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**To:** **Critical Access Hospitals**  
**Swing Beds in Critical Access Hospitals**

**From:** Alfred C. Johnson, Director  
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**Via:** Otis Woods, Administrator  
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**Novel Influenza A (H1N1) / 2009**  
**Considerations for Emergency Preparedness / Disaster Planning for Pandemic Influenza**

This Division of Quality Assurance (DQA) memo expands upon information already provided in DQA Memo 09-018 Novel Influenza A (H1N1) / 2009 (Swine Flu).

The purpose of this memo is to:

- Provide information about the significance of Novel Influenza A (H1N1)/2009
- Explain the need for providers to prepare for pandemic influenza, identify what they need to do to be prepared, and explain how they can develop and implement a pandemic influenza preparedness plan.
- Provide infection control guidance for the care of patients with confirmed or suspected Novel Influenza A (H1N1)/2009

According to the Centers for Disease Control and Prevention (CDC), a pandemic is a global disease outbreak. A flu pandemic occurs when a new influenza virus emerges for which people have little or no immunity and for which there is no vaccine. The disease spreads easily person-to-person, causes serious illness, and can sweep across the country and around the world in a very short time.

In April 2009, a new influenza virus identified as Novel Influenza A / 2009 (H1N1 influenza) was first detected in the United States. On April 26, 2009, the United States (US) Department of Health and Human Services (DHHS) declared that a public health emergency exists nationwide due to the increasing numbers of confirmed or suspected cases of this new virus. On April 30, 2009, Governor Jim Doyle declared a public health emergency in Wisconsin in response to the presence of H1N1 influenza in the state. On May 2, 2009, the State of Wisconsin, Department of Health Services (DHS) announced three confirmed cases of H1N1 influenza in Wisconsin.

Currently, there are an increasing number of confirmed cases of human infection with this virus in Wisconsin, the United States and throughout the world. Health professionals are concerned about the possibility that this new virus could become a pandemic for the following reasons:

- It is a never-before seen combination of human, swine, and avian influenza viruses for which people have no immunity and there is no vaccine available to protect humans against this virus.
- It is being spread from person to person.
- The age group most affected is healthy, young adults (unlike seasonal flu)
- Like other influenza viruses, it continues to evolve.

The World Health Organization (WHO) has developed a system of six (6) levels of alerts for pandemic influenza. Level 1 indicates that there are no new influenza viruses in humans, although one may be present in animals with a low risk to humans. Level 6 indicates a full scale pandemic. As of June 11, 2009, the WHO set its pandemic alert at Level 6, which means all countries should be activating their pandemic preparedness plans.

Thus an influenza pandemic is occurring, and H1N1 influenza has spread across populations in the world. In a pandemic, hospitals and other healthcare providers may be overwhelmed with massive numbers of acutely ill persons. It is also expected that staff will be ill, leading to widespread absenteeism. Most disasters are time limited; a pandemic is expected to last for weeks and even months.

## **REGULATORY REQUIREMENTS**

Federal regulation 42 CFR 485.623(c)(4) (Federal Tag C-0230): Taking other appropriate measures that are consistent with the particular conditions of the area in which the critical access hospital(CAH) is located. Interpretive Guidelines state: The CAH must develop and implement a comprehensive plan to ensure that the safety and well being of patients are assured during emergency situations.

DHS 124.08(5) Reporting Disease. Hospitals shall report cases and suspected cases of reportable communicable disease to local public health officers and to the department pursuant to ch. DHS 145.

DHS 124.24 (2) 4. Emergency Services. The hospital's emergency services shall be coordinated with the community's disaster plan, if there is one.

## **PANDEMIC PLANNING**

The above regulations are applicable to pandemic influenza. It is for these reasons that critical access hospitals need to ensure that they have an emergency preparedness/disaster plan for pandemic influenza. If your hospital does not have a plan for pandemic influenza, the DQA strongly recommends that you develop one now. The U.S. Department of Health and Human services has established a web site devoted to pandemic planning that includes planning checklists to assist providers in developing a plan and help identify what providers need to do to

be prepared. This site is located at <http://www.pandemicflu.gov/plan/healthcare/healthcare.html>. Those providers with existing plans are encouraged to review them and make plans for their implementation. It is recommended that providers regularly monitor the Centers for Disease Control and Prevention (CDC) and Wisconsin Pandemic Flu websites (listed at the end of this document) for current information.

As with any potential disaster, preparations can be time-consuming and expensive, and if the disaster does not occur for a prolonged period or when expected, there is a tendency to feel such preparation is wasted and unnecessary. However, adequate preparation and planning are essential to survive a major event like a pandemic influenza.

## **INFECTION CONTROL**

### **Definition of Influenza-like Illness:**

Influenza is a highly infectious viral respiratory disease. Influenza-like Illness (ILI) is defined as fever 100°F or higher **and** either a cough, nasal discharge or sore throat. Because fever may be difficult to determine in elderly persons, the definition of fever used for ILI may be defined as a temperature of 100°F or higher, or 2 degrees above the established baseline for that patient.

### **Transmission:**

According to the CDC, influenza is primarily transmitted from person-to-person via large virus-containing droplets that are expelled when infected persons cough or sneeze; these large droplets can then settle on the mucosal surfaces of the upper respiratory tracts of susceptible persons who are near (e.g., within about 6 feet) infected persons. Transmission may also occur through direct contact or indirect contact with respiratory secretions such as when touching surfaces contaminated with influenza virus and then touching the eyes, nose or mouth. Adults may be able to spread influenza to others from 1 day before getting symptoms to approximately 5 days after symptoms start. Children may be able to spread influenza to others as long as upper respiratory symptoms continue.

Unlike persons infected with seasonal influenza, persons with H1N1 influenza infections should be considered infectious from 1 day before the onset of illness to at least 7 days after illness onset. Persons who continue to be ill longer than 7 days after illness onset should be considered infectious until 24 hours after the resolution of fever and improvement of symptoms, whichever is longer.

### **Infection Control Measures:**

At this time there is no available vaccine specific to H1N1 influenza. Vaccination with seasonal influenza vaccine does not appear to provide protection against this virus. However, vaccinating healthcare personnel and patients for seasonal influenza remains appropriate.

The following infection control measures are recommended to prevent person-to-person transmission of ILI and to control outbreaks in healthcare facilities (including hospice residential and inpatient facilities):

1. Surveillance – Routinely monitor patients and employees for symptoms consistent with ILI

- Employees with confirmed, probable or suspected H1N1 influenza infection must stay at home and be removed from contact with patients or their environment for 7 days after the onset of illness **or** 24 hours after the resolution of fever and improvement of symptoms, whichever is longer.
2. Education – Educate personnel about the signs and symptoms of influenza-like illness, control measures, and indications for obtaining appropriate testing.
  3. Influenza Testing - Test patients who present with symptoms of ILI by submitting specimens to a laboratory equipped to test for H1N1 influenza. Please see <http://pandemic.wisconsin.gov/category.asp?linkcatid=3124&linkid=903&locid=106> for the most up-to-date Wisconsin guidance on who should be tested.
  4. Reporting – A single laboratory-confirmed case of H1N1 influenza is reportable to the local health department. Confirmed H1N1 influenza will be reported by the laboratory where it has been identified. Follow-up will be initiated by the health department, although providers may choose to initiate contact in order to receive guidance.

Outbreaks of respiratory illness are always reportable to the local health department or to the Wisconsin Division of Public Health (DPH). A respiratory disease outbreak is defined as three or more patients from the same unit whose onset of illness was within 72 hours of each other who have pneumonia, ILI or laboratory-confirmed viral or bacterial infection (including influenza) or a sudden increase in ILI or pneumonia over the facility's normal background rate. Please see <http://pandemic.wisconsin.gov/category.asp?linkcatid=3124&linkid=903&locid=106> for detailed guidance on testing, treatment, and reporting of outbreaks.

5. Antiviral Treatment – Guidance for antiviral treatment for H1N1 influenza is available from the WI Division of Public Health <http://pandemic.wisconsin.gov/category.asp?linkcatid=3124&linkid=903&locid=106> .
6. Respiratory Hygiene / Cough Etiquette Programs – Respiratory hygiene/cough etiquette should be implemented whenever patients or visitors have symptoms of respiratory infection. This includes the following:
  - Posting visual alerts instructing patients and visitors to inform healthcare personnel if they have symptoms of respiratory infection.
  - Providing tissues or masks and waste containers in waiting rooms and public areas for patients and visitors who are coughing or sneezing so that they can cover their nose and mouth.
  - Ensuring that supplies for hand washing are available where sinks are located; providing dispensers of alcohol-based hand rubs in other locations such as waiting rooms and public areas.
  - Providing space for coughing persons to sit at least 3 to about 6 feet away from others, if feasible.

## 7. Isolation Precautions

- Standard and Contact precautions plus eye protection should be used for all patients who are being evaluated for or are in isolation precautions for H1N1 influenza.

### **For patients:**

Whenever possible, patients should be immediately placed in private rooms with doors kept closed. If a private room is not available, the patient should be placed with a roommate who is able to maintain at least 6 feet from the infected patient. Privacy curtains may be used to create a physical barrier between patients and their environments.

If a patient must leave his or her room, the patient must perform hand washing or use alcohol-based hand sanitizer **and** wear a surgical mask while outside the room.

### **For providers:**

Personal Protective Equipment (PPE) should be donned upon room entry. This includes non-sterile gloves, gowns and eye protection.

Respiratory Protection – All healthcare workers should wear fit-tested N-95 respirators (or powered air purifying respirators) upon entering the rooms of patients in isolation and during all patient care, including during nebulization treatments.

Note: This recommendation differs from current infection control guidance for seasonal influenza, which recommends that healthcare personnel wear surgical masks for patient care.

Hand hygiene by washing with soap and water or using alcohol-based hand sanitizer should be performed immediately after removing PPE and after any contact with respiratory secretions.

- Duration of precautions – Isolation precautions should be continued for seven (7) days from symptom onset **or** until 24 hours after the resolution of fever and improvement of symptoms, whichever is longer.

8. Visitors – In communities where H1N1 influenza is being transmitted, providers should limit points of entry so screening for ILI among visitors can occur upon arrival to entrances. Indiscriminate visiting by persons not essential to patients' emotional well-being and care should be discouraged during this time. Visitors should be instructed to practice good hand hygiene and wear gowns, gloves, eye protection, and either surgical masks or N-95 respirator when entering isolation rooms.

9. Environment – Routine cleaning and disinfection strategies used during influenza seasons can be applied to the environmental management of H1N1 influenza. Management of

laundry, utensils and medical waste should also be performed in accordance with procedures followed for seasonal influenza.

**RESOURCES:**

[Centers for Disease Control and Prevention](#)

[Wisconsin Pandemic Flu](#)

[Infection Control](#)

[Standard Precautions](#)

[Contact Precautions](#)

[Respiratory hygiene/cough etiquette](#)

[Respirators](#)

**CONTACTS:**

[Local Public Health Departments](#)

[For Regulatory Questions Only](#)