

PANDEMIC INFLUENZA RESPONSE PLAN

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Connecticut Department of Public Health

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I. INTRODUCTION

In Connecticut, the lead state agencies for pandemic influenza preparedness planning include the departments of Public Health, Emergency Management and Homeland Security, Administrative Services, Education, Agriculture, and Environmental Protection. These agencies form the core of the State's interagency pandemic influenza strategic planning team. The departments of Information Technology and Public Works, and the offices of the Attorney General, Policy and Management, and Labor Relations also are involved.

The Department of Public Health (DPH) is the lead administrative and planning agency for public health initiatives, including public health emergency preparedness. DPH works with federal, state, regional, and local partners to improve Connecticut's ability to respond to public health emergencies. The *Connecticut Public Health Emergency Response Plan* (Connecticut PHERP) identifies the DPH response activities during a public health emergency. The plan supports the public health and medical care component, (Emergency Support Function #8), in existing state disaster and emergency plans.

From the standpoint of disease control, DPH's overall goals are to assure that the sick get treated, infections are prevented, and social and economic impact are minimized. During an influenza pandemic, he agency attempts to ensure that:

- Those who are ill do not infect others, by treating those who are ill and isolating those who are infectious;
- Those who are infected do not get ill, by providing antivirals to those who have been exposed;
- Those who are not infected do not become infected, by providing those who are well with protection from infection, via barrier methods or social distancing.

Connecticut's Public Health Emergency Response Authority

In Connecticut, Public Act 03-236 established criteria and mechanisms for declaring a public health emergency and made major revisions to the provisions for isolation and quarantine.. Under a Declaration of a Public Health Emergency, the Governor may order the Commissioner of Public Health to implement a response plan, isolate and quarantine groups and/or individuals, and vaccinate. As it relates to isolation and quarantine, the Declaration lessens the burden of proof for the court to a preponderance of the evidence and allows law enforcement agents to take into custody anybody who disobeys the order. The Commissioner may delegate this authority to any local health director or employee of the Department of Public Health.

In the absence of a declared public health emergency, the authority to order isolation and quarantine abides solely with the local director of health, as in the past. Section 12 of the Public Health Emergency Response Authority (PHERA) replaces Section 19a-221 of the *Connecticut General Statutes* and is about local authority to order a person isolated or quarantined when there is no Governor's Declaration. Under such circumstances, the burden of proof for the court used the heightened scrutiny of clear and convincing evidence for the action.

The present Plan assumes that under PHERA, the Governor has declared a public health emergency in response to the arrival or the impending arrival of pandemic influenza in Connecticut. Under PHERA, the Governor may also: (1) order the DPH Commissioner to implement all or part of a public health emergency response plan; (2) authorize the DPH Commissioner to order the isolation or quarantine of persons; (3) order the DPH Commissioner to vaccinate persons; or (4) apply for federal assistance (CGS §19a-131a).

A. Purpose

The *Connecticut Pandemic Influenza Response Plan* is an annex to the *Connecticut Public Health Emergency Response Plan*. It was developed to provide a framework for government agencies and private organizations to work together to mitigate the consequences of pandemic influenza.

The present document is a working draft and as such is subject to revision. It will be reviewed periodically to ensure that its provisions are consistent with current public health knowledge and information.

The purpose of the *Connecticut Pandemic Influenza Response Plan* is to support the following four functions of the Connecticut emergency response effort:

- Maximize the protection of lives and health care properties, while minimizing preventable morbidity and mortality;
- Document which DPH procedures to implement in response to an influenza pandemic that threatens the public health of Connecticut;
- Contribute to emergency support functions (ESFs), as appropriate, particularly ESF #8 (Public Health and Medical Services) at the state level, to define policies and procedures for DPH and other public health partners to prepare for and respond to an influenza pandemic; and
- Enable the State of Connecticut to continue to operate and provide services as normally and effectively as possible, in the event of an influenza pandemic.

B. Scope of the Plan

The *Connecticut Pandemic Influenza Response Plan* presents emergency situations, planning assumptions, and detailed descriptions of the roles and responsibilities of DPH in an influenza pandemic, including the direction of local and regional public health and health care providers.

C. Ethical Framework for Decision Making¹

During an influenza pandemic, governments and public health authorities will have to make difficult decisions (e.g., access to vaccines and antivirals, reallocation of people and resources). Stakeholders, including, members of the public, patients, health care workers, and other organizations, are more likely to accept the difficult decisions if the decision-making processes are:

¹ Adapted from: Ontario Ministry of Health and Long-Term Care. Ontario Health Plan for an Influenza Pandemic (http://www.health.gov.on.ca/english/providers/program/emu/pan_flu/pan_flu_plan.html) and Ethics in a Pandemic Influenza Crisis. Framework for Decision Making, by Dr. Jennifer Gibson, of the Joint Centre for Bioethics, University of Toronto.

- ***Open and transparent.*** The process by which decisions are made must be open to scrutiny, and the basis for decisions should be explained.
- ***Reasonable.*** Decisions should be based on reasons (i.e., evidence, principles, values) and be made by people who are credible and accountable.
- ***Inclusive.*** Decisions should be made explicitly with stakeholder views in mind, and stakeholders should have opportunities to be engaged in the decision-making process.
- ***Responsive.*** Decisions should be revisited and revised as new information emerges, and stakeholders should have opportunities to voice any concerns they have about decisions through dispute and complaint mechanisms.
- ***Accountable.*** There should be mechanisms to ensure that ethical decision-making is sustained throughout the pandemic.

Core Ethical Values

Connecticut's response to an influenza pandemic will be based on the following core ethical values. More than one value may be relevant in any given situation, and some values may be in tension with others. This tension may cause ethical dilemmas to emerge during a pandemic, and reinforces the importance of shared ethical language and a decision-making processes that assigns moral weight to each value when values conflict.

- ***Individual Liberty.*** Individual liberty (i.e., respect for autonomy) is a value enshrined in our laws and in healthcare practice. During a pandemic, it may be necessary to restrict individual liberty to protect the public from serious harm. Individual liberty can be preserved to the extent that the imposed limits and the reasons for them are transparent. Restrictions to individual liberty will:
 - Be proportional to the risk of public harm.
 - Be necessary and relevant to protecting the public good.
 - Employ the least restrictive means necessary to achieve public health goals.
 - Be applied without discrimination.
- ***Protection of the Public from Harm.*** Public health authorities are obligated to protect the public from serious harm. For public health to fulfill this obligation and minimize serious illness, death, and social disruption, public health may isolate people or use other containment strategies, require healthcare facilities to restrict public access to some areas, or limit some services (e.g., elective surgeries). For protective measures to be effective, citizens must comply with them. The ethical value of individual liberty is often in tension with the obligation to the protect the public from harm; however, it is also in individuals' interests to serve the public good and minimize harm to others. When making decisions designed to protect the public from harm, public health authorities will:
 - Weigh the benefits of protecting the public from harm against the loss of liberty of some individuals (e.g., isolation).
 - Ensure all stakeholders are aware of the medical and moral reasons for the measures, the benefits of compliance, and the consequences of non-compliance.

- Establish mechanisms to review decisions as the situation changes and to address stakeholder concerns or complaints.
- **Proportionality.** Restrictions on individual liberty and measures to protect the public from harm should not exceed the minimum required to address the actual level of risk or need in the community. Decision-makers will:
 - Use the least restrictive or coercive measure possible when limiting or restricting liberties or entitlements.
 - Use more coercive measures only in circumstances where less restrictive means have failed to achieve appropriate public health ends.
- **Privacy.** Individuals have a right to privacy, including the privacy of their health information. During a pandemic, it may be necessary to override this right, to protect the public from serious harm; however, to be consistent with the ethical principle of proportionality, public health authorities will:
 - Determine whether the good intended is significant enough to justify the potential harm of suspending privacy rights (e.g., potential stigmatization of individuals and communities).
 - Require private information only if less intrusive means to protect public health are not available.
 - Limit any disclosure to information required to achieve legitimate public health goals.
 - Take steps to prevent stigmatization (e.g., public education to correct misperceptions about disease transmission).

Note: References in the Plan to the collection, use or disclosure of information or data concern non-identifiable information or data whenever possible. Any collection, use, or disclosure of personal information will comply with governing legislation.

- **Equity.** All patients have an equal claim to receive the health care they need, and health care institutions are obligated to ensure sufficient supply of health services and materials. During a pandemic, tough decisions may have to be made about who will receive antiviral medication and vaccinations, and which health services will be temporarily suspended. Depending on the extent of the pandemic, measures taken to contain the spread of disease may limit access to emergency or essential services. In these circumstances, decision makers will:
 - Strive to preserve as much equity as possible between the needs of influenza patients and patients who need urgent treatment for other diseases.
 - Establish fair decision-making criteria and processes.
- **Duty to Provide Care.** Health care workers have an ethical duty to provide care and respond to suffering. During a pandemic, demands for care may overwhelm health care workers and their institutions, and create challenges related to resources, practice, liability and workplace safety. Health care workers may have to weigh their duty to provide care against competing obligations (i.e., to their own health, family and friends).

Providers may be faced with moral dilemmas when they cannot provide appropriate care because of constraints caused by the pandemic. To support providers in their efforts to discharge their duty to provide care, decision-makers will:

- Work collaboratively with stakeholders, regulatory agencies, and labor associations to establish practice guidelines.
- Work collaboratively with stakeholders, including labor associations, to establish fair dispute resolution processes.
- Strive to ensure the appropriate supports are in place (e.g., resources, supplies, equipment).
- Develop a mechanism for provider complaints and claims for work exemptions.
- **Reciprocity.** Society has an ethical responsibility to support those who face a disproportionate burden in protecting the public good. During a pandemic, the greatest burden will fall on public health practitioners, other health care workers, patients, and their families. Health care workers will be asked to take on expanded duties. They may be exposed to greater risk in the workplace, suffer physical and emotional stress, and be isolated from peers and family. Individuals who are isolated may experience significant social, economic, and emotional burdens. Decision-makers will:
 - Take steps to ease the burdens of health care workers, patients, and patient's families.
- **Trust.** Trust is an essential part of the relationship between government and citizens, between health care workers and patients, between organizations and their staff, between the public and health care workers, and among organizations within a health system. During a pandemic, some people may perceive measures to protect the public from harm (e.g., limiting access to certain health services) as a betrayal of trust. In order to maintain trust during a pandemic, decision-makers will:
 - Take steps to build trust with stakeholders before the pandemic occurs (i.e., engage stakeholders early).
 - Ensure decision making processes are ethical and transparent.
- **Solidarity.** Stemming an influenza pandemic will require solidarity among community organizations, health care institutions, state and local public health agencies, and government. Solidarity requires good, straightforward communication and open collaboration within and among these stakeholders to share information and coordinate health care delivery. By identifying that the health of the general public (and service providers) is a good worth promoting during an influenza pandemic, government decision-makers, public health workers and other health care professionals could model values of solidarity while encouraging others to broaden traditional ethical values focused on rights or interests of individuals.
- **Stewardship.** In our society, both institutions and individuals will be entrusted with governance over scarce resources, such as vaccines, antivirals, ventilators, hospital beds and even health care workers. Those entrusted with governance should be guided by the notion of stewardship, which includes protecting and developing one's resources, and being accountable for public well-being. To ensure good stewardship of scarce resources, decision makers will:
 - Consider both the benefit to the public good and equity (i.e., fair distribution of both benefits and burdens).

II. SITUATION AND ASSUMPTIONS

Pandemic preparedness planning is based on assumptions regarding the evolution and impacts of a pandemic. The following pandemic planning assumptions are from the Implementation Plan for the National Strategy for Pandemic Influenza:

- Susceptibility to the pandemic influenza virus will be universal.
- Efficient and sustained person-to-person transmission signals an imminent pandemic.
- The clinical disease attack rate will be 30 percent in the overall population during the pandemic. Illness rates will be highest among school-aged children (about 40 percent) and decline with age. Among working adults, an average of 20 percent will become ill during a community outbreak.
- Some persons will become infected but not develop clinically significant symptoms. Asymptomatic or minimally symptomatic individuals can transmit infection and develop immunity to subsequent infection.
- While the number of patients seeking medical care cannot be predicted with certainty, in previous pandemics about half of those who became ill sought care. With the availability of effective antiviral medications for treatment, this proportion may be higher in the next pandemic.
- Rates of serious illness, hospitalization, and deaths will depend on the virulence of the pandemic virus and differ by an order of magnitude between more and less severe scenarios. Risk groups for severe and fatal infection cannot be predicted with certainty but are likely to include infants, the elderly, pregnant women, and persons with chronic or immunosuppressive medical conditions.
- Rates of absenteeism will depend on the severity of the pandemic. In a severe pandemic, absenteeism attributable to illness, the need to care for ill family members, and fear of infection may reach 40 percent during the peak weeks of a community outbreak, with lower rates of absenteeism during the weeks before and after the peak. Certain public health measures (closing schools, quarantining household contacts of infected individuals, “snow days”) are likely to increase rates of absenteeism.
- The typical incubation period (interval between infection and onset of symptoms) for influenza is approximately 2 days.
- Persons who become ill may shed virus and can transmit infection for one-half to one day before the onset of illness. Viral shedding and the risk of transmission will be greatest during the first 2 days of illness. Children will play a major role in transmission of infection as their illness rates are likely to be higher, they shed more virus over a longer period of time, and they control their secretions less well.
- On average, infected persons will transmit infection to approximately two other people.
- Epidemics will last 6 to 8 weeks in affected communities.
- Multiple waves (periods during which community outbreaks occur across the country) of illness are likely to occur with each wave lasting 2 to 3 months. Historically, the largest waves have occurred in the fall and winter, but the seasonality of a pandemic cannot be predicted with certainty.
- Each pandemic phase, stage, and interval is associated with a range of preparedness and response activities directed by the Commissioner of the Department of Public Health, in consultation with national, state and local authorities and others, as necessary.

Defining the potential magnitude of a pandemic is difficult because of the large differences in severity for the three 20th-century pandemics. While the 1918 pandemic resulted in an estimated 500,000 deaths in the U.S., the 1968 pandemic caused an estimated 34,000 U.S. deaths. This difference is largely related to the severity of infections and the virulence of the influenza viruses that caused the pandemics. The 20th

century pandemics have also shared similar characteristics. In each pandemic, about 30% of the U.S. population developed illness, with about half seeking medical care. Children have tended to have the highest rates of illness, though not of severe disease and death. Geographical spread in each pandemic was rapid and virtually all communities experienced outbreaks.

The following table provides estimates of the “most likely” impact of an influenza pandemic in Connecticut. These estimates are for one season only and provide estimates for a Category 2 (1968-like) pandemic and a Category 5 (1918-like) pandemic, using a 30% illness rate (percentage of clinical influenza illness cases per population) and Connecticut’s estimated population (3,510,297) in 2005. Calculations were done using the CDC software, FluAid 2.0 (<http://www2.cdc.gov/od/fluaid/default.htm>).

Table 1. Most Likely Estimates of Potential Impact of an Influenza Pandemic with a 30% Illness Rate in Connecticut

Health Outcome	30% Illness Rate	
	Category 2 (1968-like)	Category 5 (1918-like)
Ill, No Medical Care	474,089	422,083
Outpatients	563,647	504,806
Hospitalizations	12,451	102,348
Deaths	2,902	23,852
Total	1,053,089	1,053,089

WHO Pandemic Phases

In 1999, the World Health Organization (WHO) Secretariat published guidance for pandemic influenza and defined the phases of a pandemic. This schema is designed to provide guidance to the international community and to national governments on preparedness and response for pandemic threats and pandemic disease. Updated guidance was published in 2005 to redefine these phases. Compared with the 1999 phases, the new definitions place more emphasis on pre-pandemic phases when pandemic threats may exist in animals or when new influenza virus subtypes infect people but do not spread efficiently. The classification is based on assessment of risk using a range of scientific and epidemiological data.

Summary of WHO Global Pandemic Phases (WHO Global Influenza Preparedness Plan, 2005):

Interpandemic Period

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

Phase 2. No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.

Pandemic Alert Period

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

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

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

Pandemic Period

Phase 6. Increased and sustained transmission in the general population.

Postpandemic Period

Return to the Interpandemic Period (Phase 1). Although not part of the WHO Phases for tracking the emergence of a pandemic, mitigation and recovery should be a part of every emergency response plan. Mitigation and recovery actions should be focused on continuing public health actions including communication with the public on issues such as when public gatherings can resume, and continued monitoring of possible outbreaks of infection.

Recognizing that at any pandemic phase, national situations will differ based on whether a country is affected or not affected by the novel influenza subtype, the World Health Organization Secretariat recommended “national subdivisions” of phases based on whether a country is experiencing disease or has extensive trade and travel links with an affected country. National authorities have designated national subdivisions of phases.

Stages of the Federal Government Response

The WHO phases provide succinct statements about the global risk for a pandemic and provide benchmarks against which to measure global response capabilities. In order to describe the Federal Government approach to the pandemic response, however, it is more useful to characterize the stages of an outbreak in terms of the immediate and specific threat a pandemic virus poses to the U.S. population (see WHO Global Pandemic Phases and the Stages for Federal Government Response between Chapters 5 and 6). The following stages provide a framework for Federal Government actions:

Stage 0: New Domestic Animal Outbreak in At-Risk Country

Stage 1: Suspected Human Outbreak Overseas

Stage 2: Confirmed Human Outbreak Overseas

Stage 3: Widespread Human Outbreaks in Multiple Locations Overseas

Stage 4: First Human Case in North America

Stage 5: Spread throughout United States

Stage 6: Recovery and Preparation for Subsequent Waves

Pandemic Intervals

In the United States, pandemic phases (USG Stages 0-6) are defined based on the global phase and determined by the Secretary of Health and Human Services. During the pandemic phase, additional subdivisions may be defined based on the extent of disease. In actual practice, the distinction between the various phases of pandemic influenza may be blurred or occur in a matter of hours, again underscoring the need for flexibility. To address this concern, the CDC developed more detailed planning for federal, state, and local responses that require a greater level of specificity than is afforded by either the World Health Organization phases or USG stages.

For the purposes of pandemic preparedness, the CDC will use seven intervals to represent the sequential units of time that occur along a hypothetical pandemic curve. For state planning, use of the intervals to describe the progression of the pandemic within communities in the state provides a more granular framework for defining when to respond with various actions and interventions. While there will be one epidemic curve for the United States, the national curve will be the composite of the smaller curves representing each community. Therefore, the intervals serve as additional points of reference within the World Health Organization Phases and USG Stages to provide a common orientation and better epidemiologic understanding of what is taking place and when to intervene. Connecticut will follow the CDC interim guidance on Use of Intervals, Triggers, and Actions (updated 5/13/2008) that corresponds to

World Health Organization guidance for national pandemic planning, as used in the Health and Human Services Pandemic Influenza Plan.

Pandemic Severity Index

In February 2007, the Centers for Disease Control and Prevention introduce the concept of a Pandemic Severity Index (PSI) to assist pre-pandemic planning. The PSI is based primarily on case fatality ratio, a measurement that is useful in estimating the severity of a pandemic on a population level and which may be available early in a pandemic for small clusters and outbreaks. Excess mortality rate may also be available early and may supplement and inform the determination of the PSI. Pandemic severity is described within five discrete categories of increasing severity (Category 1 to Category 5). Other epidemiologic features that are relevant in overall analysis of mitigation plans include total illness rate, age-specific illness and mortality rates, the reproductive number, intergeneration time, and incubation period. However, it is unlikely that estimates will be available for most of these parameters during the early stages of a pandemic; thus, they are not as useful from a planning perspective.

The PSI provides a tool for scenario-based contingency planning to guide pre-pandemic planning efforts. Upon declaration by WHO of having entered the Pandemic Period (Phase 6) and further determination of U.S. Government Stage 3, 4, or 5, the CDC's Director shall designate the category of the emerging pandemic based on the PSI and consideration of other available information. Pending this announcement, communities facing the imminent arrival of pandemic disease will be able to define which pandemic mitigation interventions are most indicated for implementation based on the level of pandemic severity.

III. CONCEPT OF OPERATIONS

In the event of a statewide or regional public health emergency, the Governor may order the Commissioner of Public Health to implement all or a portion of the *Public Health Emergency Response Plan*. Please refer to the *Connecticut Public Health Emergency Response Plan*.

In accordance with the State emergency plan and the DPH emergency response plan, the Governor has the authority to order the activation of this Connecticut Pandemic Influenza Response Plan. The Commissioner may be delegated this authority by the Governor.

The State of Connecticut emergency response mechanisms follow the National Incident Management (NIMS) and Incident Command Systems (ICS), which focus on preparing for and responding to emergency incidents while resuming or sustaining business functions. The State's *National Incident Management System Implementation Plan* is located on the Web at http://www.ct.gov/demhs/lib/demhs/nimsImplementation_plan10_27_05.pdf.

Connecticut's preparedness and response activities are identified in the *Natural Disaster Plan*, prepared by the Connecticut Department of Emergency Management and Homeland Security (DEMHS), and located at http://www.ct.gov/demhs/lib/demhs/jan2006_natural_disaster.doc.

The Department of Public Health is in compliance with both NIMS and ICS through its current organizational structure and emergency response activities. DPH is the State's lead planning and response agency for public health emergencies. The Public Health Emergency Response Plan (PHERP) is located at <http://www.dph.state.ct.us/avian/PHERP.pdf>.

DPH works closely with the state's 80 local health departments. There are 32 full time municipal departments, 20 full time health districts and 28 part time municipal departments. Health districts are made up of two or more towns, with over one hundred of the 169 municipalities in Connecticut as

members of full-time districts. There are two full time Tribal Nation Health Departments as well. (Mashantucket-Pequot and Mohegan) The DPH houses the Local Health Administration Branch, which oversees the activities of the local health departments and is the liaison branch for the Commissioner. Local Health Directors are Agents of the DPH Commissioner and work closely on daily emergency preparedness issues and core public health functions that are the infrastructure in Connecticut. The Public Health Preparedness Managers Group meets bi-monthly to address planning needs and use of PHP funds. The group consists of the co-chairs from the “old” public health preparedness focus areas, one from the DPH and one a local partner. Decisions are made in conjunction with the Connecticut Association of Directors of Health, (CADH) the SACCHO in Connecticut. This organization represents membership covering over 90% of the State’s population. The CADH facilitates the Local Public Health Quarantine and Isolation Working Group on behalf of local health departments in Connecticut.

IV. ORGANIZATIONAL RESPONSIBILITIES

The Governor has overall authority for protecting the health, safety, and welfare of residents, as directed in the Connecticut General Statutes (C.G.S.) §28-9. However, DPH is responsible for providing the essential public health services related to statewide epidemics. Please refer to the Connecticut Public Health Emergency Response Plan for additional details.

A. Responsibilities of the Connecticut Department of Public Health

WHO Pandemic Phases 1 and 2

- The Governor designates the DPH Commissioner responsible for the overall direction and control of health care personnel and resources related to pandemic influenza control at the state level.
- The Commissioner designates the State Epidemiologist to monitor influenza activity at the state, national, and international levels and to provide pandemic influenza updates as needed.
- The Commissioner will designate a Core Team Leader in charge of the Pandemic Influenza Planning and Response Team.
- The Core Team Leader will assemble a group of public health care personnel to prepare a pandemic influenza plan with input from selected public and private health care agencies and governmental organizations.
- The *Connecticut Pandemic Influenza Response Plan* will be submitted as an annex to the *Public Health Emergency Response Plan*, ESF #8 to State Emergency Plans.
- DPH officials will keep the Governor, local health departments, hospitals, and other key response partners updated as necessary.

WHO Pandemic Phase 3 (Documented human cases, but no human-to-human transmission)

- DPH officials will keep the Governor, local health departments, hospitals and other key response partners updated as necessary.

WHO Pandemic Phase 4 (Verified human-to-human transmission, but no cases in the U.S.)

- DPH officials will keep the Governor, local health departments, hospitals, and other key response partners updated as necessary.

WHO Pandemic Phases 5 and 6 (Community-level outbreaks, with cases in the U.S.)

- The Governor will declare a “Public Health Emergency.”
- The Governor will work with DPH and Department of Emergency Management and Homeland Security (DEMHS) to oversee the state’s response to the influenza pandemic, including opening the State Emergency Operations Center (EOC) as needed.
- The Commissioner of Public Health will open the DPH Emergency Command Center (ECC), and the DPH Incident Command System will be activated.
- The State Epidemiologist will manage the epidemiologic and immunization aspects of the state’s pandemic influenza response in collaboration with local health departments, hospitals, and other key response partners.
- Other DPH units, including but not limited to the following ones, will provide assistance to the pandemic response as needed: Epidemiology Program, Immunizations Program, Environmental Health Section, Health Care Systems Regulation Branch, Laboratory Branch, Local Health Administration Branch, Regulatory Services Branch, Office of Communications, Office of Emergency Medical Services, and Office of Public Health Preparedness (OPHP).

WHO Post-Pandemic Period

- DPH will participate in the evaluation of the pandemic response.

B. DPH Incident Command System

- The DPH Incident Command System will serve as the operating protocol for the DPH response. Please refer to the *Connecticut Public Health Emergency Response Plan* for additional details.

C. Local Health Departments

WHO Pandemic Phases 1 and 2

- Each local health departments should develop or update its own pandemic response plan to be consistent with the *Connecticut Pandemic Influenza Response Plan*.
- Each local health department should participate in development of a regional pandemic influenza response plan that is consistent with the *Connecticut Pandemic Influenza Response Plan*.

WHO Pandemic Phase 3 (Documented human cases, but no human-to-human transmission)

- Each local health department will maintain awareness of the evolving situation and provide information to constituents as needed.

WHO Pandemic Phase 4 (Verified human-to-human transmission, but no cases in the U.S.)

- Each local health department will maintain awareness of the evolving situation and provide information to constituents as needed.

WHO Pandemic Phases 5 and 6 (Community-level outbreaks, with cases in the U.S.)

- Each local health department will establish its own Emergency Operations Center and be prepared to collaborate with DPH as needed to:
 - Provide information and respond to public inquiry;
 - Quarantine and isolate individuals and groups as needed;

- Vaccinate constituents and/or provide vaccine and antiviral agents to health care providers in their jurisdiction; and
- Conduct and enforce other activities as may be declared necessary by the Governor and Commissioner of Public Health.

WHO Post-Pandemic Period

- Local health departments will participate in the evaluation of the pandemic response.

D. Hospitals and Medical Care Providers

WHO Pandemic Phases 1 and 2

- Each hospital and medical care provider should develop or update its own pandemic response plan to be consistent with the national and Connecticut *Pandemic Influenza Response Plans*.
- Each hospital and medical care provider should participate in development of a regional pandemic influenza response plan that is consistent with the national and Connecticut *Pandemic Influenza Response Plans*.

WHO Pandemic Phase 3 (Documented human cases, but no human-to-human transmission)

- Each hospital and medical care provider will maintain awareness of the evolving situation and provide information to all employees as needed.

WHO Pandemic Phase 4 (Verified human-to-human transmission, but no cases in the U.S.)

- Each hospital and medical care provider will maintain awareness of the evolving situation and provide information to employees as needed.

WHO Pandemic Phases 5 and 6 (Community-level outbreaks, with cases in the U.S.)

- Each hospital and major medical care provider will establish its own Emergency Operations Center and be prepared to collaborate with DPH as needed to:
 - Collect information to monitor the pandemic;
 - Provide information and respond to patient inquiries;
 - Isolate patients and enforce quarantine of employees and patients as needed;
 - Vaccinate employees and patients and/or provide antiviral agents to health care providers and patients in accordance with DPH recommendations; and
 - Conduct and enforce other activities as may be declared necessary by the Governor and Commissioner of Public Health.

WHO Post-Pandemic Period

- Hospitals and major medical care providers will participate in the evaluation of the pandemic response.

E. All Tasked Organizations

All tasked organizations are responsible for participation in the State of Connecticut's emergency response system under the incident command format. All tasked organizations are responsible for the activities outlined in the Natural Disaster Plan, Public Health Emergency Response Plan, and the appropriate Pandemic Influenza Plan/Annex. Specific to pandemic influenza, all tasked

organizations are additionally responsible to develop continuity of business plans to address the expected staff absences and resource limitations for 3-6 months.

V. RESPONSE ACTIONS

A. Communications Technology

Please refer to the *Connecticut Public Health Emergency Response Plan* for details.

B. Public and Crisis Information (Risk Communication)

WHO Pandemic Phases 1 and 2

- Assess readiness to meet communications needs in preparation for an influenza pandemic, including regular review, exercise, and update of communications plans.
- Plan and coordinate emergency communication activities with private industry, education, and non-profit partners (e.g., local Red Cross chapters).
- Identify and train lead subject-specific spokespersons.
- Provide public health communications staff with training on risk communications for use during an influenza pandemic.
- Engage business leaders in pandemic influenza continuity planning (see *Connecticut Public Health Emergency Response Plan*).
- Work with other non-public health sectors to help provide communications tools for their communities.
- Develop and maintain up-to-date communications contacts of key stakeholders and exercise the plan to provide regular updates as the influenza pandemic unfolds.

WHO Pandemic Phase 3 (Documented human cases, but no human-to-human transmission)

- Coordinate pandemic influenza media messages to ensure consistency.
- Provide regular updates about situations that pose potential pandemic influenza threats (e.g., through Health Alert Network [HAN] notices and Web site postings).
- Distribute educational messages about pandemic influenza and ways that people can protect themselves and their families
- Distribute practical information, such as travel advisories, infection control methods, availability and use of antiviral medications and vaccines, and specific public health actions that may be needed.
- Quench rumors and false reports regarding pandemic influenza threats.

WHO Pandemic Phase 4 (Verified human-to-human transmission, but no cases in the U.S.)

- All actions in the Phase 3 response will be initiated or continued.

WHO Pandemic Phases 5 and 6 (Community-level outbreaks, with cases in the U.S.)

- Coordinate pandemic influenza media messages to ensure consistency.
- Coordinate communications activities with state and local communications staff, including regional or local communications centers as appropriate.

- Promptly respond to rumors and inaccurate information to minimize concern, social disruption, and stigmatization.
- In coordination with epidemiologic and medical personnel, obtain and track information daily on the numbers and location of:
 - Newly hospitalized cases;
 - Newly quarantined persons; and
 - Hospitals with pandemic influenza cases.
- Use these reports to determine priorities among community outreach and education efforts, and to prepare for updates to media organizations in coordination with state and local partners.

WHO Post-Pandemic Period

- Participate in the evaluation of the pandemic response.

C. Response Training

Please refer to the *Connecticut Public Health Emergency Response Plan* for details.

D. Public Health Investigation

WHO Pandemic Phases 1 and 2

CDC U.S. Influenza Sentinel Surveillance Network

- This disease-based surveillance network provides epidemiologic data specific for influenza and influenza-like illnesses (ILI) and monitors antigenic changes in influenza viruses during the interpandemic period.
- Connecticut has 33 sites in this surveillance network. The sites consist of the following medical specialties: college health service (11), family practice (8), internal medicine (5), other (4), pediatrics (3), emergency medicine (1), and urgent care (1).
- This network is one of the earliest indicators of influenza activity nationally. The data it gathers can reflect both the intensity of activity and its actual severity.
- Health care providers count the number of cases of influenza and ILI seen weekly year round.
- The network's health care providers report their weekly patient statistics via phone, fax, or the Internet to CDC. The Connecticut data are available online to DPH. The CDC collates the data regularly and publishes on its web site the statistics for the nation as a whole and broken down into different regions of the country.

Pneumonia and Influenza Death Reporting

- The national 122-city reporting network for pneumonia and influenza deaths monitors the severity of widespread influenza activity by comparing it to expected levels of death from pneumonia and influenza in previous years. It is not sensitive to initial changes in influenza activity, reflecting the severity of such activity several weeks later.
- Connecticut's four largest towns (Bridgeport, Hartford, New Haven and Waterbury) are part of this nationwide reporting system. They report deaths weekly to the CDC, which publishes the data in the MMWR (*Morbidity and Mortality Weekly Report*) the following week..

Hospital Admissions Syndromic Surveillance System

- This Connecticut-specific system reflects the intensity of moderately severe influenza activity within several weeks of a sharp increase. Hospitals report daily to DPH by fax or telephone. The DPH Epidemiology Program monitors this system to watch for clusters of disease or newly emerging illnesses. Several of the diagnoses (pneumonia, hemoptysis, acute respiratory distress syndrome) represent respiratory illness.

Outbreaks of Upper Respiratory Illness in Long-Term Care Facilities

- Connecticut's Long-Term Care Facilities (LTCFs) are required year round to report outbreaks of upper respiratory illness (URI) to the DPH Licensing and Epidemiology Programs. Long-term care facilities in Connecticut are also required by State statute to vaccinate their residents in accordance with CDC guidelines for influenza and pneumococcal disease. Nursing homes are encouraged to conduct influenza testing through the State laboratory when a URI outbreak is reported during the influenza season. The Epidemiology Program maintains an outbreak database that includes all reported URI outbreaks in LTCFs.

DPH Laboratory Influenza Virus Identification

- This system is useful for determining which strains of influenza virus are circulating in Connecticut and are causing outbreaks in institutions, and it reflects initial levels of influenza activity.
- The DPH Laboratory provides free influenza testing for medical offices and nursing homes in Connecticut and to the sentinel surveillance sites.
- Testing is done year round on throat swab specimens collected with viral reference culture (VRC) kits. All positive test results are reported to the Epidemiology Program and entered into a database.

Hospital and Private Clinical Laboratory Influenza Reporting

- Together the DPH Laboratory system described above, this system has become especially useful since rapid diagnostic tests for influenza became available. It documents the introduction of influenza each year and provides an initial and sustained index of how rapidly influenza builds up and lasts.
- Both hospital and private clinical laboratories in Connecticut report viral test results (mostly from rapid test kits) to the DPH Epidemiology Program. Results are confirmed by typing at the DPH Laboratory. All positive laboratory results are entered into a database, which is available for daily analysis.

Influenza Medication Tracking

- During a pandemic influenza outbreak, it will be critical to monitor and help manage public and private sector supplies of vaccines and relevant antiviral agents. A system to measure and monitor hospital supplies of critical medications has been established with public health preparedness funding.

WHO Pandemic Phase 3 (Documented human cases, but no human-to-human transmission)

- The DPH Epidemiology Program will intensify and, if needed, expand disease-based and laboratory-based influenza surveillance.
- Expanded surveillance will include rapid reporting from sources noted above and added collaboration with local departments of health, hospitals, and emergency departments.
- Surveillance criteria will be reviewed to take into account the season-specific and novel-virus-specific information about the current circulating respiratory pathogens.
- CDC updates and guidance will be monitored regarding virologic, epidemiologic, and clinical findings associated with novel influenza virus strains.

WHO Pandemic Phase 4 (Verified human-to-human transmission, but no cases in the U.S.)

- All actions in Phase 3 response will be initiated or continued.

WHO Pandemic Phases 5 and 6 (Community-level outbreaks, with cases in the U.S.)

The response to a pandemic influenza outbreak initially requires efforts directed at investigation of individual suspected cases and at control around them. This is also a key time to determine who is at risk for severe illness, thus guiding vaccination recommendations. These efforts mostly take place simultaneously. The objectives, methods for achieving them, and groups that are involved in each step of the investigation and control response are outlined below.

Enhanced Active Surveillance

- Specific investigational objectives and activities include:
 - Examination of populations particularly susceptible to influenza. Special efforts will be undertaken to determine the groups most at risk from influenza morbidity and mortality so that limited vaccine supplies can be used most effectively.
 - Determination of age-specific attack rates for disease resulting in severe morbidity (hospitalization) and mortality.
 - Determination of the efficacy of influenza vaccine and of chemoprophylaxis.
 - Monitoring of the ability of hospitals and outpatient clinics to manage increased patient loads. If resources become overwhelmed, then assistance from the State Emergency Response Plan through other state agencies becomes imperative.
 - Assessment of the effectiveness of influenza control methods. This includes the implementation of novel influenza control methods and communication with the public about viable and ineffective disease prevention methods.
- The Pandemic Influenza Response Team will develop an investigation and control work plan.

- *Overall Response Team:* CDC, Governor's Office, DEMHS, DPH, State Police, all local health departments, all hospitals, Attorney General's Office, transport staff.
- *Partners for investigation:* DPH, CDC, local health departments (particularly those with suspect cases), hospitals (particularly those with suspect cases).
- The team will meet as quickly as possible (within 1 to 2 hours) after CDC confirms a pandemic. An overall work plan will be developed, the State and DPH Emergency Operations Centers will be opened or on call to open, and interacting Incident Command Systems will be set up by the State and DPH.
- Three DPH investigative teams will be established. All three teams will work under the joint supervision of the DPH ID Division Director and a CDC-appointed field leader. The Field Interview Team, The Case Surveillance and Case Investigation Teams will be composed of:
 - *The Field Interview Team* (CDC and DPH epidemiologists), with support from local health, will begin interviews of the cases, family, friends, and co-workers to establish full detail of movements of cases and persons with whom they had contact in the 10 days prior to the onset of symptoms and following onset of symptoms. Partners for Field Response: are DPH, CDC, local health, and State Police as needed.
 - *The Case Investigation Team* (CDC and DPH epidemiologists) will review medical history of each patient to determine when the case likely began to be infectious to others.
[Partners for Case Investigation: DPH, CDC.]
 - *The Case Surveillance Team* (CDC and DPH epidemiologists) will do active surveillance.
[Partners for Active Surveillance: DPH, local health, CDC, hospitals.]
 - Medical Examiner's records and hospital discharge records may be examined retrospectively to determine if influenza cases may have been missed.
 - If the number of cases permits, the Case Surveillance Team will make a list of all contacts and communicate with them daily. If not, the media may be used to tell the public who is most at risk for influenza and what to do if symptoms develop.
 - All health departments, hospitals, emergency departments and physicians will be notified via the HAN to report immediately by telephone any cases of influenza-like illness meeting certain exposure criteria (criteria to be determined).
 - The Case Surveillance Team will receive reports and assure that appropriate diagnostic testing is done on all potential cases of influenza.

Mortality Data

During an influenza pandemic, it will be crucial to monitor deaths in an accurate and timely manner. This will be done using Connecticut's Web-Based Electronic Death Registry System (EDRS) (<http://www.ct.gov/dph/cwp/view.asp?a=3132&q=450196>).

WHO Post-Pandemic Period

- Public health investigation entities will participate in the evaluation of the pandemic response.

E. Public Health Intervention

WHO Pandemic Phases 1-4

Mass Vaccination

- DPH will follow the guidelines in “Supplement 6 Vaccine Distribution and Use” of the *HHS Pandemic Influenza Plan*: <http://www.hhs.gov/pandemicflu/plan/sup6.html>. Please see the Vaccine Distribution Annex of this *Connecticut Pandemic Influenza Response Plan* for state-specific details.

Antiviral Medications

- DPH will follow the guidelines in “Supplement 7 Antiviral Drug Distribution and Use” of the *HHS Pandemic Influenza Plan* <http://www.hhs.gov/pandemicflu/plan/sup7.html>. Please see the Antiviral Distribution Annex of this *Connecticut Pandemic Influenza Response Plan* for state-specific details.

WHO Pandemic Phases 5-6

Community Mitigation (Isolation, Quarantine, and Social Distancing)

- Given the potential for a pandemic strain to suddenly emerge and rapidly spread globally, and the limitation on the rate at which vaccine can be produced, it is critical to slow the spread of a pandemic strain to allow time for sufficient vaccine to be produced.
- DPH will follow the guidelines in “Supplement 8: Community Disease Control and Prevention” of the *HHS Pandemic Influenza Plan* <http://www.hhs.gov/pandemicflu/plan/sup8.html>. Please see the Community Mitigation Annex of this *Connecticut Pandemic Influenza Response Plan* for state-specific details.
- The principles of influenza control in the absence of vaccination or specific treatment include:
 - Isolation of infected persons until they are no longer infectious;
 - Quarantine of exposed persons until the incubation period has ended;
 - Judicious use of respiratory protection (masks);
 - Screening for symptoms and isolating those with symptoms, or having them use masks. Please see the appendix, “Guidance for the Operation of Fever Check Stations During an Influenza Pandemic” of this *Connecticut Pandemic Influenza Response Plan* for details.
 - Limiting the number of people each person has contact with by limiting non-essential gatherings (e.g., closing schools, movie theaters, malls) and/or screening all persons going to them for symptoms or requiring all to wear respiratory protection. The Connecticut Department of Education document, “Dismissal of Students and Closure of Child Care Programs” has been added as an appendix to the Community Mitigation Annex of this *Connecticut Pandemic Influenza Response Plan*. Please see this document for details.
 - Use of antiviral agents for selected persons who anticipate continuous exposure (e.g., some health care workers) or who have been recognizably exposed and are still in the incubation

period. Please see the Antiviral Distribution Annex of this *Connecticut Pandemic Influenza Response Plan* for state-specific details.

- Inform the public about how to protect themselves from contracting or spreading influenza. Please see the Crisis and Emergency Risk Communications (CERC) Annex of this *Connecticut Pandemic Influenza Response Plan* for state-specific details.

WHO Post-Pandemic Period

- DPH will participate in the evaluation of the pandemic response.

F. Environmental Management

Please refer to the *Connecticut Public Health Emergency Response Plan* for details.

G. Public Health Laboratory

Please refer to the *Connecticut Public Health Emergency Response Plan* for an overview of laboratory activities, and the Surveillance and Laboratory Capability Annex of this *Connecticut Pandemic Influenza Response Plan* for state-specific information.

Laboratory guidelines can be found in “Supplement 2: Laboratory Diagnostics” of the *HHS Pandemic Influenza Plan*: <http://www.hhs.gov/pandemicflu/plan/sup2.html>

H. Medical Management

Please refer to the *Connecticut Public Health Emergency Response Plan* for details.

Additional guidelines can be found in Supplement 5: Clinical Guidelines of the *HHS Pandemic Influenza Plan*: <http://www.hhs.gov/pandemicflu/plan/sup5.html>

I. Clean-up/Recovery

Please refer to the *Connecticut Public Health Emergency Response Plan* for details.

VI. ADMINISTRATION AND LOGISTICS

Please refer to the *Connecticut Public Health Emergency Response Plan* for details.

- DPH has developed a continuity of operations plan for essential health department services, including contingency planning for increasing the public health workforce in response to absenteeism among health department staff and stakeholder groups that have key responsibilities under a community's response plan. Please see the Continuity of Operations Annex of the *Connecticut Public Health Emergency Response Plan* for details. .
- In addition, DPH will ensure availability of psychosocial support services (including educational and training materials) for employees who participate in or provide support for the response to public health emergencies such as influenza pandemics.

VII. PLAN DEVELOPMENT AND MAINTENANCE

Please refer to the *Connecticut Public Health Emergency Response Plan* for details.

VIII. AUTHORITY AND REFERENCES

Please refer to the *Connecticut Public Health Emergency Response Plan* for details.

TABLE 2
Potential Target Groups for Influenza Vaccine during a Pandemic in Connecticut^a

Priority Populations	Number
Age groups	
65 years of age and older ^a	472,812
From 1 to 64 years of age, with high-risk medical conditions ^b	467,500
Less than 1 year of age ^c	41,789
Licensed health care workers^d	
Physicians/Surgeons/Naturopath/Homeopath ^j	12,074
Physician Assistants	1,286
Registered Nurses	42,173
Advanced Practice Registered Nurses	2,604
Licensed Practical Nurses	10,623
Paramedics	1,712
Emergency Medical Technicians	9,881
Emergency Medical Technicians – Intermediate	787
Medical Response Technicians (MRT)	6,317
Essential service providers	
Firefighters, career and volunteer ^k	28,000
Local Law Enforcement ^l : Total	7,862
Sworn	6,614
State Law Enforcement ^m	1,280
Air National Guard ^p	1,026
Army National Guard ^p	3,270
State Public Health workforce ⁿ	839
Local Public Health workforce	1,643
Schoolchildren, grades pre-K to 12, public and private ^h	649,376
Certified school staff ^{h,i}	51,861
Household contacts of persons with high-risk medical conditions	1,402,500
Population living in group quarters ^e	107,939
Institutionalized ^e	55,256
Correctional institutions ^f	19,413
Nursing facilities ^g	27,446
Non-institutionalized ^e	52,683

a From 2007 American Community Survey; estimates based on total Connecticut population of 3,502,309.

b Estimate from FluAid 2.0. Household contacts is this estimate multiplied by 3.

c Connecticut live births, 2006.

d DPH Licensure Database as of 1/31/09.

e U.S. Census Bureau, 2000 Census data.

f Connecticut Department of Correction, *2008 Annual Report*.

g Connecticut Office of Policy and Management, *Annual Nursing Facility Census, Sept. 30, 2007*.

h Connecticut State Department of Education, *Connecticut Education Facts, 2006-2007*.

i Given as full-time equivalents (FTEs). Includes regular and special program teachers, other instructional and student support specialists, and administrators.

j Includes 11,893 physicians/surgeons, 169 naturopathic physicians, and 12 homeopathic physicians

k Estimate as of May, 2009, Connecticut Fire Academy.

APPENDIX 1

Guidance for the Operation of Fever Check Stations During an Influenza Pandemic

A. Introduction

As part of its influenza pandemic preparedness activities, the Connecticut Department of Public Health (DPH) produced a guidance document in February 2008 titled “Preparing Connecticut State Agency Workers and Workplaces for Continued Operation during an Influenza Pandemic”. That guidance document provided information for agency decision-makers, as well as individual workers, regarding the appropriate use of work practice and engineering controls, administrative controls, and personal protective equipment (PPE), and was based on the Occupational Safety and Health Administration (OSHA) model of dividing workplaces and work operations into “risk zones”. Agencies should refer to the original guidance document to assess which risk zone(s) apply to their individual workplaces.

The following guidance has been prepared as an appendix to the February 2008 guidance document in order to provide agencies with more specific information regarding the operation of fever check stations. Fever check stations are only one example of the many controls that agencies should use to protect their workforce during an influenza pandemic (see February 2008 guidance document). First and foremost, agencies should make it clear that sick employees are encouraged to stay home. In conjunction with this message, agencies should also communicate leave policies (including any emergency provisions that have been implemented during an influenza pandemic), policies for getting paid, and transportation issues. Equally as important, agencies should develop policies that encourage well employees to work from home in the event of an influenza pandemic, and clearly communicate to employees what options may be available to them for working from home. Each of these preventive measures will be much more effective than screening at fever check stations in keeping sick employees from entering the workplace.

B. Purpose

In all situations, some percentage of an agency’s workforce will report on-site for work. Therefore, agencies with workplaces or work operations classified as medium, high, or very high risk for pandemic influenza (see February 2008 guidance document) may consider operationalizing fever check stations. In some instances, workplaces categorized as “lower exposure risk” may choose to operationalize fever check stations as well, although this is not one of the specific recommendations listed in the guidance document. The purpose of operating fever check stations during an influenza pandemic is to screen employees for signs and symptoms associated with influenza, and more specifically to exclude employees exhibiting influenza signs or symptoms from on-site work. Fever check stations can and should also be an important source of information for employees working on-site, and should be used in conjunction with other communication mechanisms to provide ongoing and frequent health and policy information. Agencies sharing building space with other agencies or non-state entities should consult with those agencies to ensure consistent policies and procedures will be followed in the event of an influenza pandemic.

C. Fever Check Station Operations

The following guidelines should be used by agencies deciding to operationalize fever check stations during an influenza pandemic.

Access

- Employee points of access to agency buildings should be limited and each point of access should have at least one operating fever check station.
- Employees should be asked to enter and exit through these designated points of access each day they report to work, except in the case of an emergency (i.e. fire alarm), where normal evacuation procedures should be used.
- Agencies should lock other entrance doors so that they cannot be accessed from the outside, however these doors should not be blocked, chained, or otherwise manipulated to prevent employees from utilizing them in the case of an emergency.
- Employees should be notified that they are required to report to the fever check station prior to accessing any other part of the building.
- Agencies should operate a sufficient number of fever check stations and points of access to provide an unhindered flow into the building. Fever check stations may do more harm than good if large groups of employees are gathered at a point of access waiting to be screened at the fever check station. As a part of continuity of operations planning, agencies should review employee schedules to anticipate potential peaks and lulls in the number of employees who may be trying to access the building during any specific time period, and plan to gear up or down the number of fever check stations available to coincide with these dynamics. In addition, agencies may wish to temporarily alter employee schedules to facilitate a more orderly flow of employees accessing the fever check stations.

Staffing

- Each fever check station should be staffed by a licensed nurse or other healthcare professional capable of performing the required screening activities
- At least one fever check station should be kept in operation at all times to screen employees who may be accessing the building at a later time than normally scheduled and to provide a point of contact for employees who may begin to feel ill during their work shift (i.e. an “on-call nurse”).
- Agencies should operate a “hotline” number for employees, staffed by at least one nurse, to act as a single point of contact for employees working off-site who may have questions about influenza signs and symptoms and their status for accessing the worksite. Allowing employees to “call-in” with their symptoms and ask questions about their access status will help to reduce the in-person burden at fever check stations. This hotline can be operated in conjunction with the fever check stations if adequate staffing is available at those stations.
- Each point of access should be staffed by an Emergency Medical Technician (EMT), Paramedic, or other healthcare professional equipped to provide clinical care in the event of a medical emergency.
- Each point of access should be staffed by a security officer to maintain crowd control and direct employees to a fever check station

- Each point of access should be staffed by at least one support person capable of performing other necessary duties, such as making copies, retrieving additional supplies, etc.
- Because of the number of face-to-face contacts they will be exposed to daily, individuals staffing fever check stations should be provided with N95 respirators to be worn when interacting with employees at the fever check stations. These respirators should be appropriately fit tested, in accordance with OSHA regulations (see <http://www.osha.gov/SLTC/etools/respiratory/oshafiles/fittesting1.html> for additional information on OSHA fit testing requirements). This respiratory protection should be provided regardless of whether or not an agency determines that their workplace or work practices constitute a risk category where providing PPE to employees is appropriate.

Screening

A sample “Fever Check Station Screening Form” has been provided with this guidance. Agencies should revise the form as needed to make it appropriate for their location, while maintaining the appropriate clinical screening information. The screening form should capture information regarding:

- The name, agency, and functional unit of the employee reporting to the fever check station.
- The date and time the evaluation occurred and the signature of the evaluator.
- Any clinical signs or symptoms reported by the employee within the last 24 hours.
- The employee’s body temperature at the time of the screening.
- Whether or not the employee was granted access to the building.
- Any personal protective equipment (PPE) provided to the employee (if appropriate).
- Any informational or other materials provided to the employee. For example, employees who are excluded from on-site work should be given information about why they were excluded, clinical information about pandemic influenza, and other agency logistical information developed for employees during this emergency period (i.e. leave policies, policies for payroll, contact numbers, etc.). Employees who are allowed entry into the workplace should be given clinical information about pandemic influenza and procedures for reporting the development of any signs or symptoms to the on-call nurse, appropriate hygiene/etiquette practices, and agency policies for social distancing, holding face-to-face meetings, sharing equipment, and interacting with the public.

Admittance and Return to Work Criteria

The decision whether to allow or deny access of any employee to the workplace should be made by the nurse or other health professional performing the clinical evaluation. These decisions should be based solely on the clinical information collected at the fever check station and not on any employees perceived need to be working on-site. Based on our current knowledge of the clinical signs and symptoms of influenza, the Connecticut DPH recommends the following criteria for exclusion of employees from the workplace:

- Oral temperature $\geq 101.0^{\circ}\text{F}$ or
- Oral temperature $> 99.0^{\circ}\text{F}$ but $< 101.0^{\circ}\text{F}$ and any one of the following symptoms (or close contact with someone with any of the following symptoms) in the last 24 hours:
 - chills
 - persistent cough
 - headache

- muscle aches/stiffness
- fatigue (tiredness)
- sore throat
- hoarseness
- stuffy/runny nose
- difficult/painful breathing
- vomiting
- diarrhea
- abdominal pain
- confusion.

Once an employee has been denied access to the workplace on the basis of the signs and symptoms listed above, the Connecticut DPH recommends that the employee not be allowed to return to the workplace until at least 24 hours after all symptoms have resolved. This includes maintaining an oral temperature \leq 99.0°F without the use of fever-reducing medications.

Again, these recommendations are based on current knowledge of the clinical signs and symptoms of influenza at the time this document was written. As such, the recommended criteria for exclusion during an influenza pandemic may change however as new information about the clinical manifestations of any particular pandemic influenza strain becomes available.

D. Questions

The information contained in this document is intended to be used as one tool in the overall planning of state agencies for protecting their employees in the event of an influenza pandemic. Several other documents and data sources have been referenced in this guidance document and elsewhere, and should be utilized as well within the scope of state agency planning for a pandemic. For more information about the general recommendations put forth in this guidance or for specific answers to questions raised by the recommendations, agencies should contact the Connecticut DPH at (860) 509-8000.

SAMPLE FEVER CHECK STATION SCREENING FORM

410 – 470 CAPITOL AVENUE COMPLEX

Access Location: 410 Capitol Ave. (Basement) Date: _____
 450 Capitol Ave. (Security)

Employee Information

Employee Name: _____

Agency: DPH OHCA DMHAS DDS OPM

Other: _____

Clinical Evaluation

Evaluation Time: _____ a.m. p.m. Temperature: _____ °F

Is the employee's temperature \leq 99.0°F? YES (STOP – Employee admitted,
skip to *Disposition* section)
 NO (continue *Clinical Evaluation*)

Is employee's temperature \geq 101.0 °F? YES (STOP – Employee excluded,
 NO (continue *Clinical Evaluation*)

Indicate which of the following employee has experienced in the past 24 hours:

Persistent Cough Headache

Fatigue (Tiredness) Muscle Aches/Stiffness

- Chills Sore Throat
- Hoarseness Stuffy/Runny Nose
- Vomiting Difficult/Painful Breathing
- Diarrhea Abdominal Pain
- Confusion NO SYMPTOMS

Has the employee had close contact with someone with any of these symptoms in the past 24 hours?

No Yes (which symptoms: _____)

- As of September, 2004. Census of State and Local Law Enforcement Agencies, 2004.
Bureau of Justice Statistics Bulletin, June, 2007.
- m Number of State Troopers as of May 12, 2009. Connecticut Department of Public Safety.
- n As of May, 2009. Connecticut Department of Public Health, Human Resources.
- o As of 2007. DPH Planning, Workforce, and Professional Development Section.
- p As of May 14, 2009. Connecticut Military Department.