state's Emergency Health Powers Act provides for registration of volunteers.[136]					
9	Determine if volunteer workers will be available to healthcare facilities, or whether they will be used solely by the state in its pandemic response.					
10	Develop policies and procedures for incorporating healthcare volunteers into the healthcare facility's emergency response plan.					
11	Prepare for spontaneous unsolicited volunteers to self-deploy to the healthcare facility; have a mechanism to redirect them to the local or state incident manager.					

A. Emergency Health Powers Act- *Quarantine and Isolation*

The authority to order the quarantine or isolation of individuals, groups or geographic areas during a public health emergency is an important tool in addressing infectious diseases, especially during the early stages of a pandemic. The Centers for Disease Control and Prevention (CDC) has recognized that quarantine and isolation were effective tools in the 1918 pandemic. The White House's *National Strategy for Pandemic Influenza Implementation Plan* (2006) recommends the early

[135] N.J.S.A. § 26:13-6(g) (2008) contains immunity from civil damages for volunteer emergency healthcare workers; public health workers; and support service personnel registered as a volunteer under this section and providing medical care or treatment related to the public health emergency.

[136] N.J.S.A. § 26:13-6 (2008) provides a registration mechanism for volunteer healthcare workers, public health workers and support services personnel.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
and aggressive use of social distancing strategies, including quarantine and isolation, in a pandemic. The use of quarantine and isolation, however, raises significant legal and operational concerns for a healthcare facility, its employees, residents and the larger community. Healthcare facilities must clearly understand who has the authority to issue quarantine and isolation orders; the scope of persons or areas subject to an order; and the rights to appeal quarantine and isolation orders. Delivering and enforcing quarantine and isolation orders will require the facility to evaluate its rights and responsibilities relative to public health officials and law enforcement. Healthcare facilities should develop operational protocols for dealing with residents subject to quarantine or isolation. Healthcare facilities should further evaluate their HR policies and legal obligations to employees required to work with residents or in facilities subject to quarantine or isolation orders.						
Authority for Quarantine/Isolation (Q/I) and Scope						
1	Locate the state's quarantine and isolation (Q/I) laws, which may be found in various places such as the Emergency Health Powers Act; a communicable disease statute or section; or in a stand-alone code section.[137]					
2	Determine how the Q/I laws interact with the State Emergency Health Powers Act and State Emergency Services Act regarding the restriction of healthcare workers who have been or may have been exposed to an infectious disease.[138]					
3	Identify who has the authority (e.g., governor and/or SHO) to issue an order of Q/I for an individual.[139]					
4	Identify if Q/I orders have to be issued only for individuals, or if they can be for groups of individuals.[140]					

[137] New Jersey laws related to Q/I during a "state of public health emergency" can be found at N.J.S.A. § 26:13-15 (2008). The general provisions for communicable disease give the Department of Health and Senior Services and the local boards of health the power to "maintain and enforce proper and sufficient quarantine, wherever deemed necessary" (N.J.S.A. § 26:4-2 et seq. (2008)). See also Communicable Disease regulations at N.J.A.C. § 8:57-1.1 et seq. and the *New Jersey Influenza Pandemic Plan* (June 2008), Section VII.H. "Community Disease Control and Prevention" which addresses the state's plan for using quarantine and isolation, as well as other community disease control measures.

[138] In New Jersey, the Civilian Defense Act and Disaster Control Act (N.J.S.A. § App.A.9:33 et seq. (2008)) interact with the Emergency Health Powers Act.

[139] During a state of public health emergency in New Jersey, the commissioner of NJDHSS may "issue and enforce orders for the isolation or quarantine of individuals subject to the procedures specified in this section" (N.J.S.A. § 26:13-15(a)(2) (2008)).

[140] In New Jersey the commissioner may either issue or seek issuance of an order of Q/I for an individual or a group of individuals, identified by name(s) or shared characteristics that give rise to the order (N.J.S.A. § 26:13-15(e)(2)(a) (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
5	If Q/I orders can be for groups of individuals, determine how the groups are defined.					
6	Identify the bases or grounds on which an individual or group can be quarantined or isolated.[141]					
7	If a healthcare facility can be quarantined, determine whether that means that no one can enter or leave the premises for the duration of the quarantine.[142]					
8	If a healthcare facility can be quarantined, identify on what grounds and for how long.					
9	Identify the process for obtaining an order of Q/I to ensure that the order has been issued properly.[143]					
Delivery of Q/I Orders						
10	Identify the process for serving or delivering the Q/I order on an individual.[144]					
11	If the person to be served the Q/I order is a resident in your facility, determine how the Q/I order will be delivered to the resident.					
12	If the Q/I order must be served on the resident to be effective, determine if law enforcement officers or others serving Q/I orders plan to use PPE to mitigate the server's potential risk of exposure. If not, establish PPE protocols for officials serving orders in the					

[141] In New Jersey, the commissioner may either issue or seek issuance of an order of Q/I for an individual or a group of individuals, identified by name(s) or shared characteristics that give rise to the order (N.J.S.A. § 26:13-15(e)(2)(a) (2008)).

[142] In New Jersey, the Q/I statute does not specifically say that a facility can be quarantined. It speaks primarily in terms of persons. However, the statute empowers the commissioner to "designate, including an individual's home when appropriate, and establish and maintain suitable places of isolation and quarantine" (N.J.S.A. § 26:13-15(a)(1) (2008)).

[143] The New Jersey process for issuing a Q/I order is found in N.J.S.A. § 26:13-15(e) (2008).

[144] The New Jersey statute provides that "a copy of the authorizing order shall be provided to the person ordered to be isolated or quarantined, along with notification that the person has a right to a hearing pursuant to paragraph (5) of this subsection" (N.J.S.A. § 26:13-15(e)(3) (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	facility.					
13	Determine if public health agencies will attempt to deputize healthcare facility workers to deliver Q/I orders on residents; evaluate how this will impact the ability to deliver care.					
Enforcement of Q/I Orders						
14	Identify the state statute(s) addressing the process for enforcing Q/I orders.[145]					
15	Determine who has the authority to enforce the Q/I order, and who is expected to enforce the order.					
16	Determine if the healthcare facility has the legal authority to enforce the order of Q/I by detaining the resident if he/she tries to leave.					
17	If the healthcare facility does not have the authority to detain a resident who is subject to the Q/I order, identify if law enforcement or someone else with such authority will remain with the Q/I resident at all times.					
18	Determine if the healthcare facility is expected to notify law enforcement or public health officials if the Q/I resident leaves the healthcare facility.					
19	Determine if it is considered malpractice not to enforce a Q/I order and, if so, whether this action would be covered under a professional liability insurance policy.					
20	If a public health official directs a healthcare facility to enforce Q/I orders and prevent the departure of infected individuals, and a					

[145] Under the New Jersey Emergency Health Powers Act, of which the Q/I statutes are a part, "the commissioner shall have the power to enforce the provisions of this act through the issuance of orders and such other remedies as are provided by law" (N.J.S.A. § 26:13-27 (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	healthcare facility fails to do so, determine if the healthcare facility will be liable for anyone who becomes sick as a result and how causation will be proved.					
21	If a resident must be detained in isolation due to an infectious condition, identify who is responsible for assuring that the resident does not leave isolation.					
22	Should some physical force be necessary to assure that residents in isolation do not leave the isolation facility, determine who, if anyone, will be responsible for physically restraining the isolated residents to prevent them from leaving.					
23	Determine if there will be sufficient numbers of law enforcement officials to physically prevent isolated residents from leaving.					
24	Identify if there are any liability protections for those who enforce orders of Q/I, including healthcare facility personnel if they are permitted or expected to do so.					
Legal Requirements to Host Persons Under Q/I						
25	Determine whether the state law grants the governor or SHO the power to compel healthcare facilities to shelter a person under Q/I.[146]					
26	If a healthcare facility must give shelter to a person under Q/I, identify if a distinction is made between a resident who presented to the healthcare facility for treatment, or who became a resident solely under the authority of the order of Q/I.					
Third-Party Payer Issues						

[146] In New Jersey, the commissioner *may* have the power to require a nursing home to shelter a person who is subject to quarantine or isolation. Specifically, the statute says that the commissioner has the power to "designate…and establish and maintain suitable places of isolation and quarantine" (N.J.S.A. § 26:13-15(a)(1) (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
27	If a person is in the healthcare facility solely as a result of a Q/I order, determine whether a third-party payer will deny payment because the care arises from a court order and not a healthcare provider's determination of medical necessity.					
28	If a third-party payer will not cover the cost of care for a person in the healthcare facility solely as a result of a Q/I order, determine who will be responsible for payment.					
29	If a person is in the healthcare facility solely as a result of a Q/I order, determine whether a third-party payer will suspend case management processes.					
Appealing a Q/I Order						
30	Understand that persons subject to Q/I orders generally have the right to a hearing before a court, either before or after imposition of the order.[147]					
31	Identify the process for appealing an order of Q/I should the order cover the healthcare facility's employees or members of key departments and the healthcare facility wants to challenge or modify the order to allow the person(s) to continue working.					
32	If the person appealing the Q/I order is a resident, determine what the courts and public health officials expect the facility to provide in this situation. Assess whether these expectations are consistent with the capabilities of the facility.					
33	Identify whether the healthcare facility has any right to appeal an order to house a person solely because they are subject to a Q/I					

[147] The commissioner must seek a written Q/I order – which may be *ex parte* – from the Superior Court authorizing the order (N.J.S.A. § 26:13-15(e)(g)(3) (2008)). "The court shall grant a hearing within 72 hours of the filing of a petition when a person has been isolated or quarantined pursuant to paragraph (3) or (4) of this subsection" (N.J.S.A. § 26:13-15(e)(5)(g) (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	order.					
Duty to Notify Public Health Officials						
34	Identify what, if any, duties (statutory, regulatory or otherwise) the healthcare facility has to notify public health officials about potential threats and recommend Q/I for residents or staff.[148]					
35	If the healthcare facility does not notify public health officials regarding residents or staff who may need Q/I, assess whether the facility is exposing itself to potential liability.					
Healthcare Facility Authority to Issue Q/I Orders for Residents						
36	Identify if the facility has the authority to issue an order of Q/I for residents to prevent them from leaving the premises or the specific isolation area.[149]					
37	If a facility is authorized to issue a Q/I order for a resident, determine under what circumstances such an order is permitted and the legal process required to obtain and enforce the Q/I order.					
Healthcare Facility Authority to Issue Q/I Orders for Staff						
38	Identify if the healthcare facility has the authority to issue an order of Q/I to prevent a staff person from leaving the facility premises or					

[148] The New Jersey Emergency Health Powers Act requires healthcare providers (which includes healthcare facilities) to report to the department and local health officials all cases of persons who "harbor or are suspected of harboring any illness or health condition that may reasonably considered to be potential causes of a public health emergency" (N.J.S.A. § 26:13-4(b) (2008)).

[149] The New Jersey Emergency Health Powers Act does not address whether a healthcare facility has the authority to issue an order of quarantine or isolation. While a nursing home may place a resident in an isolation room, it does not have the authority to hold the resident there against the resident's will.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	the facility's isolation area if it has been determined that the staff member has contracted the virus.[150]					
39	If a healthcare facility is authorized to issue a Q/I order for staff, determine who will issue such an order; under what circumstances such an order is permitted; and the legal process required for obtaining and enforcing the Q/I order.					
Work Quarantines						
40	Identify if the healthcare facility is authorized to issue "work quarantine" restrictions (like those used in the Toronto SARS epidemic) in which staff are prohibited from going any place other than work and home.					
41	Determine if there are any laws that would inform work quarantine restrictions or whether this would be considered a facility policy.					
42	Determine if a healthcare facility can require that an employee observe work quarantine restrictions, and how such restrictions will be enforced.					
43	If a healthcare facility can use work quarantine, determine if the facility is required to provide employees with essential goods (e.g., groceries) that they cannot get because they are not allowed to leave the house except to go to work.					
44	Determine how the employee will be compensated for the period under a work quarantine restriction.					
45	If a healthcare facility can issue orders of quarantine or work quarantine restrictions for employees, assess whether these orders or policies expose the healthcare facility to liability for:					

[150] Under the New Jersey Emergency Health Powers Act, there are no provisions that would give the healthcare facility the authority to unilaterally issue a "work quarantine" order. The commissioner could potentially issue a "work quarantine" order by describing the "work quarantine" in the terms and conditions section of the order.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Lost wages • Defamation (damage to reputation from being under quarantine) • Intentional infliction of emotional distress (to force employee to stay at home with family, not knowing if they are sick or can give illness to family may be emotionally trying.)					

B. Emergency Services Law- *Initial Planning*

Each state has a set of statutes that grant the governor the authority to declare a state of emergency or a disaster when circumstances warrant. After declaring a disaster or emergency, the governor – and potentially others within the state's executive branch – is vested with additional responsibilities, rights and powers that will allow him/her to respond to the disaster most effectively and efficiently. In many states, these statutes are collectively referred to as the Emergency Services Act. In some states, however, this is not the case. For example, the New Jersey Emergency Services Act of 1972 (N.J.S.A. § 52:14E-1 et seq. 2008) describes the authority of the Governor's Advisory Council for Emergency Services and the use of the Emergency Services Fund; however, the Civilian Defense Act and Disaster Control Act (N.J.S.A. § App.A:9-33 et seq. 2008) contains the statutes related to the governor's authority to declare an emergency and the powers that flow from such a declaration.

Emergency Declaration

1	Identify and review the state's Emergency Services Act.[151]					
2	Identify whether a pandemic can be declared an "emergency" under the Emergency Services Act.[152]					
3	Identify who under state law has the power to declare an emergency.[153]					
4	Identify the mechanisms for and pre-requisites to declaring an emergency.[154]					

[151] The New Jersey Emergency Services Act is located at N.J.S.A. § App.A:9-33 et seq. (2008).

[152] Pursuant to N.J.S.A. § App. A:9-33.1 (2008), a "disaster shall mean any unusual incident resulting from natural or unnatural causes which endangers the health, safety or resources of the residents of one or more municipalities of the state, and which is or may become too large in scope or unusual in type of be handled in its entirety by regular municipal operating services." Under this same statute, an "emergency" includes a "disaster." A pandemic caused by an influenza virus can be both a disaster and an emergency.

[153] N.J.S.A. § App. A: 9-40.5 (2008) grants the municipal emergency management coordinator the ability to proclaim a state of local disaster or emergency within his/her municipality. Under N.J.S.A. § App. A: 9-51 (2008), the governor has the authority to proclaim an emergency.

[154] In New Jersey the municipal emergency management coordinator can proclaim a state of local disaster or emergency when a disaster has occurred or is imminent in his/her municipality (N.J.S.A. § App. A: 9-40.5 (2008)). The governor can proclaim an emergency when, "in his/her opinion, the control of any disaster is beyond the capabilities of local authorities" (N.J.S.A. § App. A: 9-51 (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
5	Determine how the healthcare facility will know that a declaration has been issued and obtain a copy of the document.					
6	Identify all provisions of the Emergency Services Act that may impact the healthcare facility.					
7	Understand the processes and procedures that are in place for a healthcare facility to respond to the governor's exercise of power under the Emergency Services Act.					
Suspension of Laws						
8	Identify if the Emergency Services Act gives the governor the authority to suspend laws and regulations.[155]					
9	Identify what state laws or regulations the healthcare facility would have difficulty complying with during an emergency.					
10	Seek to include those suspension provisions into draft emergency declarations that are being prepared for the governor.					
Interaction with Other Laws						
13	Determine if other persons or agencies are granted additional rights and powers as a result of the declaration that could impact the healthcare facility.[156]					

B. Emergency Services Law- *Control, Use and Closure*

State emergency management laws may authorize the governor to take control of healthcare facilities, equipment, medicines and supplies, as well as compel licensed health professionals to report to work during a declared public health emergency. Healthcare facilities should carefully understand the processes for issuing and appealing such orders, and procedures for re-opening the facility and recouping the value of property taken or used. Healthcare facilities must develop strategies, such as securing business interruption insurance to mitigate the effects of a closure or confiscation.

Closure of Healthcare Facilities

[155] In New Jersey the governor may suspend regulatory provisions of law, the enforcement of which would be detrimental to the public welfare during preparations for emergencies, or the threat or imminence of danger in an emergency (N.J.S.A. § App. A: 9-47 (2008)).The governor also has the power to make orders, rules and regulations necessary to address the various problems presented by an emergency (N.J.S.A. § App. A: 9-45 (2008)).

[156] In New Jersey the municipal emergency management coordinator, in accordance with regulations promulgated by the state director of emergency management, has authority to issue and enforce orders to "carry out emergency management operations and to protect the health, safety and resources of the residents of the municipality" (N.J.S.A. § App. A: 9-40.5 (2008)). Such orders could impact healthcare facilities within the municipality.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Identify if the governor or another delegated official is permitted to close a healthcare facility under the Emergency Services Act. [157]					
2	Identify if there is a process to appeal closure under the Act and, if so, what is the process for appeal.					
3	Identify if an appeal will allow for a stay in the order to close.					
Control of Persons						
4	Identify if the governor has the authority to require licensed medical professionals to report for work.[158]					
Control of Healthcare Facilities						
5	Identify if the governor or another delegated official is permitted to take control of the healthcare facility under the Emergency Services Act.					
6	Identify if there is a process to appeal a governmental decision to assume control of a healthcare facility under the act. If so, identify the process for appeal.					
7	Identify if an appeal will allow for a stay in the governmental order assuming control of a healthcare facility.					
8	Clarify who is responsible for continued operation post-seizure – the healthcare facility's current management or the government.					
9	Clarify that, upon governmental seizure of the healthcare facility, the organization has no further liability for acts that occur during the period of seizure.					
Confiscate Supplies, Equipment or Medicines						
10	Identify if the governor or another delegated official has authority to confiscate a healthcare facility's supplies, equipment or medication under the Emergency Services Act.[159]					

[157] The New Jersey Emergency Services Law (N.J.S.A. § App. A: 9-34 (2008)) gives the governor the authority to commandeer and utilize any personal services and any privately owned property necessary to avoid or protect against any emergency subject to reasonable compensation.

[158] New Jersey law does not explicitly address the governor's authority to require licensed medical professionals to report to work.

[159] Presumably, under the authority cited, the Governor could commandeer a healthcare facility's property, including supplies, equipment and medication, during an emergency (N.J.S.A. §§ App. A:9-34 and 9-51 (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
11	Identify if there is a process to appeal a governmental order to confiscate a healthcare facility's supplies, equipment or medication under the act. If so, identify the process for appeal.					
12	Identify if an appeal will allow for a stay in the governmental order to confiscate a healthcare facility's supplies, equipment or medication.					
Mitigation and Compensation						
13	Determine if there is any mechanism for cooperation if a healthcare facility is closed or commandeered.					
14	Determine if the healthcare facility has business interruption insurance and, if so, the extent of coverage and policy limits.					
15	Determine the process for regaining control or re-opening the healthcare facility after a pandemic.					
16	If the governor has the ability to commandeer the healthcare facility and/or its supplies, or require people to report to work, identify the compensation that is available to the healthcare facility or employees.[160]					
B. Emergency Services Law- *Providing Care and Volunteers* The State Emergency Services Act provides liability protections for healthcare professionals volunteering in a declared public health emergency. Healthcare facilities should familiarize themselves with the rights and duties of healthcare workers during a declared public health emergency.						
1	Determine whether, and to what extent, the Emergency Services Act provides liability protection for persons providing care in a healthcare facility during a pandemic.[161]					
2	Evaluate whether liability protection is limited to volunteers, licensed providers or any other specific group of persons.[162]					
3	Identify any gaps in liability protections and determine if gaps can be addressed by regulation and emergency orders, or if they will					

[160] In New Jersey, with respect to personal services compensation "shall be paid at the prevailing established rate for services of a like or similar nature" (N.J.S.A. § App. A:9-51 (2008)).

[161] The New Jersey Emergency Services Law (N.J.S.A. § App. A: 9-52 (2008)) provides immunity protections.

[162] N.J.S.A. § App. A:9-52 (2008) provides immunity for agents or representatives of the state, including all volunteers, who in good faith carry out, comply with or attempt to comply with any order, rule, or regulation promulgated pursuant to N.J.S.A. § App. A: 9-30 et seq. (2008), or who perform authorized services. This statute does not appear to give immunity to private actors like healthcare providers, unless they are acting under direct orders from the governor.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	require an amendment to the law.					
4	Identify whether and to what extent immunity is available for healthcare facilities giving the government use of their property in responding to the pandemic.					
5	Determine whether the Emergency Services Act allows for out-of-state licensed healthcare providers to come into the state to provide care in a healthcare facility. If so, determine the responsibilities of the healthcare facility regarding tracking and reporting of volunteers' activities.					

C. Facility Licensure and Regulatory Issues- *Initial Planning*

Healthcare is heavily regulated at the state and federal level. While healthcare facilities are well aware of these legal requirements and operate in compliance with numerous regulations every day, many have not considered how they will operate in compliance with these requirements during a pandemic. Although healthcare facilities should continue to seek regulatory relief, a basic planning assumption should be that the legal requirements remain in full force and effect, even in the midst of a pandemic.

1	Identify any legal provisions that require a healthcare facility to have an emergency operations plan, including but not limited to Joint Commission requirements.					
2	Understand how failure to have a plan or other possible violations of these legal requirements will impact the healthcare facility's licensure status.					
3	Even if not specifically legally mandated, evaluate the liability risk for negligent failure to prepare if the healthcare facility does not have a comprehensive emergency preparedness and response plan.					
4	Create a list of those statutes and regulations for licensure or permits with which it may be difficult to comply during an emergency.[163]					
4a	Identify any legally mandated staffing ratios for long-term care					

[163] The New Jersey Standards for Licensure of Long-term Care Facilities (N.J.A.C. 8:39) may be accessed electronically at http://www.state.nj.us/publicadvocate/home/reports/pdfs/NursingHomeRegs.pdf.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	facilities.					
4b	Identify any legal mandates regarding the maximum number of residents in a room.					
4c	Identify any legal requirements regarding the location of nursing home beds that would otherwise prevent the placement of beds in areas that are not resident rooms (e.g., conference rooms, procedure rooms, cafeteria.) Consider licensed bed capacity and life safety fire codes.					
4d	Identify any legal requirements regarding services that residents must be offered.					
4e	Identify regulatory reporting requirements that are considered "routine" in normal times but which could be difficult to meet during a pandemic due to severe staffing shortages.					
5	Understand how non-compliance with these statutes and regulations during a pandemic will impact the healthcare facility's ability to continue operations, and how it might expose the facility to administrative fines or penalties or other types of liability.					
6	Once the list of statutes and regulations is compiled in accordance with Item 4, determine whether any can be suspended or modified during a pandemic.					
C. Facility Licensure and Regulatory Issues- *Surge Considerations: Licensure* Surge planning is an important component of a healthcare facility's overall pandemic preparedness activities. Because surge planning involves the introduction of additional beds, facilities should consider licensing and other regulatory issues associated with surge.						
1	Determine if the nursing home has, or is required to have, a written surge capacity plan.					
2	Identify the agency responsible for oversight of the healthcare facility's surge plan.					
3	Determine if and when the licensing agency should be notified if the nursing home increases its number of beds through implementation of the facility's surge plan.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
4	Consider whether notification should be given before or after the beds are put into service and whether the duration of service is relevant.					
5	If notification is necessary, create a notification plan that may include a template notification.					
6	If the nursing home notified the licensing agency when it implemented its surge beds, consider implementing a mechanism to notify the same agency of the decommissioning of surge beds.					
7	Determine whether "surge beds" have to be licensed by the state and, if they do, understand the process for such licensure.					
8	Identify the reimbursement mechanisms for these surge beds and consider the impact on reimbursement if the beds are not licensed by the state.					
9	Identify any legal requirements regarding obtaining a Certificate of Need to create surge capacity.					

C. Facility Licensure and Regulatory Issues- *Surge Considerations: Certificate of Need Requirements*

Certificate of Need (CN) programs regulate a healthcare provider's ability to introduce new or expand existing services by requiring approval from the state before such actions are taken. To the extent that a healthcare facility is planning to expand bed capacity or other services as part of its surge plan, it may require a CN that could impact the effectiveness of the facility's surge strategy.

1	Determine whether the state has a Certificate of Need (CN) program and identify the applicable statutes and regulations.					
2	Identify any CN requirements that could inhibit a nursing home's ability to continue or discontinue services during a pandemic.					
3	Identify any CN requirements related to reduction in the number of staffed beds.					
4	Identify any CN requirements for increasing the number of beds. To the extent that such requirements exist, determine whether they are applicable to surge beds. If they are applicable to surge					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	beds, determine whether the requirements can be suspended during a pandemic since typical CN processes do not yield rapid determinations.					
5	Identify any services that the nursing home may want to begin providing during a pandemic for which a CN is required.					
6	Identify any services that the nursing home may want to expand during a pandemic for which a CN is required.					
7	Understand the mechanisms for expedited review if the nursing home may need a CN to discontinue or implement services during a pandemic.					

C. Facility Licensure and Regulatory Issues- *Medicare Conditions of Participation*

The Centers for Medicare and Medicaid Services (CMS) requires nursing homes to meet certain conditions to participate in federal healthcare programs such as Medicare and Medicaid. Some of these conditions of participation (CoPs) will be difficult to meet during an emergency or disaster. Under Section 1135 of the Social Security Act, the Secretary of Health and Human Services may waive compliance with some of these CoPs, but it is difficult to predict whether such a waiver will be forthcoming, or the scope of the waiver if one is issued. As a result, nursing homes should begin to identify any such CoPs now and must consider the legal and regulatory impact on their facility for failure to comply with CoPs. This section addresses the legal issues related to long-term care facility CoPs.

1	Identify the basic conditions of participation (CoPs) for a long-term care facility and the services it provides. See http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr483_01.html					
2	Assess which CoPs are most likely to pose a compliance challenge during a pandemic.					
3	Identify any penalties to the facility for failing to comply with CoPs during a pandemic.					
4	Determine whether submission of a claim during a pandemic requires a certification that the facility is in compliance with all CoPs.					
5	Evaluate the potential liability that could result from a certification of compliance during an emergency when the facility is not in compliance with all CoPs.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
6	Develop a process for obtaining and evaluating the impact of any Section 1135 waiver that is issued by the Secretary of Health and Human Services.					
C. Facility Licensure and Regulatory Issues- *Treatment and Disposition of the Dead*						
If the next pandemic is as severe as the influenza pandemic of 1918, it could result in the death of approximately 1.9 million people, many of whom will die in a healthcare facility. Nursing homes need to be prepared to handle the increased volume of deaths in compliance with all applicable laws.						
Jurisdiction of the State Medical Examiner						
1	Determine whether deaths in the nursing home related to pandemic influenza will be under the jurisdiction of the state medical examiner (SME).[164]					
2	To the extent that such deaths will be under the jurisdiction of the SME, understand the process for reporting the deaths.					
3	Initiate discussions with the SME regarding handling large volumes of deaths in a manner that complies with the law but does not compromise facility operations.					
Applicable Statutes and Regulations						
4	Identify the statutes and regulations that govern death of persons in the nursing home. Consider that in the early stages of a pandemic, it may be unclear if the deaths are from natural causes, the first wave of a pandemic or bioterrorist attack.					
5	Determine who within the healthcare facility has the authority to pronounce a death.					
6	Determine how and when a death certificate is executed.[165]					

[164] Pursuant to N.J.S.A. § 52:17B-86 (2008), a medical examiner shall conduct an investigation when, among other things, a death occurs within 24 hours of admission to a hospital or institution or results from a cause that might constitute a threat to public health. When thinking about pandemic influenza, these two causes of death will bring all pandemic influenza deaths in the healthcare facility under the jurisdiction of the medical examiner's office.

[165] Pursuant to N.J.S.A. § 26:6-8 (2008), "within a reasonable time, not to exceed 24 hours after the pronouncement of death, the attending, covering or resident physician or the county medical examiner shall execute the death certification."

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
7	Identify requirements related to notification of family members.					
8	Identify the requirements regarding disposition and handling of the deceased in the nursing home. Note any statutes or regulations that require compliance with the burial customs of specific religions.					
9	Identify any statutes or regulations that relate to disposition and handling of remains during a pandemic.[166]					
10	Evaluate how a pandemic will impact a healthcare facility's ability to comply with the relevant statutes and regulations.					
11	Identify any statutes or regulations that should be modified or suspended during a pandemic because they will impair a healthcare facility's ability to respond to the pandemic effectively and efficiently.					
12	Determine whether the statutes and regulations governing other parties who handle the deceased (e.g., SME, funeral directors) will impact the healthcare facility's ability to handle the deceased.[167]					
Liability						
13	Determine the potential for liability exposure for failure to comply with applicable statutes and regulations.[168]					
14	Evaluate the potential liability to third parties that can arise in connection with the handling of remains. Consider claims for negligent or intentional infliction of emotional distress, claims					

[166] During or in response to a public health emergency, N.J.S.A. § 26:13-7 (2008) controls the handling and disposing of human remains.

[167] If all pandemic influenza deaths come under the jurisdiction of and must be investigated by a county medical examiner, the county and state medical examiner's offices may become quickly overwhelmed. The sheer volume of cases may impede the offices' ability to take control of bodies in a timely manner, thus leaving nursing homes in the position of having to store these bodies for longer amounts of time than they are accustomed.

[168] Failure to report a death caused by the reasons set forth in N.J.S.A. § 52:17B-86 (2008) (see Item 1) is a misdemeanor (N.J.S.A. § 52:17B-90 (2008)). Persons who fail to comply with the applicable statutes and regulations for the disposal of remains under N.J.S.A. § 26:6-8.4 (2008) can be subject to a fine of up to $1,000 for each violation of the act.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	based on property rights, negligent mishandling of a corpse and violation of requirements to respect religious customs.[169]					

D. HIPAA- *Initial Planning*

During an emergency, including a pandemic, healthcare facilities should assume that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will remain in full force and effect; therefore, all uses or disclosures of protected health information (PHI) must be HIPAA compliant. Information will have to be shared quickly during an emergency. As a result, healthcare facility counsel should be familiar with the HIPAA exceptions that apply during an emergency and those that do not.[170] Healthcare facilities must also be familiar with their state's privacy laws and understand their interaction with HIPAA.

1	Identify the state privacy laws regarding medical information.[171]					
2	Determine whether the state privacy law pre-empts HIPAA in the applicable areas discussed in this section because the state law is more protective.					
3	Identify those uses and disclosures of PHI that will be necessary during a pandemic outside of treatment, payment and healthcare operations. Consider uses and disclosures related to public health activities, notification of family members, responses to general inquiries about a resident's status and sharing of information for response coordination.					
4	Identify all HIPAA exceptions that may apply to the use or disclosure of PHI during a pandemic.					
5	Be familiar with the Office of Civil Rights' HIPAA emergency planning tool available at: http://www.hhs.gov/ocr/hipaa/decisiontool.					
6	Examine the healthcare facility's existing HIPAA policies to determine whether they allow the healthcare facility to share information pursuant to the applicable HIPAA exceptions.					

[169] New Jersey "has recognized a quasi property right in the body of a dead person. '[I]t is now the prevailing rule that the right to bury the dead and preserve the remains is a quasi right in property, the infringement of which may be redressed by an action in damages'" (*Strachan v. John F. Kennedy Memorial Hospital*, 109 N.J. 523, 531 (N.J. 1988) quoting *Spiegel v. Evergreen Cemetery Co.*, 117 N.J.L. 90, 93 (Sup.Ct.1936)).

[170] See *Sharing Information During Disasters: HIPAA Implications* at http://www.troutmansanders.com/files/upload/Sharing_Information_During_Disasters-HIPAA_Implications.pdf.

[171] For New Jersey, see N.J.S.A. § 26:2H-12.8 (2008) and N.J.A.C. § 13:35-6.5 (2008).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
7	Amend policies and procedures to the extent necessary to account for the use of the applicable HIPAA exceptions during a pandemic.					
8	Amend policies and procedures with respect to the creation of HIPAA accounting disclosure logs to take into consideration the fact that a public health authority may request ongoing access to medical records of all residents treated for pandemic influenza.					
9	Review (and amend, where appropriate) existing business associate agreements to account for disclosures that may be necessitated by a pandemic.					

D. HIPAA- *Specific Exceptions and Applications*

There are various exceptions to HIPAA that may apply during a pandemic to enable healthcare facilities to share protected health information more easily. Healthcare facilities should incorporate the application of these exceptions into their planning process.

Treatment, Payment and Healthcare Operations						
1	Be familiar with the scope of "treatment" and how it may expand the types of allowable uses and disclosures in a pandemic. Consider that treatment includes not only sharing information with other providers, but also sharing with others who help coordinate resident care (e.g., emergency relief workers).					
Required by Law						
2	Understand the application of the "required by law" HIPAA exception, 45 CFR § 164.512(a) (2008).					
3	Identify the state laws regarding reporting of communicable diseases.[172]					
4	Determine whether influenza is a reportable disease under the state law identified in Item 3.[173]					

[172] N.J.A.C. § 8:57-1 et seq. (2008) contains regulations related to reportable diseases.

[173] New Jersey's list of reportable diseases can be found in N.J.A.C. § 8:57-1.3 (2008). While influenza is not specifically listed as a reportable disease, "any outbreak or suspected outbreak" of a disease is included in the list.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
5	Develop HIPAA compliant policies, procedures and mechanisms for complying with the mandatory state reporting laws identified in Item 3.					
Public Health Activities						
6	Understand the application of the "public health activities" HIPAA exception.					
7	Determine which entities within the state are "public health authorities," as that term is defined in regulation.					
8	Understand the healthcare facility's ability under HIPAA to inform an individual or others, such as family members or employers, that the individual may have been exposed to a communicable disease, 45 CFR § 164.512(b)(1)(iv) (2008).					
9	Determine if and how the healthcare facility will conduct HIPAA compliant notifications of exposure during a pandemic.					
Averting a Threat to Health or Safety						
10	Understand the application of the "averting a threat to health or safety" HIPAA exception, 45 CFR § 164.512(j) (2008).					
National Security						
11	Understand the application of the "national security" HIPAA exception, 45 CFR § 164.512(k)(2) (2008).					
Facility Directory						
12	Understand the application of the "facility directory" HIPAA exception, 45 CFR § 164.510(a) (2008).					
13	Determine whether existing healthcare facility policies regarding operation of the facility directory will be sufficient during a pandemic, or whether they should be amended to account for the expected increased call volume.					
Notification						

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
14	Understand the application of the "notification" HIPAA exception, 45 CFR § 164.510(b) (2008).					
15	Determine whether the healthcare facility is going to partner with any disaster relief organization to help identify, locate and notify disaster victims' family members.					
Section 1135 Waiver						
16	Understand the process for obtaining, and the impact of, a Section 1135 waiver by the Secretary of Health and Human Services with respect to the application of HIPAA during a pandemic.					
17	Determine how the healthcare facility will obtain a copy of a Section 1135 waiver if one is issued.					
18	Determine who will carefully review the Section 1135 waiver to understand its implications.					
19	Develop processes for implementing any changes allowed by a Section 1135 waiver.					

E. Staffing Issues- *Initial Planning*

In the *New Jersey Influenza Pandemic Plan* (June 2008), the state estimates the following impacts of a pandemic on communities and in healthcare facilities: "Depending on the severity of the disease, absenteeism is expected to reach 30%-50% in all sectors of the work force as the pandemic progresses. More specifically, widespread illness in communities will increase the likelihood of sudden and potentially significant shortages of personnel in sectors that provide critical community services (e.g., police, fire fighters, school staff, utility and transportation workers). In addition, shortages of healthcare workers are anticipated as they would be at higher risk of exposure and illness than the general population, which would further strain the healthcare system."

1	Consider the impact of each of the following federal laws on the healthcare facility's pandemic preparedness plan.					
1a	Americans with Disabilities Act, 42 U.S.C. § 12101 et seq. (2008)					
1b	Fair Labor Standards Act,29 U.S.C. § 201 et seq. (2008)					
1c	Family and Medical Leave Act, 29 U.S.C. § 2601 et seq. (2008)					
1d	National Labor Relations Act, 29 U.S.C. § 151 et seq. (2008)					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1e	Title VII of Civil Rights Act of 1964, 42 U.S.C. § 2000e et seq. (2008)					
1f	Occupational Safety and Health Act, 29 U.S.C. § 651 et seq. (2008)					
1g	Worker Adjustment and Retraining Notification Act, 29 U.S.C. 210l, et seq. (2008)					
2	Consider the impact of each of the following state laws on the healthcare facility's pandemic preparedness plan: • Wage and Hour laws[174] • Workers' Compensation laws[175] • Anti-Discrimination laws[176] • Medical Leave laws[177]					

E. Staffing Issues

Maximizing Delegable Duties: *Unlicensed Personnel Performing Clinical Duties*

During a pandemic it may be necessary for non-clinical personnel to take on additional clinical duties that are not part of their daily practice. Healthcare facilities should determine how, if at all, to use non-clinical personnel for certain clinical duties in light of the 30-40 percent absenteeism rates predicted during a pandemic.

1	Identify the clinical activities that the healthcare facility may delegate to unlicensed personnel during a pandemic to mitigate the impact of staffing shortages. Consider activities like taking vital signs, assisting with toileting activities and transfers.					
2	Identify any statutes and regulations that allow or prohibit the clinical activities identified in Item 1 from being delegated to unlicensed personnel.					

[174] See N.J.S.A. § 34:11-56a et seq. (2008) and N.J.A.C. § 12:56 et seq. (2008).
[175] See N.J.S.A. § 34:15-1 et seq. (2008); N.J.S.A. § 34:15-43 (2008); N.J.A.C. § 12:235–1.1 et seq. (2008).
[176] See N.J.S.A. § 10:5-12 (2008).
[177] See N.J.S.A. § 34:11B-1 et seq. (2008).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
3	Determine whether the healthcare facility's policies inhibit the ability to assign the clinical tasks identified in Item 1 to unlicensed personnel.					
4	Determine whether additional policies are necessary to allow the healthcare facility to delegate the activities identified in Item 1 to unlicensed personnel during a pandemic.					
5	Determine whether the licensed provider may be held liable for the acts or omissions of the unlicensed personnel and whether insurance coverage is available for this liability.[178]					
6	Analyze whether the healthcare facility's insurance policies will cover any liabilities associated with unlicensed personnel performing clinical duties.					

E. Staffing Issues

Maximizing Delegable Duties: *Scope of Practice Issues Involving Licensed Healthcare Practitioners*

During a pandemic, it may be necessary for licensed healthcare practitioners to take on additional duties that are not part of their daily practice and that may either be outside the scope of duties permitted by the nursing home's policies and procedures, or even outside the scope of practice as defined by relevant licensing laws. Nursing homes may need to determine how to use licensed personnel to the fullest extent by maximizing delegable duties, while avoiding placing these individuals and the residents to whom they provide care in harm's way.

1	Identify how existing facility policies restrict providers' scope of practice.					
2	Determine whether the facility's policies are more restrictive than the statutory and regulatory scope of practice.					
3	Determine whether additional policies are necessary to allow the healthcare facility to maximize delegable duties during a pandemic.					

[178] In New Jersey, the applicable supervising board may also revoke a license if the licensee permits an unlicensed person to perform an act for which a license is required (N.J.S.A. § 45:1-21(n) (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
4	Understand the statutes and regulations that restrict a licensed provider's scope of practice and any limitations on delegation of duties.					
5	Be familiar with each agency or board that is responsible for setting the scope of practice for each type of licensed healthcare provider in the healthcare facility.					
6	Identify the penalties for a licensed provider who practices outside his scope of practice.					
7	Determine what actions a licensed healthcare provider may be asked to perform during a pandemic that are not part of that provider's normal activities and whether such actions are properly within the provider's scope.					
8	Review the state's Pandemic Influenza Response Plan to determine if it discusses the ability of providers to provide services that are not part of their normal activities.					
9	Assess whether requiring a provider to practice outside the scope of the license would constitute a liability risk under applicable state law.					

E. Staffing Issues- *Provision of Scarce Countermeasures to Staff*

The term "countermeasures" is used to describe those actions and supplies that can be used to help protect individuals against infection with the pandemic influenza virus. Nursing homes will have some medical and non-medical countermeasures, like medications and PPE, available to protect their personnel against infection with the pandemic influenza virus. These countermeasures are likely to be limited in supply and may have to be allocated according to a priority distribution list established by the facility. Providing a select group of personnel with a benefit that is not available to others causes understandable anxiety on the part of counsel. Care must be taken to assure that allocation decisions are based on objective criteria related to the ability of the nursing home to sustain operations so that it can respond to the pandemic.

Initial Planning Considerations

1	Identify any federal or state prioritization schemes for countermeasures.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
2	Presumably, the healthcare facility will only want to provide countermeasures to employees who agree to report to work during a pandemic. Consider how the healthcare facility will do this.					
3	If any employees are covered by collective bargaining agreements, review agreements to determine if the healthcare facility can require attendance in exchange for access to countermeasures.					
Discrimination Analysis						
4	Determine whether the allocation plan will withstand a discrimination allegation.					
5	Consider the criteria used to determine who receives the countermeasure and who does not, and determine whether any of these criteria violate federal anti-discrimination laws.					
6	Consider the criteria used to determine who receives the countermeasure and who does not, and determine whether any of these criteria violate state anti-discrimination laws.[179]					
Liability Considerations						
7	Consider any liability the healthcare facility could face for allocating countermeasures according to a scheme difference from that proposed by the federal or state government.					
8	Identify any liability that a healthcare facility could face if the countermeasures are unsuccessful and an employee becomes ill.					
9	Consider whether an employee who misuses the countermeasure, becomes ill and sues the healthcare facility can be barred from recovery based on contributory negligence.					

[179] See N.J.S.A. § 10:5-12 (2008).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
10	Determine whether employees who are provided with countermeasures should be asked to sign a waiver of liability and whether it would be enforceable under state law.					
11	Draft a waiver of liability, if appropriate.					
12	Determine whether such a waiver is enforceable under state law.					
13	Discuss with state government whether an emergency declaration could include liability protection for healthcare facilities that provide countermeasures, but employees still become ill.					
14	Understand the Public Readiness and Emergency Preparedness (PREP) Act, which is a part of the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act of 2006, Pub. L. 109-148.					
15	Determine whether the PREP Act provides any liability protection for injuries caused by the countermeasures provided by the healthcare facility both before and during a pandemic.					
16	Be familiar with the declaration under the PREP Act designating the pandemic influenza A (H5N1) vaccine as a covered countermeasure, 72 FR 4710.					
Employee Family Members						
17	Determine whether the nursing home will provide countermeasures to employees' family members.					
18	Determine whether the nursing home will charge family members for the countermeasures.					
19	Determine if the provision of medical countermeasures to employees' family members can be covered under the nursing home's health plan.					
20	Consider whether family members who receive countermeasures should sign a waiver of liability.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
21	Draft a waiver of liability, if appropriate.					
22	Determine whether such a waiver is enforceable under state law.					

E. Staffing Issues- *Employee Screening*

During a pandemic, it will be important to ensure that personnel infected with the pandemic influenza virus do not report to work. To help ensure this, some facilities will screen employees at the beginning of each shift to identify symptoms or a history that would suggest infection. Because the information collected during the screening is health information, it may be protected by state and federal privacy laws. These laws must be understood so that facilities can design screening programs that are compliant with applicable laws.

Initial Planning

1	Determine the purpose(s) for employee screening.					
2	Determine the mechanism for employee screening.					
2a	Identify the location and times for screenings.					
2b	Identify those who will perform screenings (clinician vs. non-clinician; employed vs. contractor vs. volunteer; in-house vs. out-source; self-report.)					
2c	Determine whether and what type of training screeners will receive.					
2d	Determine what type of information will be collected during screenings (e.g., presence of physical symptoms and/or contact history.)					
2e	If the screener will inquire about contact history, determine what type of contact will trigger action (e.g., protected v. unprotected contact; close v. casual.)					
2f	Determine how screening records will be kept and for how long.					
2g	Identify those actions that will be taken when a screener finds a symptomatic individual or an individual whose contact history suggests infection.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
3	Identify any state laws regarding an employer's ability to require a medical screening or examination of an employee and determine whether the healthcare facility's screening mechanism is compliant with these laws.[180]					
Privacy of Information Collected During Screening						
4	Determine whether information collected during the screening is protected health information (PHI) under HIPAA or state law.					
4a	Consider the method of collection – self-report versus collection by a screener.					
4b	If a screener is used, consider whether the screener is a clinician or a non-clinician, employed or not employed by the healthcare facility.					
4c	Consider the type of information collected.					
5	If the information is PHI, consider whether a notice of privacy practices (NPP) will have to be delivered and consent will have to be obtained at the screening.					
6	If the information is PHI, consider whether there are any exceptions to HIPAA that are applicable to the use or disclosure of the information.					
6a	Consider the exception that allows a covered entity to provide PHI to an employer regarding an employee, 45 CFR § 164.512(b)(1)(v) (2008).					
7	Determine whether the information collected during the screening is protected under state privacy and confidentiality laws.					
8	Analyze the use and disclosure of screening information to ensure compliance with HIPAA, if applicable, as well as applicable state laws.					

[180] N.J.S.A. § 34:11-24.1 (2008) contains requirements related to medical examinations requested by employers.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
9	Even if the information is not protected under state or federal law, determine whether it is personal information that should be given the same level of confidentiality that is given to other personnel records.					
Liability Associated with Screening						
10	Analyze the healthcare facility's liability for "under screening" – failing to identify an infected person when it should have detected the infection.					
11	Analyze the healthcare facility's liability for "over screening" – categorizing a person as infected when they are not. Consider liability associated with defamation and lost wages.					
12	Consider whether outsourcing screening services may mitigate liability for the healthcare facility.					
E. Staffing Issues- *Legal Considerations Related to Contractors* Certain individuals contract to provide specific services at healthcare facilities. During a pandemic this status may pose certain challenges for both the nursing home and the contractor which must be appreciated and taken into account in pandemic preparedness plans.						
1	Identify healthcare facility personnel who are contractors and the services they provide.					
2	Determine whether a contractor's services will be needed during a pandemic.					
3	To the extent that a contractor does not work exclusively for the facility, determine whether the contractor's duties at the facility will take precedence over the contractor's other obligations during a pandemic. If the healthcare facility desires such precedence, consider amending the contractor's agreement to require it.					
4	Review all contractor agreements to determine whether there are any provisions that clearly require a contractor to continue providing services in the event of a pandemic at the discretion of the nursing home. If these provisions do not exist, consider					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	amending the agreements to incorporate them.					
5	Identify any provisions in contractor agreements that would provide an excuse for non-performance.					
6	Evaluate if a contractor's compensation can be reduced if it is a monthly fixed fee and the contractor fails to perform all services.					
7	Evaluate the healthcare facility's potential liability if a contractor is infected while performing services at the facility. Consider liability under the terms of the agreement and the potential non-applicability of workers' compensation.					
8	To the extent that contractors will be asked to serve on triage committees or otherwise allocate scarce resources, determine whether they are covered by the nursing home's insurance policy.					
9	If it is determined that contractors are not covered for their roles on triage committees or for the allocation of scarce resources, consider whether it is advisable or desirable to offer incentives to contractors by ensuring that they are so covered.					

E. Staffing Issues- *Infrastructure for Decision Making During Disasters*

Healthcare facilities should have in place an effective incident command structure to be used in the event of an emergency. In 2004, the Department of Homeland Security released the National Incident Management System (NIMS) as required by Homeland Security Presidential Directive (HSPD) 5-Management of Domestic Incidents and HSPD-8 Preparedness. NIMS provides a consistent nationwide template for federal, state, tribal and local governments and private sector/nongovernmental organizations to work together effectively and efficiently to prepare for, prevent, respond to and recover from domestic incidents, regardless of cause, size or complexity, including acts of catastrophic terrorism. NIMS benefits include a unified approach to incident management; standard command and management structures; and emphasis on preparedness, mutual aid and resource management.[181]

Incident Command Structure (ICS)

[181] Excerpted from *NIMS Compliance – Overview* available at: http://www.fema.gov/emergency/nims/faq/compliance.shtm.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Determine if there are any liability protections available for those making decisions under ICS, including: • Malpractice or other liability insurance through the employer • Indemnification by employer • Sovereign immunity through the state • Any other statutory or common law liability protections.					
2	Identify and assess the potential consequences and liabilities if an employee fails to follow the ICS and as a result causes harm. Consequences and liabilities may include: • Liability through the employer (e.g. termination or reprimand) • Civil liability • Criminal liability.					
NIMS Compliance[182]						
3	If the healthcare facility is required to be NIMS compliant, assess whether it has completed the NIMS activities that were required as of Sept. 30, 2008.					
4	Determine whether the healthcare facility has maintained sufficient documentation related to required NIMS training.					
5	If the healthcare facility is not NIMS compliant, but is required to be, determine what aspects are deficient and identify the reasons for the deficiencies.					
6	Identify the penalties for failing to be NIMS compliant.					
7	Identify whether failing to be NIMS compliant has any impact on the healthcare facility's reimbursement from federal payers (e.g., Medicare, Medicaid, CHAMPUS.)					
8	Understand the relationship between NIMS and the Incident Command System (ICS) or Nursing Home Incident Command System (NHICS).					

[182] See http://www.fema.gov/emergency/nims/compliance/assist_non_govt.shtm.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
F. Contract Issues- *Initial Planning*						
1	Identify the various contracts and agreements to which the nursing home is a party.					
2	Understand that a pandemic is predicted to occur in multiple waves over a period of 12 to 18 months, so contracts for a wide variety of goods and services are "critical."					
3	Review state laws and regulations for provisions that address suspension of a nursing home's, healthcare provider's or third-party payer's obligation to meet certain contract provisions during a pandemic.					
4	Identify staff that will be responsible for ensuring contractors meet their contractual obligations to the facility.					
F. Contract Issues- *Supply Vendors*						
1	Identify any provisions in contracts with vendors that may be applicable to a pandemic or emergency scenario.					
2	Identify any provisions in vendor contracts that would either require the vendors to continue performance during a pandemic or provide them with an excuse for non-performance.					
3	Determine what, if any, legal recourse the nursing home would have if a supplier fails to deliver supplies during a pandemic. Consider emergency services laws, the terms of the contract and any applicable state laws.					
4	Assess whether the nursing home has legal recourse against vendors who fail to perform during a pandemic. Consider the reason for failure to perform (e.g., closed roads vs. vendor's employees do not want to deliver to the nursing home during a pandemic); this may affect the legal recourse available.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
5	Identify any MOUs that the nursing home has entered into with other healthcare facilities related to regional sharing or allocation of supplies during a pandemic.					
6	Determine if any of the supply MOUs are applicable during a pandemic.					
7	Because the nursing home may experience disruption in reimbursement during a pandemic, determine if the facility can amend its agreements with vendors to allow for delayed payment during a pandemic.					
8	Identify or create contract language that requires vendors to continue performing, even if the nursing home cannot pay in accordance with the contractual payment terms during a pandemic.					
9	Determine if the nursing home has any legal duty to protect the health of vendors who come to the healthcare facility to deliver supplies during a pandemic.					
10	Determine if the nursing home has a duty to inform vendors of the potential risks associated with making deliveries to the facility during a pandemic.					
11	Identify procedures and practices that could minimize the risks to vendors making deliveries to the facility during a pandemic.					
12	Identify the impact on a vendor's obligation to perform if the nursing home has been quarantined or is located within an area that has been quarantined.					
F. Contract Issues- *Utilities*						
1	Identify how the nursing home will maintain utility services during a pandemic.					
2	Determine if the facility will likely need to expand any of its utility services during a pandemic, such as expanding the number of telephone lines to accommodate a dramatically increased call volume or increasing Internet capabilities if employees will be telecommuting.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
3	Once the utilities requiring surge capacity during a pandemic have been identified, the facility should engage in discussions and negotiate agreements now with those utilities to provide for that surge capacity.					
4	Determine if the facility will be liable for failure to sustain operations due to the lack of essential utilities during a pandemic. Conduct an analysis for each utility the facility uses.					
5	Determine if the nursing home's potential liability for failure to sustain operations due to the lack of essential utilities during a pandemic will be mitigated if the facility has a plan for the utility failure.					
6	Determine if the liability for utility failure depends on whether the facility has exhausted its plan for the utility failure (e.g., used all five days worth of bottled water reserve and is in day six of a water shortage.)					
7	Determine if the healthcare facility has any written contracts with utility companies for the provision of services.					
8	Identify any provisions in contracts with utilities that would either require the utilities to continue performance during a pandemic or provide them with an excuse for non-performance.					
9	Determine whether the nursing home has any recourse against the utility company for failure to provide services.					
10	Because the healthcare facility may experience disruption in reimbursement during a pandemic, determine if the healthcare facility can amend its agreements with utilities to allow for delayed payment during a pandemic.					
11	Identify or create contract language that requires utilities to continue performing, even if the nursing home cannot pay immediately during a pandemic.					
12	Determine if the nursing home has any legal duty to protect the health of utility employees who come to the facility to make service calls during a pandemic.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
13	Determine if the nursing home has any duty to inform the utility employees of the potential risks associated with making service calls to the facility during a pandemic.					
14	Identify procedures and practices that could minimize the risks to the utility employees making service calls at the facility during a pandemic, including the procurement of medical and non-medical countermeasures.					
15	To the extent that a utility provider must come to the nursing home to perform a task, identify the impact on a utility's obligation to perform if the facility has been quarantined or is located within an area that has been quarantined.					

F. Contract Issues- *Third-Party Reimbursement Statutory and Regulatory Issues*

During a pandemic, healthcare facilities must maintain a revenue stream to continue operating and providing healthcare services. Failure to maintain an adequate revenue stream may expose nursing homes to liability for, among other things, failure to meet contractual obligations to employees, vendors, contractors and other service providers. Federal and state statutes and regulations govern the manner in which third-party payers are required to process and pay claims for healthcare services provided to members of private health plans, as well as those provided to individuals covered under state and federal healthcare programs. Continued payment from third-party payers during an emergency is essential. Nursing homes must be familiar with these laws and regulations and must understand what, if anything, may change with regard to payment from third parties during an emergency. This section addresses the legal issues surrounding third-party reimbursement.

Initial Planning

1	Review state and federal statutes and regulations that govern health insurance plans, policies and payment systems.[183]					
2	Identify state and federal statutes and regulations that specifically address third party reimbursement, including those that relate to publicly funded health insurance (i.e., Medicaid and Medicare.)					
3	Identify state and federal statutes and regulations that address reimbursement during a pandemic.					

[183] The *New Jersey Influenza Pandemic Plan* (June 2008), Section VII.C. "Healthcare Planning" includes information about the state's plans for addressing obstacles to healthcare planning, including health insurance payment issues, available at: http://www.state.nj.us/health/flu/panflu_plan.shtml. Also, N.J.S.A. § 26:2J-1 et seq. (2008) contains statutes regulating health maintenance organizations (HMOs.)

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
Prompt Pay Laws						
4	Review federal and state prompt payment statutes and regulations, 5 CFR § Part 1315 (2008).[184]					
5	Identify provisions of the prompt payment regulations that address the timing of payment during an emergency, including a pandemic.[185]					
Claims Submission						
6	Review state and federal statutes and regulations related to billing and/or claims submission requirements for healthcare facilities.					
7	Identify any statutes or regulations regarding billing and claims submission with which it may be difficult to comply during a pandemic.					
8	Determine whether these statutes or regulations can be waived during a pandemic.[186]					
9	Determine whether there are state statutes or regulations regarding waiver of certain requirements, including: claims submission and/or claims processing; eligibility; authorization; pre-certification; utilization review; coding; and medical record requirements during a declared state of emergency or pandemic.					
10	Identify the ramifications for failure to submit claims properly during a pandemic and to receive reimbursement.					
Stafford Act						

[184] New Jersey's prompt payment law can be found in N.J.A.C. § 11:22-1.1 (2008).

[185] The New Jersey Prompt Payment statutes and regulations do not address whether these time frames for prompt payment may be altered during a pandemic or other emergency.

[186] The New Jersey Emergency Health Powers Act directs the commissioner of Health and Senior Services to "confer with the Commissioner of Banking and Insurance to request that the Department of Banking and Insurance waive regulations requiring compliance by a healthcare provider or healthcare facility with a managed care plan's administrative protocols, including but not limited to, prior authorization and pre-certification" (N.J.S.A. § 26:13-9(b)(5) (2008)). As a result, during a public health emergency, it will be important for healthcare facilities to not only monitor the orders issued by the commissioner of NJDHSS, but also the orders issued by the Commissioner of Banking and Insurance.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
11	Review the Stafford Act, 42 U.S.C. § 5121-5206 (2008), and determine whether a pandemic will be a "major disaster" or "emergency" as those terms are defined in the Act.					
12	Determine whether the nursing home is eligible for payment under the Stafford Act. Consider that compensation under the Act is only available for nonprofit entities, but for-profit entities may be able to enter into a relationship with a nonprofit entity which will entitle the for-profit entity to compensation.					
13	Be familiar with FEMA's Disaster Assistance Policy for Emergency Assistance for Human Influenza.[187]					
14	Determine the availability of payment for services provided by a nursing home in response to a pandemic.					
14a	Consider the distinction between definitive medical care, emergency medical care and sheltering.					
14b	Consider the availability of reimbursement for the purchase of "medicine and other consumable supplies."					
15	To the extent the nursing home is part of a special needs shelter plan, determine whether reimbursement is available for these activities.					
Section 1135 Waivers						
16	Understand the Secretary of the Department of Health and Human Service's ability to waive certain Medicare requirements under Section 1135 of the Social Security Act. These waivers may help providers who are unable to meet the requirements of the Social Security Act to be reimbursed for items and services furnished in good faith during a pandemic.					
17	Determine how the healthcare facility will obtain a copy of a Section 1135 waiver if one is issued.					
18	Determine who will carefully review the Section 1135 waiver to understand its implications.					

[187] FEMA's *Disaster Assistance Policy for Emergency Assistance for Human Influenza* can be accessed electronically at http://www.fema.gov/pdf/government/grant/pa/9523_17.pdf.

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
19	Develop processes for implementing any changes allowed by a Section 1135 waiver.					
20	If a Section 1135 waiver is not issued and the healthcare facility is unable to comply with applicable Medicare regulations, determine whether it will still be eligible for Medicare/Medicaid reimbursement.					

F. Contract Issues- *Third-Party Reimbursement Payer Contract Issues*

Healthcare facilities generally have detailed agreements with various third party payers that govern the manner in which facilities must submit claims for reimbursement; whether services provided are covered services, pre-certification, referral requirements; and various other matters that ultimately determine whether the healthcare facility is reimbursed for the care provided. Both parties to such an agreement may find it difficult to comply with the terms of the agreement during an emergency. Healthcare facilities must determine what provisions of the agreement may be difficult to meet, as well as those a payer may have trouble meeting, during an emergency. This section addresses the legal issues related to payer contracts.

Third-Party Payer Contracts

1	Identify the appropriate contact person responsible for managed care contracts and related health insurance matters at the State Bureau of Insurance, State Department of Health and State Department of Medical Assistance.					
2	Review all third-party payer contracts with a focus on provisions that require continued payment during pandemic.					
3	Evaluate how provisions in third-party payer contracts that address the manner in which claims must be submitted to ensure proper reimbursement are likely to be affected during a pandemic.					
4	Engage in discussions with third-party payers regarding amendments to contracts to address alternative payment and claims submission processes during a pandemic. • Create minimum data sets to be used during emergencies. • Consider allowing for reimbursement for services delivered during a pandemic by providers who do not ordinarily provide such services. • Consider eliminating the need for authorization, pre-certification and utilization management during a declared emergency or pandemic.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
Insuring Against Risks Presented by a Pandemic						
5	Determine the types of risks against which the nursing home should insure related to a pandemic. Consider lost profits related to governmental closure or quarantine orders; commandeering of the facility; lack of reimbursement for services provided; and contamination with an infectious disease.					
6	Identify and review any insurance policies that the healthcare facility has related to the risks identified in Item 5. Consider business interruption insurance, civil authority coverage, ingress/egress coverage, contingent business interruption insurance and accounts receivable coverage.					
7	Determine whether a pandemic is a "covered peril" under the identified policies.					
8	Evaluate whether the identified insurance policies are only triggered by physical damage to the nursing home. If so, determine whether contamination by an infectious agent (e.g., pandemic influenza) is sufficient physical damage.					
9	Determine whether the identified insurance policies allow for payment to the nursing home in circumstances other than a complete cessation of operations.					
10	Determine whether the nursing home's civil authority coverage can be triggered by a preventative civil authority order.					

G. Volunteers- *Initial Planning*

Volunteers may come from the community in which the healthcare facility is located, from neighboring localities or from other states. Volunteers can be used to supplement existing clinical staff, cover gaps in services for staff unable to serve during an emergency or act as relief staff to existing clinical staff. In a pandemic, it is unclear the extent to which volunteers will be available to serve. Nursing homes should evaluate how volunteers will be identified, how volunteers will be used during a pandemic and what liability protections are needed for the facility and the volunteers.

1	Determine if volunteers will be used to supplement facility staff in a pandemic.					
2	Determine if the facility needs liability insurance for volunteers during a pandemic, and whether the facility already has this coverage or needs to purchase additional coverage.					

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
G. Volunteers- *Good Samaritan and Other Volunteer Protections*						
Volunteer protections are available through "Good Samaritan" laws, state emergency volunteer laws and federal emergency volunteer laws. Nursing homes must understand the differences among the various legal mechanisms for volunteers so that facility staff volunteering elsewhere will receive appropriate liability protection and injury compensation and to ensure that they understand the rights of the healthcare professionals volunteering at the nursing home during an emergency. Nursing homes should carefully evaluate how "volunteer" is defined under a volunteer protection law, and whether or not volunteers are permitted to receive pay from their employer while volunteering and/or retain eligibility for liability and compensation protections.						
Good Samaritan Laws						
1	Identify if the state has a Good Samaritan law. Determine who is covered under the Good Samaritan law, the types of acts permitted and the extent of liability protections available under it.[188]					
2	Identify if and how the state's Good Samaritan law will apply during a pandemic.					
3	Determine if Good Samaritan protections will apply to care provided in the healthcare facility by paid healthcare facility staff during a pandemic.					
4	Determine if Good Samaritan protections will apply to care provided in the healthcare facility by non-paid volunteers during a pandemic.					
State Volunteer Protection Laws						
5	Identify if the state has an additional law that provides volunteer immunity protections and determine the extent of protections available under it.[189]					
6	Identify how "volunteer" is defined for the purposes of immunity under the state's volunteer protections law.					

[188] New Jersey has a Good Samaritan Act that provides complete or partial immunity for specified actors responding to certain events, but does not contain a blanket provision addressing healthcare professionals providing care in an emergency (N.J.S.A. § 2A:62A-2 et seq. (2008)).

[189] Protections for volunteer healthcare professionals during a public health emergency are included in the New Jersey Emergency Health Powers Act (N.J.S.A. § 26:13-1 et seq. (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
7	Determine if the definition of "volunteer" includes or excludes paid nursing home staff.					
8	Identify if and how the state's volunteer immunity protections apply to care provided during a pandemic.					
Federal Volunteer Protection Laws						
9	Review the Federal Volunteer Protection Act and assess its applicability to the healthcare facility in terms of providing volunteers with liability protections and injury compensation.[190]					
10	Understand that the definition of "volunteer" is limited under the VPA and plan accordingly.[191]					
11	Determine if the definition of "volunteer" includes or excludes paid healthcare facility staff.					
12	Identify if and how federal volunteer immunity protections apply to care provided during a pandemic at the healthcare facility.					

G. Volunteers- *EMAC and Other Mutual Aid Agreements*

States use the Emergency Management Assistance Compact (EMAC) to request and send mutual aid between states during emergencies. If covered under EMAC, volunteers are eligible for liability and workers' compensation protection. Some states may have formal intra-state mutual aid agreements or other authorizing statutes to permit localities within a state to exchange assistance in emergencies; volunteers under intra-state agreements may be similarly entitled to liability and workers' compensation protections.

[190] The Federal Volunteer Protection Act (VPA) (42 U.S.C.S § 14501-14505 (2008)) provides immunity to volunteers who are: acting within the scope of his/her responsibility; properly licensed, certified or authorized to engage in the activity or practice (if such licensure is required by the state in which the damage occurred); and engaged in those activities within the scope of the volunteer's responsibility.

[191] The VPA narrowly defines volunteers eligible for coverage under the act. The VPA specifically protects volunteers (including officers, directors, trustees and direct service volunteers) who perform services for a nonprofit organization or a governmental entity, and do not receive (1) compensation other than reasonable reimbursement or allowance for expenses actually incurred; or (2) anything of value in lieu of compensation in excess of $500 per year (42 U.S.C.S § 14505(6) (2008)).

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Identify if the state plans on making a request for Emergency Management Assistance Compact (EMAC) assistance during a pandemic.[192]					
2	Identify who is responsible under EMAC for credentialing and privileging volunteers and how will this be done.					
3	If the state brings in volunteers under EMAC, determine how and where the state intends to deploy the EMAC volunteers.					
4	Identify the licensure reciprocity provisions of the state's EMAC agreement.					
5	Determine if using EMAC will make it easier for an out-of-state volunteer to provide care in the state receiving aid.					
6	Identify if there are other mutual aid agreements through which healthcare facility can place or receive volunteers.[193] Other compacts can include: • Interstate regional compacts and MOUs • Local management assistance compacts and ordinances.					
7	Identify the liability protections and injury compensation protections under each mutual aid agreement.					
8	Identify if the state will seek volunteers to deploy to other states under EMAC.					

[192] New Jersey has adopted the Emergency Management Assistance Compact (NJEMAC) at N.J.S.A. § 38A:20-4 et seq. (2008). EMAC has been adopted by all 50 states, the District of Columbia and Puerto Rico. NJEMAC extends several legal protections to emergency response personnel and volunteers deployed under it, including: waiver of professional licensure requirements for individuals licensed in another party state; immunization from civil liability for good faith acts by officers or employees of a party state acting pursuant to NJEMAC, except for willful misconduct or acts of gross negligence or recklessness; and workers compensation coverage for members of a state's emergency personnel while they are rendering aid under NJEMAC.

[193] New Jersey also belongs to the Interstate Compact for Mutual Military Aid in an Emergency (N.J.S.A § 38A:20-2 (2008)) and the Interstate Civil Defense and Disaster Compact (N.J.S.A. § 38A:20-3 (2008)). The New Jersey Emergency Health Powers Act authorizes the commissioner to coordinate with other states during a public health emergency (N.J.S.A. § 26:13-3c(3) (2008)).

APPENDICES

Sample Policy for Staff

Contacted by the Media

Sample Policy for Staff Contacted by the Media*

- If you receive a call from the media, **do not answer any questions or engage in any other discussion with the reporter** unless specifically advised to do so by Administration. Simply take a message that includes the reporter's name, organization and phone number; specific purpose of the call; and the reporter's deadline. Advise the reporter that the call will be returned promptly.

- Contact Administration and relay the information. If you reach voicemail, follow the instructions to page the individual, or contact the designated backup person.

- All members of the news media (including photographers and camera crews) are prohibited from entering the facility unless escorted by a member of Administration or an approved designee. If you see a reporter or photographer attempting to enter or on the premises without an escort, ask the person to wait in Reception while you contact Administration. Call for Security backup, if necessary.

- Photographing, filming or videotaping patients or patient care activities could be a violation of federal HIPAA regulations and may only be authorized by Administration.

*Adapted from *Media Communications Procedures, Geisinger Health Systems, Danville, PA* as published in *Crisis Communications in Healthcare, Society for Healthcare Strategy and Market Development*, AHA, publication year.

Guidelines for the

Release of Information on

Patient Conditions to the Media

GUIDELINES FOR THE RELEASE OF INFORMATION ON PATIENT CONDITIONS TO THE MEDIA

NEW JERSEY HOSPITAL ASSOCIATION ■ NEW JERSEY PRESS ASSOCIATION

(2003 Edition, Compliant with HIPAA Regulations)

Hospitals and the media recognize that a delicate balance exists between protecting patient privacy and providing access to information that is newsworthy.

Beginning in April 2003, the federal Health Insurance Portability and Accountability Act (HIPAA) regulates certain aspects of patient privacy and confidentiality. These HIPAA regulations specify how information may be released to the media.

To clarify these changes, the New Jersey Hospital Association, in cooperation with its member hospitals, the New Jersey Press Association and major media outlets statewide, has developed this reference to serve as a model for consistency and cooperation.

The following information is provided as a general guideline that provides a minimum standard of patient privacy protection under HIPAA. Healthcare facilities should consult with legal counsel before finalizing any detailed policy on the release of patient information.

RELEASE OF INFORMATION

- **A hospital now has the responsibility of telling patients that it can release general condition information (directory information) and to whom that information will be disclosed. Patients have the option of stating that they do not want information released at all, including confirmation of their presence in the facility. If the patient requests that no information be released, the hospital *must* honor that request.**
- **The fact that a patient has been treated or admitted to the hospital, as well as his or her general condition (under evaluation, good, fair, serious or critical, etc.) may be given if the inquiry contains the patient's name and as long as the patient has not requested that the information be withheld.**
- HIPAA allows no discretion for reporting any details other than general condition. Any specific information such as time of admission, extent of injuries or type of treatment, interviews with patients or attending physicians and photographs can only be released with the specific written authorization of the patient.
- The patient's location within the hospital is part of the directory information that may be released under HIPAA. Hospitals should use discretion in releasing this information. HIPAA specifically prohibits releasing the patient's location in the hospital if that information could prove harmful to the patient.
- No information regarding treatment for psychiatric conditions, substance abuse, the AIDS virus or any other sensitive conditions or circumstances should be released. Special discretion should be used when releasing information regarding minors, victims of sexual assault and attempted suicides.

- If a patient is unconscious and cannot express an information release preference, the hospital must determine if the patient expressed a preference during a past hospital stay. If no preference is known, the hospital must decide if disclosure is in the patient's "best interest."

MATTERS OF PUBLIC RECORD AND PUBLIC FIGURES

- Under HIPAA, matters of public record (those situations that are by law reportable to public authorities such as the police, coroner or public health officials) are now no different than other cases. Victims of accidents, explosions, falls, shootings, stabbings, injury from fire, natural disasters or terrorism have the same privacy rights as all other patients. Media calls requesting patient information should be answered with only the one-word condition.
- As with any patient, when a public figure is hospitalized and the media inquiry contains the patient's name, confirmation and the one-word condition may be given unless the patient requests that no information be released.
- In high-profile cases, especially those resulting in multiple injuries or mass casualties, only information as to number of injured and general conditions can be released without names.

PATIENT CONDITIONS

- Unless the patient has expressed otherwise and opted out of releasing any information, only the following one-word conditions about the patient's condition should be released.
- **UNDER EVALUATION -** Patient undergoing assessment.
- **GOOD -** Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.
- **FAIR -** Vital signs are stable and within normal limits. Patient is conscious, but may be uncomfortable. Indicators are favorable.
- **SERIOUS -** Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators questionable.
- **CRITICAL -** Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators unfavorable.
- **TREATED AND RELEASED -** Received treatment but not admitted.
- **TREATED AND TRANSFERRED -** Received treatment. Transferred to a different facility.
- If the patient has expired, this fact can be reported to the media only after the patient has been pronounced dead and family has been notified. However, **death** is a condition subject to HIPAA restrictions, so if the patient initially opted out of providing information altogether a hospital cannot say the patient has died.

NOTE: The term "stable" should not be used as a condition or in combination with other conditions.

SPECIAL THANKS

NJHA Release of Patient Information Task Force
The Associated Press
Newark Star-Ledger
WCTC Radio
McGimpsey and Cafferty
American Hospital Association
The Ohio Hospital Association

For additional copies call NJHA's Communications Department at (609) 275-4058

Media Inquiry Form

COMMUNICATIONS
MEDIA INQUIRY

REPORTER	NEWS MEDIUM
DATE	
TIME	LOCATION
DEADLINE	PHONE

INFORMATION REQUESTED:

INFORMATION FURNISHED:

ADDITIONAL COMMENTS:

HANDLED BY:

Communication Vehicle

Worksheet

COMMUNICATION VEHICLE WORKSHEET

	Audiences							
Communication Vehicles	**Residents**	**Managers**	**Employees**	**Affiliates**	**Physicians**	**Board**	**Media**	**Community/Others**
Telephone								
Special Meetings								
Voice Mail								
Intranet								
Overhead Announcements								
E-mail								
Distribution of Special Newsletter Editions								
Broadcast Fax								
Video Teleconference								
Town Hall Meetings								
Web Site Announcements								
One on One Meetings								
Press Release								
Mail								
Hand Delivered Memos/Fliers								
Cafeteria Announcement Boards								
Tent/Tray Cards								
Staff Communication Boards								
Advertisement								
Call Center								
Public Service Announcements								
Information Center								
Hotline								

NJHA extends its appreciation to Meridian Health Systems for its contribution.

Sample Pre-Event Messages

PRE-EVENT:
Message to Employees

Over the last several months, we have been working diligently to develop a flu pandemic planning and response document. This plan will allow us to maintain our operations under what we believe will be challenging conditions. Equally important, we want to ensure your safety and that of our residents and their family members. The safety of your family is also of importance to us.

We will be giving you more specific information regarding our anticipated policies and operations during a pandemic. Having this information now will provide you with an opportunity to ask questions, receive feedback and voice any concerns you may have.

Enclosed are some facts regarding flu pandemic. If you have more specific questions, contact _____and he/she will be happy to meet with you. You are a valued staff member and critical to our day-to-day operations. With your ongoing commitment, we will do our best to meet the needs of our community during a time of crisis.

PRE-EVENT:
Message to Funeral Directors

During a pandemic, the resources and services of the healthcare system will be severely taxed as will the community resources that support the day-to-day operations of our facility. (Name of facility) is developing an extensive plan to ensure continuity of operations during a pandemic and planning for mortuary services is a critical component of that plan.

We are coordinating a meeting with representatives from local funeral homes to discuss how we will work together and support each other during a time of crisis. Your participation in this effort is critical. The meeting is scheduled for

Date
Time
Location

Our objective is to facilitate the sharing of contact information, discuss the planning process for a pandemic and identify issues of importance and/or concern for our respective organizations. Resolving issues and addressing concerns is a key objective of coming together in the planning process.

Please complete the enclosed meeting reply form regarding your interest and ability to attend this first meeting. We look forward to working with you.

PRE-EVENT:
Message to Government Leaders

We continue to see articles in the newspapers regarding the novel flu. These articles tend to raise concerns about how prepared we are and how people will be protected if we do experience a pandemic. We recognize that you are in a critically important position to educate the members of your constituency on what a pandemic would mean to them. To help in that effort, we are providing you with some materials that will address many of the questions and concerns that could be raised.

We welcome your assistance in providing information and education to your constituency. We want to work together with you to prepare members of our community for an eventual pandemic. I would be happy to schedule time to meet with you and others to discuss the work we are undertaking at (name of facility). Hopefully, we can discuss the goals we have for each other in planning and preparing for a pandemic. More important, I look forward to an ongoing working relationship that will allow for open communication and mutual assistance both now and in the future.

PRE-EVENT:
Message to Independent Contractors

Our facility is developing a comprehensive flu pandemic planning and response document. As part of this effort, we have identified operational and clinical areas in our facility requiring special attention in the planning process. Examples of these areas include employees that fall under collective bargaining agreements and independent contractors that work our facility, among other groups.

You play a critical role in the operations of our facility and it is our commitment to ensure your safety. Although we are addressing the business relationship we have, we welcome your participation in the planning process.

Prior to any crisis, it is critical that there is a common understanding of what is expected. While I recognize that working in our facility is dictated by the terms and conditions reflected in your contract, there are some situations that should be covered well in advance of an event, for example:

- An independent contractor is responsible for continuing to work during a declared state of emergency unless directly impacted by the emergency, i.e., falling ill.

- Should care for a sick family member be required, compensation will be adjusted according to the terms of the contract, specifically_____. (*Policies may provide paid sick leave, may allow for leave without pay, may require some kind of compensatory action against the company representing the independent contractors, prohibits leave time during a declared state of emergency, etc.*)

- Failure to report to work when an absence does not meet the conditions required of an "authorized" absence will be subject to the penalties reflected in the contract.

- Notification of an absence must occur prior to the employee's scheduled shift, at which time a determination will be made if the absence is covered by the conditions reflected in contract.

- Protocols regarding the provision of care may need to be changed to respond to the challenges posed by a pandemic.

Facility should add any other bullet that relates to a policy that independent contractors will be held to during a pandemic or other major crisis.

You will receive a copy of our flu pandemic response plan and I would be happy to meet with you to discuss any questions you may have. Appropriate staff will be speaking to company contacts to ensure appropriate changes are reflected in the contract and that you are provided with complete information. We look forward to working hand-in-hand with you to meet the needs of our community during this crisis.

PRE-EVENT:
Message to Volunteers

Over the last several months, we have been working diligently to develop a flu pandemic planning and response document. This plan will allow us to maintain our operations under what we believe will be challenging conditions. Equally important, we want to ensure your safety and that of our patients and their family members.

We will be giving you more specific information regarding our anticipated policies and operations during a pandemic. Having this information now will provide you with an opportunity to ask questions, provide feedback and voice any concerns you may have.

Enclosed are some facts regarding flu pandemic. If you have more specific questions, contact _____and he/she will be happy to meet with you. You are a valued member of our facility. With your ongoing commitment to service, we will do our best to meet the needs of our community during a time of crisis.

PRE-EVENT:

Message to Home Health Agencies, Skilled Nursing Facilities, Rehabilitation Centers, Emergency Medical Services (EMS) and Hospitals

Articles continue to appear in the media regarding the novel flu. Our facility has developed a flu pandemic planning and response document. Given the close relationship our facility has with your agency/facility, we wanted to ensure that we plan collaboratively to ensure we meet the needs of our community during the crisis resulting from a pandemic. Toward that end, we would like to schedule the first of what may be several meetings to begin to identify needs and how we can collectively meet those needs.

_____has been designated as the hospital's contact to coordinate and facilitate these planning meetings. She/he will be reaching out to you within the next week to schedule the first meeting.

In the meantime, I have enclosed materials that may address many of the questions and concerns that your patients/residents may raise regarding a pandemic. We welcome your suggestions as to how we can continue to educate your constituents and the people within our community in order to reduce the uncertainty and fear associated with a pandemic.

I look forward to working with you in the coming months.

Sample Event Messages

EVENT:
To Family/Healthcare Representatives of Residents

The Governor has declared a public health emergency because of pandemic influenza. A pandemic means that it is widespread. There are cases across the entire U.S. and in other countries as well.

Pandemic influenza is a highly contagious disease. However, we are taking steps to protect both you and our residents. To continue to provide the best possible care for our residents and to protect you from influenza, we are implementing the following:

- In our facility, patients infected with influenza are isolated in special rooms. These rooms contain the spread of infectious diseases, such as influenza.

- All our employees and volunteers have received information and training in infection control measures. This means they will use the proper equipment to protect themselves and you against the spread of influenza germs. They will wear masks, they will wash their hands and practice good hygiene to prevent the spread of germs.

- Only immediate family members/health care representatives are allowed to visit[194] at this time. In the future, it may be necessary to restrict all visits to protect both residents and the public.

- If you visit our hospital, you will have to wear a mask to prevent the spread of germs and wash your hands frequently.

- Staff availability is less than normal because many are sick or taking care of family members. This will not compromise the quality of care being provided to your loved one. We appreciate your patience since we are taking care of an extremely high number of residents.

Because the health of our residents and their family and friends is our priority, please rest assured that we are taking all precautions to provide protection to both residents and you. You may contact _____with any concerns or questions you may have.

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[194] See NJHA's *H1N1 Visitation Guidelines for Healthcare Facilities* at http://www.njha.com/h1n1flu/pdf/H1N1VisitationGuidelinesforHealthcareFacilitie.pdf.

EVENT:
Message to Physicians

Multiple cases of influenza have been reported in our neighboring states and several cases have also been reported within our own state. While we are waiting for formal notification by our Commissioner of Health we should be prepared to implement our influenza pandemic plan.

As part of this plan, we will be activating our Emergency Command Center and will implement the Incident Command System. Communication with various groups, including physicians and (name of facility) employees will occur on a regular basis. A telephone hotline will be established for employees, providing an opportunity for them to communicate and receive information in a more timely way. A separate telephone number for physicians and employees will also be established to report absences.

If necessary, (name of facility) will implement a facility lock-down to control the flow of employees and the public. Access will be available only through the main entrance. All physicians and staff will be required to wear their (name of facility) identification badges to gain access to the facility. This practice is critical since large numbers of the sick will attempt to enter the facility.

We will communicate with you on a regular basis, however, if you have any questions or concerns please do not hesitate to contact us. Thank you for your support, assistance and efforts in the coming months. This will be a challenging time for our facility. However, we will do what we have always done best, which is to care for those within our community.

EVENT:
Update to Board Members and Physicians

Our facility is feeling the full force of the flu pandemic, specifically:

- Our supplies are limited with little anticipation of them being fully replenished.

- We are close to exceeding our surge capacity. This will create challenges as to how and where residents should be directed as most health care facilities will also be at surge capacity.

- There is a staff absenteeism rate of approximately ___ percent.

Currently, we are sustaining operations. However, we expect that it will become even more challenging without adequate supplies. We are working closely with our local Office of Emergency Management to consult with all medical/surgical distributors to see what supplies can be acquired in the coming weeks.

We will continue to keep you informed of our situation and the ongoing challenges that we will face as we respond to this statewide healthcare crisis.

EVENT:

Message to Volunteers

Cases of influenza have been reported in surrounding states and we anticipate cases will be diagnosed within our state. Going forward, we will be communicating with you on a regular basis to keep you advised of how you can assist us in this trying time.

We ask you to look beyond many of your routine contributions as volunteers as you may be asked to help in other tasks such as providing childcare for our employees and food preparation assistance, among other tasks. Your assistance is critical in our changing environment and will contribute to the overall well-being of our hospital.

Please remember to practice appropriate infection control measures, including good, consistent hand hygiene. Our commitment is to provide you with a safe and supportive work environment. If you have any questions or concerns, please do not hesitate to speak to _____.

It is critical that we educate the community on the impact flu pandemic may have and what preventive measures they can use. For this reason we have provided you with a flu pandemic fact sheet attached to this letter.

Thank you for your commitment to serve your community during this challenging time.

EVENT:
Message to Board Members

Currently there are multiple cases of influenza in our state. Earlier this week, cases were also diagnosed and confirmed in both Pennsylvania and New York. The Centers for Disease Control and Prevention has declared a pandemic and instructed all healthcare providers to implement their flu pandemic plans.

The State's Commissioner of Health and Senior Services has requested that all hospitals monitor and report all diagnosed cases of influenza and implement hospital flu pandemic emergency response plans. DHSS has reported that soon it will activate its Health Command Center to ensure the 24/7 availability of its staff to support healthcare providers to effectively respond to this potential health crisis.

Here at our facility, we will be activating our Command Center and implementing our Incident Command System. At this time, we will not maintain Command Center operations on a 24/7 basis. However, we will operate for twelve-hour shifts. We will reevaluate the hours of our Command Center on a daily basis particularly if the number of diagnosed cases increases over the coming days and weeks.

We will be communicating with both external and internal stakeholders on a regular, scheduled basis. We are also implementing the employee telephone hotline where we will provide updated information, respond to questions and concerns and communicate information regarding operations within our facility during the coming weeks. In turn, I will be communicating with you on a regular basis. You will also have access to our employee hotline.

As a Board member you should anticipate being approached by members of the community that are concerned about flu pandemic. We have provided you with talking points to assist you in assuring the community that our facility has implemented an action plan that will protect our employees and the public to the greatest extent possible.

You may also be approached by the media. Please refer media inquiries back to Administration. This will give us the opportunity to control the message being communicated and to hopefully avoid creating panic within our community.

I will provide you with updates on diagnosed cases and the impact they are having on our facility operations. In the interim, please feel free to contact me with questions or concerns. From this point on, I will coordinate conference calls with the Board, rather than having on-site meetings where the risk of exposure would be much greater. I thank you for your support in the coming months. Your understanding and cooperation will be critical in sustaining our facility operations during this challenging time.

EVENT:
Message to Clergy

Cases of influenza have been diagnosed in surrounding states including (number) of cases in our state. We will be activating our emergency operations plan, which includes providing regular information and updates to you as well as the community.

Our facility's use of infection control practices will reduce the spread of influenza within our facility. Please remind your congregation about the role they can play in preventing the spread of flu and/or minimizing its impact. We have provided you with an information sheet that can be distributed to your congregation. It will help guide them in responding to a pandemic.

For additional information on what community residents can do to protect themselves and their family members, please see the following resources:

- U.S. Department of Health and Human Services: http://www.flu.gov/
- NJ Department of Health and Senior Services: http://www.nj.gov/health/

We may also be contacting you for possible assistance in matters such as grief counseling and religious support for both patients and staff.

_____has been designated as a communication liaison between our facility and your organization. If you have specific questions or need information, you may contact _____at _____.

EVENT:
Message to Employees

Cases of influenza have been reported in surrounding states and we anticipate cases will soon be diagnosed within our state. Going forward, we will be communicating with you on a regular basis to keep you advised of diagnosed cases, the impact these cases are having on facility operations and how, if at all, you may be affected as an employee.

You will be informed of operational changes, if any, that we may require you to make in response to a significant influx of influenza cases.

Please remember to practice appropriate infection control measures, including good, consistent hand hygiene. Our commitment is to provide you with a safe and supportive work environment. If you have any questions or concerns, please do not hesitate to speak to your supervisor.

An employee hotline is available to provide you with regular updates. We also encourage you to review the following resources for additional information on what you can do to protect yourself and your family:

- U.S. Department of Health and Human Services: http://www.flu.gov/
- NJ Department of Health and Senior Services: http://www.nj.gov/health/

Thank you for your commitment to provide quality healthcare to our community during this challenging time.

EVENT:

Message to First Responders

As you're well aware, cases of influenza have been diagnosed in both New York and Pennsylvania and our understanding is that several cases have also been diagnosed within New Jersey. While we are awaiting formal notification by our Commissioner of Health, at this time (name of facility) is prepared to implement our pandemic influenza plan.

As part of this plan, we will be activating our Emergency Operations Center and will implement the Incident Command System. Communication with you and your colleagues will be critical to our success.

If our facility experiences a sharp increase in the number of ill residents we will try to limit requests for transport to only those in need of acute care services.

We will communicate with you on a regular basis, however, if you have questions or concerns at this point, please do not hesitate to contact _____ so that we may address them. Thank you for your support, assistance and efforts in the coming months. This will be a challenging time for our facility as well as for your organization. However, we will do what we have always done best, care for those within our community.

EVENT:

Message to Funeral Directors

Confirmed cases of novel flu have been reported in our state. The pandemic will severely tax our facility's resources and we are contacting you for assistance. (Name of facility) is implementing an extensive plan, developed specifically for a flu pandemic, to ensure continuity of operations and planning for mortuary services is a critical component of that plan.

We will be contacting you by phone to discuss our needs as well as your own during this pandemic. You should expect an increased demand for mortuary services during the next few months. We encourage you to practice hygienic procedures such as hand sanitation in order to remain healthy. We have attached a pandemic flu fact sheet for you to read and share with your family and friends.

We greatly appreciate your efforts at this time in caring for the deceased in our community and thank you for your hard work.

EVENT:
Message to Independent Contractors, including Staffing Agencies and Off-Site IT

Cases of the flu have been reported in surrounding states and we anticipate cases soon will be diagnosed within our state. Going forward, we will communicate with you on a regular basis to keep you advised of diagnosed cases, the impact these cases are having on our operations and how, if at all, you may be affected.

Please practice proper infection control measures, including good, consistent hand hygiene. Our commitment is to provide you with a safe and supportive work environment. If you have any questions or concerns, please do not hesitate to speak to _____.

An internal Web site is available that will provide you with regular updates. We encourage you also to review the external Web site that has been established to respond to community members' concerns. It is critical that we educate the community on the impact flu pandemic may have and what preventive measures they can use to protect themselves.

Thank you for your commitment to provide quality healthcare to our community during this challenging time.

EVENT:
Message to Residents, Family/Healthcare Representatives, and Friends

Our state has declared a public health emergency because of a flu pandemic. A pandemic means that it is widespread. We have attached a fact sheet about flu pandemic. There are cases throughout the United States and in other countries as well.

Flu pandemic is a highly contagious, communicable disease. However, there are precautions that can be taken. Here's what we are doing to continue to provide you with the best possible care as well as our efforts to protect you from getting the flu.

- Patients that have influenza are isolated special areas in our facility. These areas are designed to contain the spread of infectious diseases, such as influenza.

- All our employees and volunteers have received information and training in infection control measures. This means they will use appropriate equipment to protect themselves and you against the spread of influenza germs. They will wear masks and wash their hands, in the practice of good hygiene to prevent the spread of germs.

- Only immediate family members/health care representatives will be permitted to visit[195] at this time. In the future, it may be necessary to restrict all visits to protect both patients and the public.

- If you visit our hospital you will be asked to wear a mask and to wash your hands frequently, to prevent the spread of germs.

- Staff availability is less than normal because many are sick or taking care of family members. This will not impact the quality of care that we will be providing to you. We appreciate your patience since we are taking care of an extremely high number of residents.

Because your health is our priority, please rest assured that we are taking all precautions to protect your health and safety. We will be happy to address any concerns or questions you may have.

[195] See NJHA's *H1N1 Visitation Guidelines for Healthcare Facilities* at http://www.njha.com/h1n1flu/pdf/H1N1VisitationGuidelinesforHealthcareFacilitie.pdf.

EVENT:
Message to Media

We currently have (number) cases of diagnosed influenza being treated at our facility. At this time, we have implemented our pandemic influenza plan. This means:

Possible responses include:

- We have established an external Web site that will provide information related to flu pandemic. This information will provide background information and guidance to the community on how they can minimize and/or respond to the spread of influenza.

- We are identifying additional space to accommodate a greater than usual number of residents to support the healthcare continuum.

- Please communicate to the public the information provided from the State Commissioner of Health. Specifically, he/she recommends that:

- We will hold regular updates with you by conference call. We would prefer no on-site press conferences.

- Any questions you have may be directed to _____.

Your assistance in keeping the public informed, prepared and confident in the healthcare system's ability to care for them is critical. We appreciate your help during this challenging time.

EVENT:

Message to Home Health Agencies, Skilled Nursing Facilities, Rehabilitation Centers, Emergency Medical Services (EMS) and Hospitals

Cases of influenza have been diagnosed in surrounding states including 20 cases in hospitals in our state. We will be activating our emergency operations plan, which includes providing regular information and updates to you in recognition of the critical role you play in partnering with our facility to provide patient care.

A conference call will be scheduled on a daily basis at (time) and will be facilitated by _____. This call will provide an opportunity to share information regarding our respective operations, identify areas where support is needed and allow us to develop a strategy to keep our organizations functioning. You may certainly keep in touch with our staff at any time as you would normally when facilitating patient placement and arranging for patient services.

Consistent with all of our plans, staff should be reminded of the importance of hand hygiene and use of personal protective equipment when dealing with ill patients or residents. I have attached a fact sheet that you may wish to distribute to your patients/residents to educate them as to how they can minimize the impact of the flu.

I am confident that by working together we can continue to provide the care our community has come to rely upon.

Tips for Press Messages/

Materials Creation

in a Crisis Environment

Tips for Press Messages/Materials Creation in a Crisis Environment

Source: United States Centers for Disease Control and Prevention. *Crisis and Emergency Risk Communication by Leaders for Leaders*. Barbara Reynolds. Atlanta: Centers for Disease Control and Prevention, 2002.

In a crisis situation, particular care should be taken with the tone and word choice in your materials. When drafting your messages/materials, it is helpful to keep the following tips in mind:

- Keep all materials relevant to the situation at hand. Brevity and use of plain language is critical. Repetition of key messages helps ensure that information is absorbed.
- Continue to state concern about the situation, prior to addressing any good news and stating reassuring updates.
- Ensure messages under-promise and over-deliver. Do not "over-reassure."
- Allow people the right to feel fear. Acknowledge it and give contextual information.
- Ensure messages give people things to do. Anxiety is reduced by action and a restored sense of control.

Review messages for the five communication steps that *boost success*:

- Execute a solid communication plan.
- Be the first source for information.
- Express empathy early.
- Show competence and expertise.
- Remain honest and open.

Review messages for the five communication failures that *kill success*:

- Mixed messages from multiple experts.
- Delayed or late release of information.
- Paternalistic or "know-it-all" attitudes.
- Not countering rumors or myths in real-time.
- Public power struggles and/or confusion.

Consider that evidence strongly suggests that media coverage is more factual when reporters have more information and more interpretative when less information is provided. Predictable information sought by the media includes:

- What has happened?
- Who is in charge?
- Who caused this situation?
- Has this been contained?
- Are victims being helped?

- What can we expect?
- What should we do?
- Why did this happen?
- Did you have forewarning?
- How can this situation be fixed?
- What are the casualty numbers, patient conditions, available treatments?
- What is the extent of property damage?
- What response and relief activities are underway?
- What are/will be the resulting effects (e.g., anxiety, stress)?
- Are families safe?
- What can people do to protect themselves and their families?
- If you're treating people that have the flu at your facility, are people safe there?

When first communicating with both internal and external audiences, ensure the following is addressed:

- Recognize/empathize with what the audience must be feeling.
- Provide only confirmed facts and action steps.
- Communicate what you don't know about the situation.
- Explain how answers will be identified.
- Verify your commitment to continue to respond to the situation and to continue communication.
- Direct people to other sites or sources of information for updates.

When developing flu pandemic communication pieces, recognize:

- Feelings of overwhelming fear in the community, particularly if the event continues over an extended period of time, if there is a high mortality rate, and/or if facility capacity is exceeded.
- People do not feel in control because individual behaviors can impact the spread of influenza. Uncertainty will create great anxiety. To reduce anxiety, give people specific things to do (e.g., practice good hygiene; disinfect surfaces in the home).
- There is reassurance in communicating that your facility's operations are under control.
- Understanding a complex issue requires simple messages delivered in plain language.
- There is an inadequate supply of vaccines/antivirals, and there may be a limited supply of medicine to treat those that become infected.
- There may be feelings of loss of control over making individual decisions (e.g., mandated quarantine, burial processes, etc.)
- Different age populations may need different messages to feel reassured.
- There may be a need for sustained communications at regular intervals.
- The need to be prepared to handle communication related to unpredictable situations (e.g., limited staff availability, staff burnout, staff errors, referrals to alternate care sites if facility reaches capacity, etc.)

Questions Frequently Asked by Journalists and the Public During Disease Outbreaks

Questions Frequently Asked by Journalists and the Public During Disease Outbreaks

The following is reprinted from "Effective Media Communication During Public Health Emergencies" with the permission of Vincent T. Covello, Ph.D., Director, Center for Risk Communication, New York City, 2007.

The following questions have often been asked by journalists and the public during past disease outbreaks. Such questions could be further refined by grouping them according to themes, such as clinical traits, epidemiological traits, accountability, blame, vulnerable groups and protective actions.

How contagious is the disease?

Can people be vaccinated? Will antibiotics and antiviral medicines work? How effective are vaccinations, antibiotics or antiviral medicines for those with the disease? How effective are vaccinations, antibiotics, or antiviral medicines for those who do not have the disease? How fast do the vaccines or antibiotics work?

What are the signs and symptoms of the disease?

Who is in charge of the disease control effort? How are you coordinating the efforts among responsible agencies?

Is the outbreak due to terrorism? Has the disease been "weaponized"? How certain are you that it is not a deliberate release? What if the disease is a genetically altered strain that is resistant to any known medical treatment?

What makes you think the disease control strategies of the past will work today?

What is being done to stop the spread of the disease?

What kind of medical care is available to the population at risk? Are there enough medical care facilities? What happens if these care facilities are overwhelmed by demand?

What resources are being used to respond to the disease outbreak?

Can the disease be treated? How effective is treatment? Are there strains of the disease that cannot be treated?

How does one know if the vaccinations, antibiotics or antiviral medicines are working?

Are laboratories able to quickly diagnose the disease? How long does confirmation take?

Is the disease airborne? Waterborne?

Can people get the disease from insects, pets, farm animals and wild animals?

What are the authorities in areas not affected doing to prepare for an outbreak?

How are the vaccines made? How are the antibiotics and antiviral medicines made? Are there enough vaccines, antibiotics or antiviral medicines for everyone who wants them? Who will pay for vaccines, antibiotics or antiviral medicines?

How will vaccines, antibiotics and antiviral medicines be distributed? How much time will be needed? Where can people be vaccinated, get antibiotics or get antiviral medicines? If there is a shortage, who will get priority? Who will make these decisions?

What should people do if they think they have the disease?

Do you recommend that people get vaccinated, take antibiotics or take antiviral medicines now? How long does protection last?

Are the vaccines, antibiotics or antiviral medicines licensed and approved? What is the expiration date? Should people be concerned?

Are the vaccines, antibiotics or antiviral medicines safe? How do you know? What studies have been done to demonstrate their safety?

Who should not get vaccinated, should not take antibiotics, or should not take antiviral medicines? What can these people do to protect themselves?

Who will tell people when to be vaccinated, take antibiotics, or take antiviral medicines?

Is there an adequate supply of medicines available to treat the complications of vaccination, or of taking antibiotics or antiviral medicines?

What are the alternatives to vaccination, antibiotics, or antiviral medicines?

How safe are people who get vaccinated, take antibiotics or take antiviral medicines?

Do you have a contingency plan if current control measures fail?

What does the contingency plan say? What is the worst case?

Who developed and approved the plan?

What is the risk to the population? How many could die?

How prepared were you for the disease outbreak?

How do you know whether the outbreak is real? Could it be a false alarm?

If people get sick from the vaccination, from taking antibiotics or from taking antiviral medicines, who will care for their families, pets, homes and property?

How common are side-effects from vaccination, taking antibiotics or taking antiviral medicines? What are the risks of each side-effect occurring?

Can pets and farm animals be vaccinated, or be given antibiotics or antiviral medicines?

Can people with HIV/AIDS, transplants, cancer and other causes of weakened immune systems be treated?

Can elderly people and children be treated? Can pregnant women be treated?

What are you recommending for your own family?

How long does it take for the vaccination, antibiotics or antiviral medicines to protect people against the disease?

Are there people who will not be protected even after getting vaccinated, taking antibiotics or taking antiviral medicines? How many people are in this category? What are their options?

How can people prevent the disease from spreading to others?

Will people be forced to be vaccinated, take antibiotics or take antiviral medicines?

Will infected people be isolated or quarantined?

How long will quarantine and isolation last?

What is the legal basis for quarantine and isolation?

How effective is quarantine and isolation in preventing the spread of the disease?

How will bills be paid while people are in quarantine or isolation?

How will people get health care, water, food and other services while in quarantine or isolation?

Where will people in quarantine or isolation be placed?

Will people in quarantine or isolation be isolated from each other?

Under what circumstances will people be put in quarantine or isolation?

What are the legal rights of a person who is quarantined or isolated?

Are there alternatives to quarantine and isolation?

How is quarantine or isolation done?

What is life like in quarantine or isolation?

Under what circumstances would a large-scale quarantine or isolation effort be started?

If someone becomes sick in quarantine or isolation, who will care for them? How good will the medical care be?

Will people in quarantine or isolation be able to communicate with family and friends?

Will a person's job be protected while they are in quarantine or isolation?

What will happen to people who refuse to be quarantined or isolated?

Can people get sick when in quarantine or isolation?

What happens if someone dies in quarantine or isolation?

What happens to facilities after they are used for quarantine or isolation?

Can people bring their pets/family/friends into a quarantine or isolation facility?

Can a community refuse to have a quarantine or isolation facility located nearby?

How will quarantine and isolation affect community life, including transportation?

Are there differences of opinion among experts about the need for and effectiveness of quarantine or isolation procedures?

After release from quarantine or isolation, will people be able to go back to work?

What are the personal, family and job consequences for people in quarantine or isolation?

In quarantine or isolation, will special provisions be made for cultural, religious and ethnic beliefs and values?

Who will pay the costs for quarantine or isolation?

Who will pay the costs for lost wages of people in quarantine or isolation?

Implementation Matrix

Implementation Matrix: *System Failure & Basic Staff Response*

Failure of:	What to Expect:	Who to Contact:	Responsibility of User:
Computer Systems	System down	Information Systems	Use backup manual/paper system
Electrical Power Failure Emergency Generators Work	Many outlets are out. Only RED plug outlets work.	Engineering Respiratory Therapy	Ensure that life support systems are on emergency power (red outlets). Ventilate patients by hand as necessary. Complete cases in progress ASAP. Use flashlights.
Electrical Power Failure: Total	Failure of all electrical systems	Engineering Respiratory Therapy	Utilize flashlights and lanterns, hand ventilate patients, manually regulate IVs, don't start new cases.
All Elevators Out of Service	All vertical movement will have to be by stairwells.	Engineering and All Managers	Review fire and evacuation plans, establish services on first or second floor, use carry teams to move critical patients and equipment to other floors.
Elevator stopped between floors	Elevator alarm bell sounding	Engineering and Security	Keep verbal contact with persons in elevator and let them know help is on the way.
Fire Alarm System	No fire alarms or sprinklers	Engineering	Institute Fire Watch, minimize fire hazards, use phone, 2-way radios or runners to report fire
Medical Gases	Gas alarms, no O2, medical air or Nitrous Oxide (NO2)	Engineering, Storeroom and Respiratory Therapy	Hand-ventilate patients, transfer patients if necessary, use portable O2 and other gases, call Respiratory for additional portable cylinders.
Medical Vacuum	No vacuum, vacuum systems fail and in alarm	Engineering, Respiratory Therapy and SPD	Call SPD/CSR for portable vacuum, obtain portable vacuum from crash cart, rush cases in progress, don't start new cases
Natural Gas, Failure or Leak	Odor, no flames on burners, etc	Engineering	Open windows to ventilate, turn off gas equipment, don't use any spark producing devices, electric switches, etc
Nurse Call System	No patient contact	Engineering and Applicable Nursing Unit	Use bedside patient telephones if possible, move patients, use bells, detail a rover to check patients
Patient Care, Equipment/ Systems including Diagnostics Imaging	Equipment/system does not function properly	Biomedical	Call Biomedical and tag defective equipment to take out service. (After hours, call "0" to report).
Sewer Stoppage	Drains backing up	Engineering	Do not flush toilets, do not use water.
Steam Failure	No building heat, hot water, laundry, sterilizers inoperative, limited cooking	Engineering and SPD	Conserve sterile materials and all linens, provide extra blankets, prepare cold meals. Use chemical sterilization or transport to other facility for sterilization.
Telephones	No phone service	Information Systems	Use overhead paging, cellular phones or pay phones, use runners as needed.
Water	Sinks and toilets inoperative	Engineering, Housekeeping, SPD	Institute Fire Watch, conserve water, use bottled water for drinking, be sure to turn off water in sinks, use RED bags in toilets. Use alternate hand washing methods such as alcohol, foam and wipes.
Water Non-Potable	Tap water unsafe to drink	Engineering, Food Services, Housekeeping and all Managers	Place "Non Potable Water- Do Not Drink" signs at all drinking fountains and wash basins. Invoke water conservation.
Ventilation, heating and/or cooling	No ventilation; no heating or cooling	Engineering	Institute Fire Watch or obtain blankets if needed, restrict use of odorous/hazardous materials

Problem	Description	Initial Response	Secondary Response	Follow Up
Bomb Threat (Code Yellow)	Notification of a bomb on-site, usually by an outside caller	Obtain as much information as possible—Where is the bomb, when will it go off, what does it look like, why was it placed, etc. Secure the area.	Report all information to your supervisor and Administration	Search the area for a bomb. Do not touch if found! Report anything suspicious.
Evacuation	Remaining in area may be hazardous to life, health or safety	Notify all in area of need to evacuate. Evacuate ambulatory, wheelchair, the bedridden. Take records if safety permits.	Report to designated assembly area and account for all who were in previous area.	Identify any personnel unaccounted for.
Fire R.A.C.E P.A.S.S. Code Red	Fire, smoke or smell of something burning	**R**escue those in immediate danger (if safe to do so.) **A**larm (pull station or ext.___) **C**ontain the fire (close doors.) **E**xtinguish the fire (if safe to do so.)	Use an extinguisher to put out the fire: **P**ull the pin. **A**im the Hose. **S**queeze the handle. **S**weep from side to side.	Evacuate if immediate danger or at the direction of senior administration.
Hazardous Materials Spill ********** Code Orange	Infectious Material Spill—Small spill presenting minimal hazard to staff, the patient or the environment. ********** Chemical Spill—Any spill which may present a hazard to people or the environment or the effects are unknown.	Trained user cleans up the spill with appropriate personal protective equipment and decontamination materials. ********** Isolate the spill area (evacuate). Call Code Orange if trained user cannot safely clean up the spill.	Appropriately dispose of materials. ********** Seek/coordinate medical treatment of decontaminated victims. For exposed staff, file report with Employee Health for evaluation.	Supervisor to complete report of the incident and send to Infection Control. ********** Supervisor to complete report of the incident and send to HAZMAT Coordinator for documentation and notification of appropriate regulatory agencies.
Code Grey—Exit Block Code Grey—Location	Used for Elopement of adult patients Staff and/or Security require additional help with patient, visitor, etc	Staff calls ext. _____ and asks operator to announce Code Grey—Exit Block Staff calls emergency phone number ext._____ for switchboard to announce Code Grey and Location	Staff should follow procedure for Exit Block Any available staff capable of assisting should report to the announced location for further directions	Refer to (policy)
Code Silver	Person observes, or is a victim of, a dangerous or potentially dangerous crime or hostage situation	Person contacts emergency switchboard ext. _____ and provides operator with as much descriptive information as possible	Operator calls “the police” and announces “Code Silver” and location	Refer to (policy)
Code Amber	Infant or Child Abduction	Staff calls ext. _____ and asks operator to announce Code Amber	Staff should follow procedure for Exit Block	

Nursing Home

Incident Command System

(NHICS)

Facility System Status Report

NHICS 251 – FACILITY SYSTEM STATUS REPORT

1. Operational Period Date/Time	2. Date Prepared	3. Time Prepared	4. Building Name:

5. SYSTEM STATUS CHECKLIST

COMMUNICATION SYSTEM	OPERATIONAL STATUS	COMMENTS *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Fax	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Information Technology System (email/registration/patient records/time card system/intranet, etc.)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Nurse Call System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Paging - Public Address	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Radio Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Satellite System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, External	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, Proprietary	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Video-Television-Internet-Cable	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
INFRASTRUCTURE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Campus Roadways	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Fire Detection/Suppression System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Food Preparation Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ice Machines	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Laundry/Linen Service Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

Purpose: Record facility status for operational period for incident **Origination:** Infrastructure Branch Director NHICS 251
Original to: Situation Unit Leader
Copies to: Safety Officer, Operations Section Chief, Business Continuity Branch Director, Planning Section Chief, and Documentation Unit Leader

Structural Components (building integrity)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
PATIENT CARE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Decontamination System (including containment)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Digital Radiography System (e.g., PACS)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ethylene Oxide (EtO)/Sterilizers	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Isolation Rooms (positive/negative air)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
SECURITY SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Door Lockdown Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Surveillance Cameras	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
UTILITIES, EXTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Electrical Power-Primary Service	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sanitation Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Natural Gas	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
UTILITIES, INTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Air Compressor	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

Electrical Power, Backup Generator	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Fuel status)
Elevators/Escalators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Hazardous Waste Containment System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Heating, Ventilation, and Air Conditioning (HVAC)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Medical Gases, Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Oxygen	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Pneumatic Tube	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Steam Boiler	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sump Pump	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Well Water System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Vacuum (for patient use)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water Heater and Circulators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
6. CERTIFYING OFFICER		
7. FACILITY NAME		

Hospital Incident Command System (HICS)

Facility System Status Report

HICS 251 – FACILITY SYSTEM STATUS REPORT			
1. Operational Period Date/Time	**2. Date Prepared**	**3. Time Prepared**	**4. Building Name:**

5. SYSTEM STATUS CHECKLIST		
COMMUNICATION SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Fax	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Information Technology System (email/registration/patient records/time card system/intranet, etc.)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Nurse Call System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Paging - Public Address	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Radio Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Satellite System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, External	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, Proprietary	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Video-Television-Internet-Cable	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
INFRASTRUCTURE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Campus Roadways	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Fire Detection/Suppression System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Food Preparation Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ice Machines	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

Purpose: Record facility status for operational period for incident **Origination:** Infrastructure Branch Director HICS 251
Original to: Situation Unit Leader
Copies to: Safety Officer, Operations Section Chief, Business Continuity Branch Director, Planning Section Chief, and Documentation Unit Leader

Laundry/Linen Service Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Structural Components (building integrity)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
PATIENT CARE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Decontamination System (including containment)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Digital Radiography System (e.g., PACS)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ethylene Oxide (EtO)/Sterilizers	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Isolation Rooms (positive/negative air)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
SECURITY SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Door Lockdown Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Surveillance Cameras	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
UTILITIES, EXTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Electrical Power-Primary Service	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sanitation Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Natural Gas	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional	

	☐ Nonfunctional	
UTILITIES, INTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Air Compressor	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Electrical Power, Backup Generator	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Fuel status)
Elevators/Escalators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Hazardous Waste Containment System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Heating, Ventilation, and Air Conditioning (HVAC)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Medical Gases, Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Oxygen	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Pneumatic Tube	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Steam Boiler	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sump Pump	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Well Water System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Vacuum (for patient use)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water Heater and Circulators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
6. CERTIFYING OFFICER		
7. FACILITY NAME		

Facility Status Update

Facility Status Update

Status Update for _____
Facility Name Date Time

Census _____ Number of patients
_____ % cases confirmed influenza

.....

Our facility is

___ Fully functioning
___ Experiencing diminished capacity
___ Reduced Staff
___ Overwhelming number of patients
___ At capacity
___ Exceeding capacity
___ Depleted supplies and medications

Additional Comments: _____

_____

_____

_____

We have had to:

____ Modify our visitation policy, as follows:

_____

_____

_____

____ Stop admissions
____ Suspend some services, specifically:
___ Alzheimer's unit
___ Dementia unit
___ Ventilator-dependent
___ Medical clinic
___ Other: _____

Additional Comments: _____

_____

_____

.....

Messages to the Community

_____ Use appropriate precautions (proper hygiene).
_____ If sick:

- Isolate yourself from family and friends that are well
- Stay home until fully recovered
- Avoid group gatherings
- Do not come to the facility if ill

Additional Comments: _____

_____

_____

Update to be provided every: _____ hours/days

Contact: _____

Influenza Specific Supplies

Influenza Specific Supplies

Source: HHS Pandemic Influenza Plan, Supplement 3: Health Care Planning. U.S. Department of Health and Human Services Web site, http://www.hhs.gov/pandemicflu/plan/sup3.html.

Examples of items needed in increased amounts for influenza-specific care may include:

- Hand hygiene supplies (antimicrobial soap; alcohol-based, waterless hand hygiene products and dispensers)
- Disposable N-95 masks; surgical and procedural masks
- Face shields (disposable or reusable)
- Gowns
- Gloves (latex and nitrile)
- Facial tissues
- Central line kits
- I.V. tubing, connectors, Tegaderm, Opsite, tape, etc.
- Ventilators and associated tubing
- Respiratory care equipment
- Beds
- I.V. pumps, tubing, I.V. catheters, etc.

Seeking Information

from Vendors

Seeking Information from Vendors

Contract:
• Is our contract current?
• Does our contract stipulate a specific level of required pandemic flu preparedness?
• Does our contract allow us to audit vendor preparedness compliance?
• Is there a procedure that would allow orders to be placed if an official purchase order could not be generated?

Purchasing Tier:
• What level client does the vendor consider our facility to be within its business (e.g., primary, secondary, intermittent, new)?
• What priority, if any, are healthcare facilities given during a pandemic?

Order Fulfillment:
• Is there a standing emergency purchase order(s) on file for our facility?
• If on file, do these purchase orders expire? When?
• Have the emergency purchase orders been customized for our facility?
• Does the vendor require several levels of purchasing actions? If so, please explain these actions.
• What trigger points will activate the different levels of purchasing activity?
• If there is a shortage, how does the vendor determine what supplies in the emergency purchase order will be provided to our facility? Are there any minimum guarantees?
• Absent of placing an order, will our facility continue to receive regular deliveries if this is how routine business has been conducted?

Vendor Operations:
• In the case of a crisis, what are the names and telephone numbers (including cell phone) of key vendor employees that may be contacted 24 hours a day with questions or concerns regarding supplies?
• Does the vendor have incident management and business continuity plans that will be in place during a pandemic? If so, will they share them with us?
• What are trigger points for certain actions in the vendor's pandemic plan (e.g., actions tied to the WHO pandemic phases, U.S. Government pandemic stages, etc.)?
• If a pandemic plan is implemented, what significant vendor actions may impact our facility's supply chain?
• How does the vendor prioritize customer orders fulfillment?
• If the vendor's primary supply sources are interrupted, what plans are in place to ensure our facility receives the supplies we need in a timely fashion?

24-Hour Emergency

Contact Form

24-Hour Emergency Contact Form

Date Completed: _____
(To be done annually)

PRIMARY VENDOR:

_____ _____
Company Name Contact Name

_____ _____
Title Day Phone

_____ _____
Cell Date Purchase Order Submitted

_____ _____
After-hours Contact Name & Phone Secondary After-hours Contact Name & Phone

---

SECONDARY VENDOR:

_____ _____
Company Name Contact Name

_____ _____
Title Day Phone

_____ _____
Cell Date Purchase Order Submitted

_____ _____
After-hours Contact Name & Phone Secondary After-hours Contact Name & Phone

---

TERTIARY VENDOR:

_____ _____
Company Name Contact Name

_____ _____
Title Day Phone

_____ _____
Cell Date Purchase Order Submitted

_____ _____
After-hours Contact Name & Phone Secondary After-hours Contact Name & Phone

Government Assistance

with Supplies

Government Assistance with Supplies

The Office of Emergency Management (OEM), or similar organization in your region, is the governmental entity with primary responsibility for managing a crisis in your community. This planning and management body may exist in a local town or city government, at the county level, or it may be organized at the state level. Within OEM, there is a person responsible for health care logistics and supplies. It is important to have a detailed discussion and set a proactive plan in place with OEM to ascertain what assistance you can expect from the government during a pandemic.

Following are discussion items to explore with OEM:

• If the normal supply chain is interrupted, can OEM help procure medical supplies? Can OEM access the Strategic National Stockpile (SNS)? If the answer is yes to either question, what supplies may be relied upon in during a pandemic and in what quantities?

• Can OEM obtain specialized items to maintain critical support functions for our facility (e.g., portable generators, potable water, ice, temporary HVAC systems, radios, fuel, propane, etc.)?

• How should our facility request items from OEM? Are there forms that must be used or procedures that must be followed?

• How does OEM track requests and give feedback to our facility? What is a reasonable timeframe in which our facility should expect replies from OEM?

• If local OEM cannot fulfill a request, how may we escalate our request to the next level (e.g., FEMA)?

• What is the emergency management hierarchy within our state/region/county/town? Who are our main contacts and emergency backup contacts?

Consumable Materials

Considerations

Consumable Materials Considerations

During a pandemic, severe shortages of consumable supplies may occur. This may be due to interruptions in the supply chain or from greatly increased product utilization. In light of this, routine infection control and patient safety activities that utilize consumable materials should be examined.

The following are examples of procedures for consideration:

- Safe extension of time between routine I.V. site changes
- Evaluation of how frequently bandages may be changed
- When disposable gloves should be used and changed and who should use them (e.g., may non-clinical areas use heavier non-disposable gloves?)
- How long masks may be worn and who should wear them
- How to safely reuse single-use items (e.g., masks under certain circumstances)

Model

Memorandum of

Understanding (MOU)

Regarding Sharing of

Personnel During a Disaster

This document was prepared by the Greater New York Hospital Association. This document was supported by Grant number U3RMCO1549-01, from the Health Resources and Services Administration (HRSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

Prepared by GYNHA 2004

MODEL
MEMORANDUM OF UNDERSTANDING REGARDING SHARING OF PERSONNEL DURING A DISASTER*

This Memorandum of Understanding (the "Agreement") is made and entered into as of this _____ day of _____, 2004, by and between _____ ("Hospital A") and _____ ("Hospital B"). "Hospital A" and "Hospital B" are collectively referred to as "Hospitals" or "parties."**

RECITALS

WHEREAS, "Hospital A" is a hospital with its main campus located at _____;

WHEREAS, "Hospital B" is a hospital with its main campus located at _____;

WHEREAS, the parties acknowledge that each party may from time to time require personnel to optimally meet the needs of patients due to the occurrence of a disaster; and

WHEREAS, the parties have determined that a Memorandum of Understanding, developed prior to a sudden and immediate disaster, is needed to facilitate the sharing of personnel in the event of a disaster;

NOW, TEHREFORE, in consideration of the above recitals, the parties agree as follows:

1. **Definitions.**

a. "Borrowing Hospital" is the party that requests personnel from the other party in the event of a Disaster.

*This document was supported by Grant number U3RMCO1549-01, from the health Resources and Services Administration. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA or the New York City Department of health and Mental Hygiene.

**This document is designed as a model. The names of the hospitals entering into this agreement should be inserted in place of "Hospital A" and "Hospital B."

b. "Designated Representative" is the individual or position designated by each party to communicate with the other party.

c. "Disaster" means an event in which the hospital's emergency management plan has been activated and the hospital is unable to handle immediate patient care needs. Disasters include, but are not limited to, natural disasters, such as hurricanes, and other events, such s acts of terrorism that generate mass casualties. A Disaster may affect the entire facility or only a portion of the facility.

d. "Lending Hospital" is the party that is available to provide personnel to the other party in the event of a Disaster.

2. **Identification of Designated Representative.** Each party agrees to identify a Designated Representative and at least one back-up individual to communicate with the other party prior to and in the event of a Disaster. The names and contact information for the parties' Designated Representatives and back-up individuals is attached hereto as Exhibit "A" and is incorporated herein by this reference.

3. **Sharing of Information Regarding Personnel**. Prior to a Disaster, each party agrees, to the best of its ability, to share information regarding the personnel that may be available to be shared in the event of a Disaster. Such information may include: the name, employment status, licensure, training, and the individuals' specific delineation of clinical privileges.

4. **Lending of Personnel**. The Lending Hospital agrees to use its best efforts to make personnel available to the Borrowing Hospital in the event of a Disaster, upon request. The Lending Hospital shall be entitled to use its own reasonable judgment regarding the personnel it can provide without adversely affecting its own ability to provide services. Personnel subject to this agreement may include professional staff such as physicians and nurses, as well as ancillary staff (such as housekeeping and food service workers).

5. **Communication of Request for Personnel**. After a Disaster has occurred, the Borrowing Hospital's Designated Representative may initially request personnel from the Lending Hospital's Designated Representative verbally. The request must be confirmed in writing as soon as possible. This should ideally occur prior to the arrival of personnel at the Borrowing Hospital. To the extent practicable, the Borrowing Hospital will identify to the Lending Hospital the following:

a. the type and number of requested personnel;

b. an estimate of how quickly the personnel are needed;

c. the location where the personnel are to report; and

d. an estimate of how long the personnel will be needed.

6. **Response to Request for Personnel**. In response to the request, the Designated Representative of the Lending Hospital will provide the Borrowing Hospital with the following information for the personnel that the Lending Hospital is able to send: the number, names, licensure status, types of personnel, and when applicable, the specific delineation of clinical privileges.

7. **Documentation**. The arriving personnel will be required to present their Lending Hospital's identification badge at the site designated by the Borrowing Hospital's Designated Representative. The Borrowing Hospital will be responsible for the following:

a. confirming the personnel's identification card with the list of personnel provided by the Lending Hospital; and

b. providing additional identification, e.g., "visiting personnel" badge, to the arriving donated personnel.

8. **Responsibility for Personnel**. The parties agree that the personnel made available to the Borrowing Hospital shall be totally under the supervision and control of the Borrowing Hospital while performing any actions in response to the Borrowing Hospital's request for personnel. [Hospitals should insert specific provisions regarding indemnification and malpractice insurance coverage for personnel that are borrowed/ loaned pursuant to this agreement. Following is an example of such language: "Borrowing Hospital agrees to notify its professional liability insurer of the circumstances under which personnel from the Lending Hospital will be performing services pursuant to this agreement. Borrowing Hospital shall use commercially reasonable efforts to extend its professional liability insurance to cover the services performed by such personnel while they are acting pursuant to this agreement."]

9. **Recall of Staff**. The Lending Hospital may recall its personnel at any time in its sole discretion. If feasible, adequate notice will be provided to allow the Borrowing Hospital to arrange staffing from other facilities or agencies.

10. **Term**. The term of this Agreement shall be _____ year(s) from the date of execution, and this Agreement shall be self-renewing for additional _____ year terms; provided however, that this Agreement may be terminated with or without cause, by either party giving sixty (60) days prior written notice of termination to the other party.

11. **Effect of Agreement**. The execution of this Agreement shall not give rise to any liability or responsibility to either party for failure to respond to any request for assistance, lack of speed in responding to such a request, or the abilities or actions of the responding personnel.

EXHIBIT A
Name of Hospital A:

_____

Title of Designated Representative:

_____

Contact Number of Designated Representative:

_____

E-Mail of Designated Representative:

_____

Name of Back-Up Individual:

_____

Title of Back-Up Individual:

_____

Contact Number of Back-Up Individual:

_____

E-Mail of Back-Up Individual:

_____

Name of Hospital B:

_____

Title of Designated Representative:

_____

Contact Number of Designated Representative:

_____

E-Mail of Designated Representative:

_____

Name of Back-Up Individual:

_____

Title of Back-Up Individual:

_____

Contact Number of Back-Up Individual:

_____

E-Mail of Back-Up Individual:

_____

Resources

ACIP Recommendation for Use of CSL Influenza Vaccine
CDC's Advisory Committee on Immunization Practices (ACIP) recommendations for use in the United States of seasonal influenza trivalent inactivated vaccine (TIV) Afluria manufactured by CSL Limited during 2010-2011.
http://www.cdc.gov/media/pressrel/2010/s100806.htm

A Guide for Older Adults
United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
http://www.georgiadisaster.info/Elders/Elderly%20FS%204/Guide%20for%20Older%20Adults.pdf

California Association of Health Facilities (CAHF) Pandemic Influenza Workbook for Long Term Care Providers
A guide that includes actions that can be taken by long term care providers.
http://www.cahfdownload.com//cahf/dpp/CAHF%20PIWB%202010.pdf

Centers for Disease Control: Infection Control in Healthcare Facilities
Summary documents, guidelines and resources related to infection control.
http://www.cdc.gov/flu/professionals/infectioncontrol/

Centers for Disease Control: Information for Health Professionals
Provides key information and resources related to vaccination, infection control, prevention, treatment and diagnosis of seasonal influenza.
http://www.cdc.gov/flu/professionals/index.htm

Centers for Disease Control: Recommendations of the Advisory Committee on Immunization Practices (ACIP)
http://www.cdc.gov/flu/professionals/acip/

Centers for Disease Control: Seasonal Flu- Free Resources
Provides free print materials, Web and video/audio tools for download.
http://www.cdc.gov/flu/freeresources/index.htm

CRS Report for Congress: Federal and State Quarantine and Isolation Authority
Swendiman, Kathleen S. and Elsea, Jennifer K. Congressional Research Service. Updated January 23, 2007.
Provides an overview of federal and state public health laws as they relate to quarantine and isolation.
http://www.fas.org/sgp/crs/misc/RL33201.pdf

Developing Cultural Competence in Disaster Mental Health Programs
U.S. Department of Health and Human Services. DHHS Pub. No. SMA 3828. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.
http://homelessness.samhsa.gov/ResourceFiles/SMA03-3828.pdf

Disaster Preparedness Plan: Template for Use in Long Term Care Facilities
Missouri Department of Health and Senior Services
http://www.dhss.mo.gov/Ready_in_3/MoEmergencyActionPlan.pdf

Free Patient/Community Education Resources
These CDC resources are available in Spanish, Arabic, Chinese, French, German, Korean, Russian, and Vietnamese.
http://www.cdc.gov/flu/freeresources/index.htm

How to Deal with Grief
United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
http://www.samhsa.gov/MentalHealth/Anxiety_Grief.pdf

Long-Term Care and Other Residential Facilities Pandemic Influenza Planning Checklist
Developed by the U.S.Department of Health and Human Services and the Centers for Disease Control.
http://www.flu.gov/professional/pdf/longtermcare.pdf

New Jersey Department of Health and Senior Services Application for Waiver
Procedure for submission of a waiver request and waiver application form.
http://nj.gov/health/forms/cn-28_28a.pdf

New Jersey Hospital Association H1N1 Visitation Guidelines for Healthcare Facilities
New Jersey Hospital Association (NJHA) November 2009 memorandum outlining suggested pandemic influenza visitation guidelines.
http://www.njha.com/h1n1flu/pdf/H1N1VisitationGuidelinesforHealthcareFacilitie.pdf

Principles and Practical Procedures for Acute Psychological First Aid Training for Personnel Without Mental Health Experience
Everly, Jr., George S., Flynn, Brian W. International Journal of Emergency Mental Health, Vol. 8, No. 2, pp. 93-100. 2006 Chevron Publishing ISSN 1522-4821
http://www.ncbi.nlm.nih.gov/pubmed/16703847

Psychological First Aid: Field Operations Guide for Nursing Homes, April, 2008
Brown, L.M., Hyer, K.
http://amhd.cbcs.usf.edu/pfanh.pdf

Question and Answers: CSL Seasonal Influenza Vaccine Safety in the United States

Information for Health Providers about ACIP recommendations for use of CSL vaccine during the 2010–2011 influenza season.
http://www.cdc.gov/flu/protect/vaccine/qa_cslfluvac.htm

Recommended Influenza Vaccines for the U.S. 2010-11 season

Table of recommended influenza vaccines for different age groups — United States, 2010-11 season. Includes presentation and dosing information.
http://www.cdc.gov/flu/protect/vaccine/vaccines.htm

Surge Staffing Resource List:

- Medical Reserve Corps (MRCs)
- Emergency System for Advanced Registration of Voluntary Healthcare Personal (ESAR-VHP)
- Community Emergency Response Teams (CERT)
- Medical Society of NJ
- Spontaneous volunteers
- Local Red Cross—New Jersey Chapters:

NORTH	CENTRAL	SOUTH
▪ Northern NJ Chapter ▪ Colonial Crossroads Chapter: *Berkeley Heights, Chatham Borough, Chatham Township, East Hanover, Florham Park, Long Hill Township, Madison, New Providence, Springfield, Summit* ▪ Millburn-Short Hills Chapter ▪ Montclair-Glen Ridge-Nutley Chapter ▪ Westfield/ Mountainside Chapter ▪ Sussex County Chapter	▪ Central NJ Chapter ▪ Greater Somerset County Chapter ▪ Tri-County Chapter: *Union County, Middlesex County, Somerset County*	▪ Burlington County Chapter ▪ Camden County Chapter ▪ Gloucester County Chapter ▪ Jersey Coast Chapter: *Monmouth County, Ocean County* ▪ Salem County Chapter ▪ Southern Shore Chapter: *Atlantic County, Cumberland County, Cape May County*

Glossary

ACIP Advisory Committee on Immunization Practices

BIA Business Impact Analysis

CDC Centers for Disease Control and Prevention

CMS Centers for Medicare and Medicaid Services

CN Certificate of Need

COOP Continuity of Operations Planning

CoPs Conditions of Participation (CMS)

DHSS Department of Health and Senior Services (NJ)

EMAC Emergency Management Assistance Compact

EMP Emergency Management Plan

EOC Emergency Operations Center

ESAR-VHP Emergency System for Advance Registration of Volunteer Health Professionals

FEMA Federal Emergency Management Agency

GETS Government Emergency Telecommunications Service

HFEL Health Facilities Evaluation and Licensing (NJ)

HICS Hospital Incident Command System

HSPD Homeland Security Presidential Directive

HVA Hazard Vulnerability Analysis

ICS Incident Command System

ISP Internet Service Provider

IT Information Technology

LEPC Local Emergency Planning Committee

LINCS Local Information Network and Communications Systems (NJ)

MCC Medical Coordination Center (NJ)

MOU Memorandum of Understanding

MRC Medical Reserve Corps

NFPA National Fire Protection Association

NHICS Nursing Home Incident Command System

NIMS National Incident Management System

OEM Office of Emergency Management

OSHA Occupational Safety and Health Administration

PACS Picture Archiving and Communication System

PHILEP Public Health Infrastructure, Laboratories, and Emergency Preparedness (NJ)

PIO Public Information Officer

PPE Personal Protective Equipment

PREP Act Public Readiness and Emergency Preparedness Act

RPO/RTO Recovery Point Objective/ Recovery Time Objective

SARS Severe Acute Respiratory Syndrome

SME State Medical Examiner

SNS Strategic National Stockpile

WPS Wireless Priority Service