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HUMAN RESOURCES
Planning & Assessment Tool

A Healthcare Guide for Pandemic Flu Planning

PLANNING TODAY
FOR A PANDEMIC TOMORROW

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

Supported by a grant from Roche Pharmaceuticals

Human Resources Planning & Assessment Tool: A Healthcare Guide for Pandemic Flu Planning

Planning Today For A Pandemic Tomorrow Publication Series

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INTRODUCTION

Through the use of a detailed assessment and planning tool, hospitals can review existing policies and procedures, identify gaps, adopt new policies and procedures and generate a pandemic influenza plan that will facilitate a more effective response during a crisis. This tool will assist hospitals in developing and adopting new policies that will be required to protect employees, patients and the hospital itself. The planning and assessment tool identifies critical elements within each module related to hospital operations during an emergency situation. In addition, the tool provides a variety of sample policies and procedures that facilities may elect to use in their planning process.

Critical areas to address when planning for a pandemic include:

Clinical Care	Leadership
Communication	Legal/Regulatory
Ethics	Operations
Finance	Psycho-Social
Human Resources	Supplies/Logistics/Support Services

How to Use This Module

Hospitals should form multi-disciplinary work teams to develop policies and procedures relating to each of the critical areas identified above. Diverse perspectives will help ensure that all issues or concerns that may be raised during a pandemic can be brought to the table while in the planning process.

The modules are to be used as a guide to facilitate discussion and to ensure that key points related to a topic such as human resources are identified and addressed in the planning process. Sample policies and/or procedures are provided; these policies and procedures are by no means all inclusive, and hospitals should not interpret the sample policies as what *must* be adopted. Sample policies are provided to assist a hospital in developing a policy that is consistent with the culture and values of the organization. Hospitals are not required to adopt any of the sample policies and procedures; they are intended simply to serve as a resource and guide in the planning process. *They are not reflective of a standard of care.*

Upon completion of the 10 modules reflected in *Planning Today for a Pandemic Tomorrow,* a "cross-walk" will be developed. This cross-walk will provide guidance for other module areas that should be referenced when developing policies and procedures. For example, when examining a Human Resources policy, the Legal and Regulatory module may need to be reviewed.

And finally, the information reflected in the planning and assessment tool modules is intended to be used as a fluid and flexible resource in dealing with the problems associated with a pandemic influenza outbreak. It is based on existing information, therefore hospitals should routinely review their plan to ensure new information is incorporated into policies and procedures as necessary.

HUMAN RESOURCES MODULE

During a pandemic, short supply of resources and supplies to meet patient 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 health care 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 clinical operations.
- Minimizing administrative chaos when managing HR problems with greatly diminished HR staff.

In the sections that follow, a series of planning/policy tasks are broken down by essential HR expertise areas. They are discretionary and are representative of the issues that *should* be considered. These tasks include:

A. Initial Planning
B. Attendance
   i. Planning
   ii. Policies for Consideration
C. Work Schedules
   i. Planning
   ii. Policies for Consideration
D. Prophylaxis
   i. Planning
   ii. Policies for Consideration
E. Staff Assignment/Reassignment
   i. Planning
   ii. Policies for Consideration
F. Incident Command Training
   i. Planning
   ii. Policy for Consideration
G. Education/Training
H. Behavioral Health
   i. Planning
   ii. Policy for Consideration
I. Non-Clinical Volunteers
   i. Planning
   ii. Policies for Consideration
J. Independent Contractors
K. Credentialing
   i. Planning
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L. Unions/Collective Bargaining
M. Isolation and Quarantine
   i. Background
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   iii. Home Quarantine: Policies for Consideration
   iv. Work Quarantine: Planning and Policy for Consideration
N. Employee Health
   i. Planning
   ii. Employee Return to Work Following Flu Diagnosis – Planning and Policy for Consideration
   iii. Employee Protection Issues – Planning

Human Resources Module

Associated with each section are appendices that offer additional details, tips and/or further explanation of important considerations for each task.

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

A. INITIAL PLANNING

In your plan consider evaluating the following:

	ASSIGNMENT	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Establish a work group to review and address HR concerns as they relate to a pandemic. Work group participants may include: • Chief Operating Officer • VP, Human Resources • VP, Medical Affairs or Chief Medical Officer • Chief Nursing Officer • Employee Health Practitioner • Union/Collective Bargaining Representatives • In-House Counsel • Infection Control Practitioners • Emergency Preparedness Coordinator • Public Relations Officer • Volunteer Services Coordinator (to serve as liaison to Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), external volunteers, etc.)					

A. INITIAL PLANNING CONTINUED

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
2	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 • General hospital policies related to pandemic flu • Patient/nurse ratios • Reassignment • Staff availability • Vaccine protection					
3	Create an outline of immediate facility concern issues. Ensure this outline includes: • Changes to standard operating procedures (SOPs) during disaster situations (e.g., changes to medical care standards; patient flow; test/procedure ordering; admission or discharge criteria; etc.). • 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, etc.). • Definition of essential work and organizational capacity (e.g., identify the most critical areas/services and examine resources available to maintain their operations).					

A. INITIAL PLANNING CONTINUED

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
4	• Independent contractors 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, etc.). • Labor and employee relations (e.g., waiving of work rule change procedures; grievance procedures; hazard pay, appeals for work reassignment; staffing ratios; shift lengths; etc.). • Occupational health and safety (including strategies to maintain a safe work environment during a pandemic; social distancing; infection control practices; etc.). • Organizational resiliency and resistance (e.g., practices to support employee attendance such as child care, elder care, pet care, assistance with family chores, etc.). • 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 patient care; managers to line worker positions; etc.). • 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; etc.). • 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; etc.).					

A. INITIAL PLANNING CONTINUED

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
5	Determine which policies may differ based on union vs. non-union employees: • Attendance • Compensation • Cross-training • Grievances • Reassignment • Staff shortages • Work hours					
6	Determine which policies and procedures may change based on the use of independent contractors for specific services.					
7	Establish/update employee contact information – update annually (at a minimum). See Appendix A1					

B. ATTENDANCE

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Identify a central point of contact to address employee questions/concerns (e.g., employee telephone hotline, web site, newsletter, etc.).					
2	Establish an expected rate of absenteeism and include as a planning consideration. • To calculate, utilize historical data to divide average number of days lost due to unscheduled absence per employee by average number of work days per employee per month. • This calculation can be expanded to address rates of absenteeism for individual departments and the Facility as a whole. • Consider using "FluWorkLoss" software available through CDC at www.pandemicflu.gov (under "Planning Tools").					
3	Determine the minimum number/categories of employees needed to care for projected number of pandemic-affected patients, plus regular patients (absent elective surgery). B1, B2					
4	Establish primary and secondary lists of employees and develop plan to address unmet facility staffing needs. • Assume that 1 out of 3 (or more) employees will be absent as a result of the pandemic due to their own illness; family member illness in a family member childcare issues; or fear of working during a pandemic. B3					

B. ATTENDANCE CONTINUED

PLANNING

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
5	Notify employees of primary (those that are necessary to sustain the operations of the facility) and secondary status (those that will be called upon to work and potentially assume different responsibilities). Ensure the responsibilities of each designation have been delineated and communicated to each employee.					
6	Assign an individual (plus at least one backup person) to be responsible for assessing daily clinical staffing needs during a pandemic.					
7	Identify emergency staffing alternatives to sustain critical operations including engineering, security, housekeeping, among others. • These may include health care workers with out-of-state licenses; retired health care workers; health profession students; clinical administrators; paramedic/EMT; pharmaceutical students; patient family members; private medical office staff among others. • Any insurance/liability implications and issues should be addressed by legal counsel and HR in advance including disability coverage, workers compensation, stop loss insurance, particularly death benefits, among other issues. B4, B5, B6					
8	Investigate the availability of an ESAR-VHP program in your state. ESAR-VHP is a pre-registration system for emergency volunteer health professionals which provides verifiable, up-to-date information regarding the volunteer's identity and credentials to other medical facilities in need of the volunteer's services					

B. ATTENDANCE continued

Planning

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
9	Investigate the availability of an MRC program in your state. • An MRC is a community-based, locally organized group of volunteers (medical professionals and others) that donate time and expertise to prepare for and respond to emergencies.					
10	Establish criteria for declaring a "staffing crisis." Such a declaration may allow for the use of emergency staffing alternatives and should identify: • Who within the facility can declare a crisis. • What incident(s) lead to the declaration of a crisis (e.g., the inability to carry out normal business functions; CDC pandemic declaration; etc.).					
11	Consider that, at the directive of the Commissioner of Health (or his/her designee), facility employees may be placed in isolation/quarantine. Plan for how this would be managed and what resources would be required to support staff. B7					
12	Explore any legal liability associated with imposing "working" quarantine policies. If such action poses too great a risk to the facility, alternative strategies should be explored. (See Section M)					
13	Identify staff that can work remotely such as those assigned to payroll, claims processing, administrative staff, etc. B4					
14	Assess and adjust availability of computer resources to support staff working from a remote location or from home. B4					

B. ATTENDANCE continued

Policies for Consideration

	POLICY RECOMMENDATIONS AND EXAMPLES	CONSIDERED	IMPLEMENTED / DATE	NOT IMPLEMENTED / REASON	LEAD STAFF MEMBER
15	**Develop policy to address employee attendance expectations during a pandemic. Note policy exceptions such as ADA, FMLA or other state regulations (e.g., New Jersey Family Work Act) (CB*).** ❒ Example: Employees are required to report to work with the exceptions of personal illness or required care of ill family member(s). Failure to do so may result in discipline, up to and including termination. B8, B9				
16	**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.				
17	**Develop policy to address pandemic shift length (CB).** ❒ Example: Employees will not work a shift that exceeds 16 hours. B10				

B. ATTENDANCE continued

Policies for Consideration

	POLICY RECOMMENDATIONS AND EXAMPLES	CONSIDERED	IMPLEMENTED / DATE	NOT IMPLEMENTED / REASON	LEAD STAFF MEMBER
18	**Develop policy to address utilization of vacation, personal days, and holiday time (CB). Examples:** ❒ 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. ❒ Employees may have all vacation, personal time and any other planned absences, including staff holidays, suspended pending a return to normal operations. ❒ 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.				
19	**Develop policy to address issues regarding employees that have more than one job (CB).** ❒ 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.				
20	**Develop policy to address additional compensation or benefits to employees that work during a pandemic (CB).** ❒ Example: Employees that work during a declared pandemic may receive additional compensation, e.g., bonus salary, extra vacation time, etc.				

B. ATTENDANCE continued

Policies for Consideration

	POLICY RECOMMENDATIONS AND EXAMPLES	CONSIDERED	IMPLEMENTED / DATE	NOT IMPLEMENTED / REASON	LEAD STAFF MEMBER
21	**Develop policy to address employee assistance during a pandemic (CB).** ❒ Example: (Name of Facility) will have resources to assist employees with child care, elder care, general errands, pet care, etc.				
22	**Develop policy to address staffing shortages.** ❒ Example: (Name of Facility) may utilize patient's family members and/or volunteers (through ESAR-VHP/MRC programs) for supportive clinical care. See Legal Module				
23	**Develop policy to address staff that may be permitted to work remotely or at home (CB).** ❒ Example: Pre-identified employees may be permitted to work from a remote location assuming workers compensation can be secured. B11				

C. WORK SCHEDULES

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Identify minimum staffing requirements for each administrative department.					
2	Identify minimum staffing requirements needed throughout the Facility during a pandemic B4					
3	Identify staff to be responsible for developing staffing plans (e.g., department director). C1					
4	Review pandemic staffing plans annually.					
5	Ensure consideration is given to individual religious beliefs, as it relates to work availability.					
6	Examine regulations regarding mandatory overtime. Exceptions should be identified. Seek a waiver of regulations regarding staffing, and other regulations that affect staffing, if necessary. B10					
7	Identify respite space for staff working overtime.					
8	Identify procedures to provide food, clothing, toiletries and chronic medications to employees working overtime and/or being housed at facility.					

C. WORK SCHEDULES continued

Policies for Consideration

	Policy Recommendations and Examples	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
9	**Develop policy to address mandatory overtime (CB).** ❒ Examples: Employees will not be expected to work more than 16 hours in a 24-hour period, even in the event a state of emergency is declared; the Commissioner of Health waives licensing regulations, such as state regulations regarding mandatory overtime. B10				
10	**Develop policy to address shift definitions in the event of a pandemic (CB).** ❒ Check state and federal wage laws and acts, e.g., FFLA, the NJ Wage and Hour Act. ❒ 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. B10				
11	**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/ANTI-VIRALS

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Coordinate with local health department to identify flu vaccine availability and how to obtain it in a pandemic situation.					
2	Identify internal and external contacts for obtaining flu vaccine.					
3	Identify internal and external contacts for obtaining anti-viral medications.					
4	Develop priority strategy for distribution of anti-viral medications and flu vaccine to facility employees (CB). D1, D2					
5	Ensure the flu pandemic response plan informs employees and volunteers that: • The availability of anti-viral medication may be limited. • Employees in certain positions, especially those with direct patient contact, may be issued anti-viral medication to prevent infection. • Specific treatment criteria, including eligibility, will be developed with public health officials. • Prophylactic and treatment regimens may change depending on the characteristics of the circulating virus.					

CB= Collective Bargaining

D. PROPHYLAXIS/ANTI-VIRALS CONTINUED

PLANNING

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
6	Educate employees regarding vaccine development. • FDA-approved pandemic flu vaccine has not been developed; in fact, a vaccine can only be made after the pandemic virus has been isolated. As a result, employees and the public should expect a lag between the emergence of the pandemic virus and the development/availability of vaccine – perhaps as long as six months. D3					
7	To evaluate feasibility of providing anti-viral medications and/or flu vaccine to employees' household members, survey facility staff (in accordance with public health policy). D2					
8	Identify emergency volunteers and key independent contractors to determine who, if any, may be eligible to receive anti-viral medications and/or flu vaccine from the facility.					
9	Develop a rapid delivery system to administer anti-viral medications and/or flu vaccine to facility employees and patients. D4					

D. PROPHYLAXIS/ANTI-VIRALS continued

Policies for Consideration

	Policy Recommendations and Examples	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
10	**Develop policy to address prophylaxis reception requirements (anti-viral or vaccine). Examples:** ❒ If and when available, anti-viral medications and/or flu vaccine shall be provided to employees and employees' household members at the direction of public health authorities. ❒ If and when available, anti-viral medications and/or flu vaccine will be provided only to employees that: a.) have direct patient care responsibilities; and/or b.) are part of an established high-risk group (e.g., immunodeficiency, pregnancy, etc.).				
11	**Develop policy to address employees that refuse provided prophylaxis (anti-viral or vaccine) (CB).** ❒ Example: An employee's refusal to accept a medical countermeasure such as anti-viral medication or flu vaccine may result in reassignment, reduction in pay, and/or unpaid leave if patients 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

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	Skill Assessment / Needs Considerations					
1	Identify skill set analysis assessment tools for key business and clinical areas that will be maintained during a pandemic. E1, E2					
2	Conduct employee skill sets inventory for reassignment consideration. Update annually.					
3	Identify staff responsible for establishing job descriptions and responsibilities (e.g., department supervisors).					
4	Identify and compile contact information for non-clinical staff that could receive just-in-time cross-training in supportive clinical functions.					
5	Develop bulleted job responsibility sheets for categories of workers (e.g. nurses, dieticians, patient intake, etc.).					
6	Develop a priority list for reassignment and recruitment of employees/volunteers (CB).					
	Procedural Considerations					
7	Develop a process for rapidly credentialing newly-recruited employees/volunteers, if appropriate.					
8	Establish mutual aid agreements and memoranda of understanding agreements with other facilities or corporations that have agreed to share their staff, as needed. E3, B6					

E. STAFF ASSIGNMENT/REASSIGNMENT CONTINUED

PLANNING

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
9	Review the Emergency Health Powers Act (P.L. 2005) to determine and address issues related to health care employees with out-of-state licenses. E4					
10	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.					
	Reassignment Considerations					
11	Establish an employee staging area (i.e., labor pool) outside of the primary emergency-response areas and communicate this location to employees.					
12	Identify a reassignment office location within the staging area for confirmation of employee assignments and reassignments.					
13	Prepare signs to clearly identify the physical location of the staging area. Include directional signs, if needed.					
14	Prepare and approve draft communications to all staff advising of the reassignment office location and how to contact by phone and e-mail.					
15	Establish a reassignment office framework that includes all needed forms, clearly defined physical space requirements, and specific technology needs.					

E. STAFF ASSIGNMENT/REASSIGNMENT CONTINUED

PLANNING

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
16	Establish principals and operational guidelines for the reassignment center. E5					
17	Establish staging area action plan that includes a detailed staffing compliment for the first 12-24 hours of deployment.					
18	Identify the hours of operation for the staging area and staffing levels needed based on operational needs (e.g., the center may initially need to operate 24/7; hours may vary as pandemic progresses).					
19	Ensure that all reassignment policies are reviewed for impact on union contracts.					
20	Identify education needs by providing job action worksheets; develop methods for providing just-in-time training.					

* = This section does not address scope of practice as it is included in the Legal and Regulatory module; however, it should be understood that staff reassignment should be made within an employee's defined scope of practice.

E. STAFF ASSIGNMENT/REASSIGNMENT CONTINUED

Policies for Consideration

	Policy Recommendations and Examples	Considered	Implemented / Date	Not Implemented / Reason	Team Leader
21	**Develop policy to address employee reassignment (CB). 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; at times, this may require night shift work or weekend work. Every attempt should be made to distribute shifts equitably. ❒ Employees re-assigned 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.				

E. STAFF ASSIGNMENT/REASSIGNMENT CONTINUED

Policies for Consideration

	Policy Recommendations and Examples	Considered	Implemented / Date	Not Implemented / Reason	Team Leader
22	**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, are 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.				
23	**Develop policy to address how reassignment requests are made.** ❒ Example: The reassignment center will assess staffing requests by need priority. Priority will be given to direct patient care requirements, then to specific administrative requirements. Managers will address reassignment requests only through the reassignment center.				
24	**Develop policy to address how the reassignment center will be staffed (CB).** ❒ Example: The reassignment center may be staffed by HR employees and managers with clinical knowledge in order to assess required staffing competencies.				

E. STAFF ASSIGNMENT/REASSIGNMENT CONTINUED

POLICIES FOR CONSIDERATION

	Policy Recommendations and Examples	Considered	Implemented / Date	Not Implemented / Reason	Team Leader
25	**Develop policy to address reassignment center logistical requirements. Examples:** ❒ The reassignment center may have multiple telephone extensions – incoming calls and outgoing calls. Additionally, the reassignment center should have a toll-free staff information line for situation updates. ❒ The reassignment center should have access to multiple e-mail addresses, as well as priority access to existing computer servers, backup servers, and IT personnel. One e-mail address should be for "staff required" requests and the other for "staff available for reassignment."				
26	**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

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
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.					
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.					
4	❒ Review the commonly used versions of ICS and choose a system to implement at your facility. This system should be compliant with National Incident Management System (NIMS) guidelines.					

Policy for Consideration

	Policy Recommendation and Example	Considered	Implemented/ Date	Not Implemented /Reason	Team Leader
5	**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 participate in ICS 100 and 700 training. F1				

G. EDUCATION/TRAINING

PLANNING

IN YOUR PLAN CONSIDER EVALUATING THE FOLLOWING:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Identify staff to provide pandemic education and training.					
2	Provide employees with personal/family emergency planning materials and training. G1					
3	Provide employees with basic information and education regarding pandemic flu, flu--associated risk, protective measures, and prophylaxis. G2					
4	Provide employees with overview of facility's action plan to continue operations during a pandemic.					
5	Inform employees how communication will take place during a pandemic (e.g., phone chain, hotline, website, newsletter, etc.). Consider "fire drill" to test system.					
6	Establish public hotline that will provide updates on current flu outbreak and information/tips on protective measures to be utilized during a pandemic. This hotline should be utilized annually, at the beginning of flu season, to provide updates on current flu vaccine availability and usage.					
7	Develop training for reassigned staff and temporary workers, including personal protection training.					
8	Identify all local health care employees and consider training regarding facility's flu pandemic plan.					

H. BEHAVIORAL HEALTH*

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Review EAP contract for performance requirements during a disaster or pandemic.					
2	Review capability and capacity of your EAP provider to provide telephone support during a pandemic. Determine the EAP's pandemic staffing plan and negotiate a minimum number of guaranteed weekly service hours.					
3	In conjunction with the facility EAP, identify staff concerns regarding pandemic.					
4	Coordinate with the county mental health administrator to ascertain what services, if any, may be available through his/her office.					
5	Establish a pandemic helpline for facility employees and volunteers staffed by internal and/or external mental health professionals.					
6	Train employees to recognize when colleagues are in need of mental health assistance and how to activate appropriate resources.					
7	Train employee health staff to ensure ability to address the pandemic-related employee concerns.					
8	Identify and develop faith-based resources to be utilized by patients and staff during a pandemic.					

* = Additional behavioral health considerations are explored in the Psycho-Social Module.

H. BEHAVIORAL HEALTH continued

Policy for Consideration

	Policy Recommendation and Example	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
9	**Develop policy to address long-term, post-response support for employees.** ❒ Example: In the event of a pandemic, the facility will provide long-term, post-response support to its employees. Such support may be arranged with an external organization or agency.				

I. NON-CLINICAL VOLUNTEERS

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	❒ Perform a skills analysis of existing volunteers and maintain the information in a database. E2					
2	❒ Liaison with local community organizations, such as places of worship, to establish a potential volunteer pool.					

I. NON-CLINICAL VOLUNTEERS continued

Policies for Consideration

	Policy Recommendations and Examples	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
3	**Develop policy to address non-clinical volunteers utilization.** ❒ Example: If volunteers will not be utilized at facility site, they may be asked to assist in external roles such as grocery shopping, pet monitoring, childcare services, etc. for working or quarantined staff. These volunteers may be utilized in pre-determined areas for a period not to exceed XX days/weeks.				
4	**Develop policy to address prophylaxis (anti-viral or vaccine) for volunteers.** ❒ Example: Volunteers placed in areas with, or that have the potential for, patient contact will receive prophylaxis (anti-viral medication or vaccine), if available. Volunteers not in high-risk areas will be eligible for prophylaxis based upon need priority and facility's supply availability.				
5	**Develop policy to identify volunteers.** ❒ Example: Skilled volunteers will be given an identification card that verifies skills and credentials, if appropriate.				

J. INDEPENDENT CONTRACTORS

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Review independent contractors' contracts to verify their work responsibilities during a pandemic. Ensure contract language clearly indicates the consequences of failure to comply with contract terms. This may include strong language such as: Failure to comply with the terms of this contract may result in its termination and require the contractor to provide compensation to the facility. Contract review should be performed by facility's attorney.					
2	Determine which independent contractors, if any, will be included in the facility's prophylaxis priority group.					

K. CREDENTIALING

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Develop mechanisms to quickly obtain license(s) copies.					
2	Develop process to contact appropriate state agencies for license confirmation (primary source verification, if possible).					
3	Ensure appropriate staff is available in reassignment center to approve temporary privileges.					
4	Ensure facility emergency credentialing process meets the Joint Commission's (JC) standards, if facility is JC accredited. K1					
5	Work with medical staff to develop and implement emergency credentialing procedures for physicians and licensed independent practitioners.					

Policy for Consideration

	Policy Recommendation and Example	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
6	**Develop policy to address the process for credentialing clinical volunteers.** ❒ Example: Professional service volunteers will require license verification and competence assessment within XX hours of pandemic plan activation. ❒ Determine if professional service volunteered is registered in ESAR-VHP or the State's MRC program, both of which address credentialing.				

L. UNIONS/COLLECTIVE BARGAINING

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Review pandemic plans with unions, particularly with regard to operational considerations in relation to collective agreements, related legislative requirements, and regulations.					
2	Review policies which will differ for each union, due to the fact that they will need to be addressed in the union contract. Include attendance, work hours, re-assignment, cross-training and compensation. (See section B)					
3	Address concerns that unionized employees may be subject to different policies as they relate to reassignment. (See section E)					
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.					

L. UNIONS/COLLECTIVE BARGAINING continued

Policies for Consideration

	Policy Recommendations and Example	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
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.				
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.				

L. UNIONS/COLLECTIVE BARGAINING continued

Policies for Consideration

	Policy Recommendations and Example	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
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 Incident Command Structure (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.				

M. ISOLATION AND QUARANTINE

BACKGROUND

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 (E4), 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* means "the separation of persons that are infected based on signs, symptoms or laboratory analysis from other persons during the period of communicability."

- *Quarantine* means "limitation of freedom of movement of healthy persons suspected to have been exposed to a communicable disease." Quarantine will last as long as the usual incubation period for the infectious agent. Employees and volunteers assigned to care for infectious or potentially infectious individuals must be protected.
  (Source: *Public Health – Seattle & King County I & Q Response Plan*)

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.

M. ISOLATION AND QUARANTINE continued

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
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 facility 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 with said disease. • *Work Quarantine* -- Work quarantine allows some health care workers to continue to work at the facility where they were exposed as long as they remain well. Developed as a strategy to ensure continuity of services during the SARS outbreak, work quarantine restricts health care workers' travel to only between work and home. Those subject to work quarantine must eliminate contact with the public, other than those they may come in contact with at the hospital 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 health care worker.					

M. ISOLATION AND QUARANTINE continued

Planning

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
2	Provide employees with a glossary which includes the definitions of relevant terms related to isolation and quarantine, including: • Home isolation and quarantine • Hospital isolation • Special isolation and quarantine facilities • Voluntary isolation and quarantine • Ordered isolation and quarantine • Detention (locked and guarded) isolation and quarantine (Source: *National Association of County and City Health Officials, January 2006.*)					
3	Determine how quarantine may be implemented in your area and/or at your facility (CB)**.**					
4	Develop hospital policies and procedures to implement quarantine should it be ordered by the county commissioner of health.					
5	Ask your public health officer for information regarding the circumstances under which voluntary or involuntary isolation and quarantine would be implemented.					
6	Identify and communicate to employees what services, if any, will be provided to employees whose movements have been restricted (e.g., food, medicine, money, etc.).					
7	Identify how people in isolation/quarantine will receive instructions, and how they will be informed of services they will be receiving (CB).					

M. ISOLATION AND QUARANTINE continued

Planning

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
8	Ensure sufficient signage/placards to label isolation/quarantine areas within the facility are available.					
9	Ensure there is re-directional signage for facility lockdown.					
10	Develop contingency plan for the rapid isolation of individuals that become symptomatic at work.					
11	Develop checklists to assess active monitoring and return-to-work procedures.					
12	Develop template to record the results of those employees on home quarantine that self-report on their clinical conditions.					

M. ISOLATION AND QUARANTINE continued

Home Quarantine

Policies for Consideration

	Policy Recommendations and Examples	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
13	**Develop policy to address necessary precautions/other requirements of health care workers under home quarantine (CB).** Example: Health care workers placed under home quarantine must follow the following guidelines: • Eat, drink, sleep and stay in a separate room in the house away from the other household members during the whole period of quarantine. • Minimize direct contact with the other household members. Wash hands thoroughly and use a facial mask if contact with other household members of the household can not 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.				

M. ISOLATION AND QUARANTINE continued

Home Quarantine

Policies for Consideration

	Policy Recommendations and Examples	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
14	**Develop policy to address compensation issues surrounding employees that are under home quarantine or isolation.** ❒ Example: (Name of Facility) may provide some compensation and other financial support for employees unable to return to work because of an isolation/quarantine order. Additionally, (Name of Facility) may provide temporary lodging, meals or reimbursement for other incidental expenses for employees that are quarantined.				
15	**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.				
16	**Develop process to monitor quarantined employees' conditions on a regular basis (e.g., daily phone calls).**				

M. ISOLATION AND QUARANTINE continued

Work Quarantine

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
17	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 (only to and from 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 in using public banks. • 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 patients infected with the flu.					
18	Screen employees via health questionnaire and/or by taking body temperatures prior to the start of each shift to minimize inadvertent exposures.					
19	Consider providing employee commuter transportation to minimize interactions. Identify volunteers that may be willing to provide transportation service.					

M. ISOLATION AND QUARANTINE continued

Work Quarantine

Policy for Consideration

	Policy Recommendation and Example	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
20	**Develop policy to educate health care workers under work quarantine.** ❒ Example: Health care 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 at work. Proper hand hygiene is also critical. • Commute to work alone in a private vehicle, if at all possible. If riding with others, the quarantined health care worker should wear an N95 or surgical mask (refer to CDC mask guidance for further information and ensure compliance with OSHA guidelines www.osha.gov/SLTC/respiratoryprotection/index.html). • Enter/exit the hospital 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 facility. Additionally, body temperatures should be monitored twice a day (Note: the facility must determine appropriate person to facilitate such monitoring, e.g., public health or hospital staff).				

M. ISOLATION AND QUARANTINE continued

Policy for Consideration

	Policy Recommendation and Example	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
	• Quarantined health care providers with offices in the community may be allowed to see their patients in the hospital if: a.) they wear an N95 or surgical mask (see CDC mask guidance and reference OSHA guidelines www.osha.gov/SLTC/respiratoryprotection/index.html to determine appropriate choice) at all times while at work; and b.) are diligent with proper hand hygiene.				

N. EMPLOYEE HEALTH

Planning

In your plan consider evaluating the following:

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
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, medical grand rounds, and other education opportunities for flu pandemic training.					
3	Implement and communicate basic hygiene (see www.cdc.gov/flu/protct/stopgerms.htm) 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 is 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, patients 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 hospital, as well as several places to wash or disinfect hands.					

N. EMPLOYEE HEALTH CONTINUED

PLANNING

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
	• Keep work surfaces, telephones, computer equipment and other frequently touched surfaces and office equipment clean and disinfected. Be sure that any cleaner used is safe and will not harm your employees or your office equipment. Use disinfectants as recommended, following all indicated directions and safety precautions. • Discourage employees from using colleagues' phones, desks, offices or other work tools and equipment. If using point-of-care devices (such as handheld computers or computers on wheels [COWS]), determine a method for adequately cleaning these units between users. In particular, computer keyboards are very difficult to clean effectively, so you may choose to assign specific COWS to specific employees or use cleanable keyboard covers. • Minimize situations where groups of people are crowded together, such as in a face-to-face meeting. Use e-mail, phones and text messages to communicate with each other. When meetings are necessary, avoid close contact by keeping a separation of at least 6 feet, where possible, and assure that there is proper ventilation in the meeting room. • Consider all situations that permit or require employees, customers and visitors (including family members) to enter the facility. Facilities which permit family visitors on-site should consider restricting/eliminating that option during a pandemic. Work sites with on-site day care should consider in advance whether these facilities will remain open or will be closed, and the impact of such decisions on employees and the operations of the hospital.					

N. EMPLOYEE HEALTH continued

Employee Return to Work Following Flu Diagnosis

Planning

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
1	Consider if employees who recover from the pandemic flu strain should be preferentially assigned to work with current flu patients 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

	Policy Recommendation and Example	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
2	**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 doctor's clearance note or documentation from the employee health department to return to work*. ❒ Example: In the event physicians or employee health staff are not available, employee may be subject to medical review upon returning to the hospital, however, this is contingent upon employee monitoring and reporting health status on a daily basis. N1				

*= 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.

N. EMPLOYEE HEALTH continued

Employee Protection Issues

Planning

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
4	Protecting employees is critical in sustaining clinical operations during a pandemic that will last for several months, particularly since staff availability will be dependent on their belief that they are safe and that the organization has placed their safety and well-being as the top priority. Toward that end, the Occupational Safety and Health Administration (OSHA) has developed extensive information and guidelines: • *Personal Protective Equipment (PPE)* - While administrative and engineering controls and proper work practices are considered to be most effective in minimizing exposure to the flu, the use of PPE may also be indicated during certain exposures. Examples of personal protective equipment are gloves, goggles, face shields, N95 and surgical masks. It is important that PPE be: o Selected based upon the hazard to the employee. o Properly fitted and periodically refitted (e.g., respirators). o Conscientiously and properly worn. o Regularly maintained and replaced, as necessary. o 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.					

N. EMPLOYEE HEALTH CONTINUED

EMPLOYEE PROTECTION ISSUES

PLANNING

	ASSIGNMENTS	COMPLETED	IN PROGRESS	NOT STARTED	DATE TO BE COMPLETED	LEAD STAFF MEMBER
5	• *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: o Respirators must be used in the context of a comprehensive respiratory protection program (see OSHA standard 29 CFR 1910.134, or www.osha.gov/SLTC/respiratoryprotection/index.html). o Medically evaluate employees to assure that they can 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). o 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. (Source: *Guidance on Preparing Workplaces for an Influenza Pandemic, OSHA 3327-02N, 2007*)					
	•					
6	Develop a comprehensive PPE/respirators fit testing plan that includes emergency fit testing.					
7	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.					

N. EMPLOYEE HEALTH continued

Employee Protection Issues

Policy for Consideration

	Policy Recommendation and Example	Considered	Implemented/ Date	Not Implemented/ Reason	Team Leader
8	**Develop policy to address employees that can not 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.				

APPENDIX A I

HEALTHCARE EMPLOYEE STAFFING PLANNING TOOL

Healthcare Employee Staffing Planning Tool

In order to effectively plan for a potential staffing crisis due to a pandemic, please provide the information below.

Name: _____

Department: _____

Hospital: _____

Contact information:

Address: _____
Street City/State Zip

Home Phone: _____ Cell Phone: _____

In order to assist us in our efforts to procure sufficient quantities of anti-virals (if available):

Household size: _____ Number of children
_____ Number of adults

I may have difficulty because:

- ❒ I provide care for an elderly immediate relative who cannot care for him or herself on a routine basis.
  - ❒ There are no other adult family members to provide this care.
  - ❒ This person would not otherwise qualify for a special needs shelter.
  - ❒ I will need help with establishing alternate care arrangements.

- ❒ I provide care that cannot otherwise be delivered for an immediate relative who is handicapped or has a chronic illness.
  - ❒ There are no other adult family members to provide this care.
  - ❒ This person would not otherwise qualify for a special needs shelter.
  - ❒ I will need help with establishing alternate care arrangements.

- ❒ I have a dependant child.
  - ❒ There are no other adult family members to provide this care.
  - ❒ Both parents work for the same hospital. (reassignment will be given).
  - ❒ I will need help with establishing alternate care arrangements.

- ❒ I have pets that will require care.

- ❒ I have no known issues at this time.

_____
Date Completed

APPENDIX B I

AHRQ/WEILL CORNELL COMPUTER STAFFING MODEL

Computer Staffing Model for Bioterrorism Response

Version 2.0 BERM

This computer model predicts the number and type of staff needed to respond to a major disease outbreak or bioterrorism attack on a given population. Version 2.0 includes a customizable staff model; it offers more flexibility but requires more inputs.

The model was funded by the Agency for Healthcare Research and Quality (AHRQ) and developed by researchers at Weill Medical College of Cornell University after testing a variety of patient triage and drug dispensing plans.

Select to Download Information.

New Resource

The Bioterrorism and Epidemic Outbreak Response Model (BERM) predicts the number and type of staff needed to respond to a major disease outbreak or bioterrorism attack on a given population. Version 2.0 includes a customizable staff model with more flexibility but requiring more inputs than the previous version.

This model will calculate estimates of recommended per-clinic and campaign-wide core staff and support staff based on user inputs These calculations are identical to those performed in earlier versions. However, this model allows users to enter each process time and population proportion individually, rather than selecting 'scenarios' as in previous versions.

BERM allows planners to formulate realistic mass antibiotic dispensing and vaccination contingency plans for their target populations. Such a model provides numerical estimates and forces critical examination of assumptions about prophylaxis clinic design and about the availability of human and materiel resources.

Estimates derived from this model should be viewed as one type of data among many that may be useful for planning. Other data might include previous local experience with immunization campaigns or the results of training exercises for response to bioterrorism attacks or natural disasters.

Download Information

Version 2.0 BERM (Bioterrorism and Epidemic Outbreak Response Model)

This tool may be downloaded from this Web page as a Microsoft® Excel workbook. To download the file, right click on the link and then select "Save Target As" (Internet Explorer) or "Save Link As" (Firefox™, Netscape®):

- Download Excel File (1.5 MB)

You may also access the program in an interactive HTML format. For the Web version, go to:

- http://www.ahrq.gov/research/biomodel3/

Version 1.1 BERM

This model (renamed and revised from the original release) was provided to the American Hospital Association (AHA) for distribution to U.S. hospitals. Users are required to register for access from the AHA Disaster Readiness Web site at: http://www.aha.org/aha_app/issues/Emergency-Readiness/index.jsp

Accessibility Notice: This file is not resident on a Government Web site and therefore does not comply with the requirements for Federal information resources under Section 508 of the Rehabilitation Act.

This model was created by Nathaniel Hupert, M.D., M.P.H., and Jason Cuomo, M.P.H., under AHRQ Contract No. 290-00-0013.

Mass Prophylaxis/Vaccination Campaign Staffing Model

The original model (Version 1) is maintained for archive purposes. The file is a Microsoft® Excel workbook. To download the file, right click on the link and then select "Save Target As" (Internet Explorer) or "Save Link As" (Firefox™, Netscape®):

- Download Excel File (1.4 MB).

For the interactive HTML format of the original model, go to: http://www.ahrq.gov/research/biomodel/index.asp

Copyright Constraints

AHRQ makes the model available under the following conditions:

- The model may be downloaded for specific individual applications by organizations and for personal use, providing the copyright notice is included.
- The model or any modifications or adaptations may not be reproduced, sold, or used for commercial purposes without the specific permission of the copyright holder.

Technical Assistance

Permission requests and technical assistance questions on the use of the model should be directed to:

Nathaniel Hupert, M.D., M.P.H.
Department of Public Health
Weill Medical College of Cornell University
411 East 69th St., KB-313
New York, NY 10021
Phone: (212) 746-3049
Fax: (212) 746-8544
E-mail: BTresponse@med.cornell.edu

More Information

If you have any questions about AHRQ's bioterrorism and health system preparedness program, contact:

Dr. Sally Phillips
Director, Bioterrorism Preparedness Research Program
Center for Primary Care Research
Phone: (301) 427-1571
E-mail: Sally.Phillips@ahrq.hhs.gov

Current as of September 2005

Internet Citation:

Computer Staffing Model for Bioterrorism Response. BERM Version 2.0. September 2005. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/biomodel.htm

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Weill Cornell Bioterrorism and Epidemic Outbreak Response Model (BERM)

Created by Daniel Wattson and Nathaniel Hupert, MD, MPH
Funded by U.S. DHHS (Agency for Healthcare Research and Quality (AHRQ), CDC, and NIH)

Help

Overall Campaign Inputs:

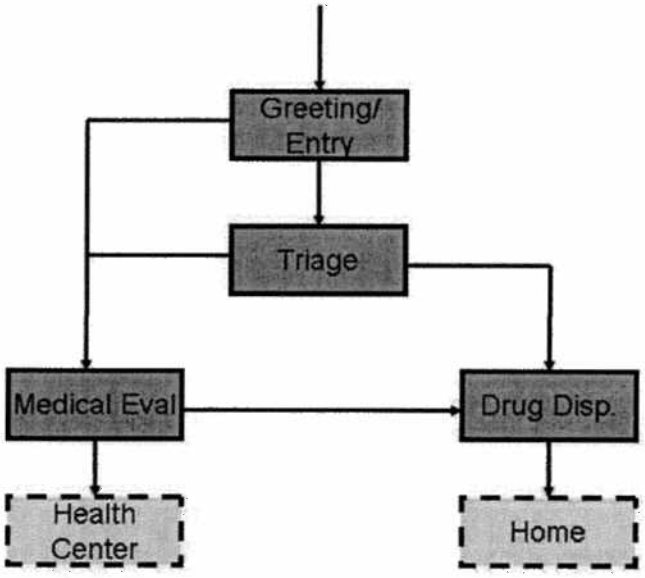
Size of Target Population	2000000
Duration of Campaign in Days	2
Hours of Operation per Day	24
Number of Staffing Shifts per Day	2
Percent Staff Downtime	15 %
Available Health Professionals	4000
Available Other Staff	8000
Percent family/peds/elderly/disabled	20 %
Service time increase factor*	25 %

* The amount that processing time is slowed for family/peds/elderly/disabled

POD Throughput or Number of PODs: 500 patients/hr.

Percent of Patients Routed from Station to Station:

From Greeting/Entry to Medical Eval	5 %
From Triage to Medical Eval	5 %
From Medical Eval to Health Center	5 %



Contact us

Per-POD Inputs:

Maximum Avg. Queue Length or Wait Time at each POD station: 5.0 patient(s)

Avg. Service Time In Minutes at Each POD:

Greeting/Entry	0.33
Triage	3
Medical Evaluation	10
Drug Dispensing	1

Click on the button below to estimate the number of core staff required for the campaign entered. You may alter these estimates before running the simulation if you wish. Estimate Core Staff

Number of Active Core Staff per POD:

Greeters	
Triage Staff	
Medical Evaluators	
Drug Dispensing Staff	

Percent of Core Staff that are Health Prof.:

Greeters	100 %
Triage Staff	10 %
Medical Evaluators	100 %
Drug Dispensing Staff	20 %

Number of Active Support Staff per POD*:

POD Managers	2
Security Staff	4
Med Resupply Staff	2
Data Entry and IT Staff	2
Other Support Staff**	3

Single Run — Run simulation

* All are non-health professionals

** Includes translation, crisis counseling, EMS,

** food service, custodial, etc.

APPENDIX B2

N.J.A.C. 8:43G-16.1 – 16.8

1 of 8 DOCUMENTS

NEW JERSEY ADMINISTRATIVE CODE

*** THIS FILE INCLUDES ALL REGULATIONS ADOPTED AND PUBLISHED THROUGH THE ***
*** NEW JERSEY REGISTER, VOL. 39. NO. 13, JULY 2, 2007 ***

TITLE 8. DEPARTMENT OF HEALTH AND SENIOR SERVICES
CHAPTER 43G. HOSPITAL LICENSING STANDARDS
SUBCHAPTER 16. MEDICAL STAFF

N.J.A.C. 8:43G-16.1 (2007)

§ 8:43G-16.1 Medical staff structural organization

(a) There shall be an organized medical staff that is responsible to the governing body of the hospital. Bylaws governing all medical staff members shall be implemented.

(b) Applications for membership, privileges, or initial appointment to the medical staff shall be processed under a system that includes, at least, the verification of applicants' credentials, periodic review of privileges, and obtaining information about any disciplinary action against the applicant available from the New Jersey Board of Medical Examiners or the Federal Clearinghouse established pursuant to the Health Care Quality Improvement Act, P.L. 99-660; 100 STAT 3743.

(c) Applications for medical staff membership, clinical privileges, or initial appointment submitted by health professionals who are not practitioners, shall be reviewed according to the same established criteria and procedures that govern physicians' applications, including obtaining information about any disciplinary action by New Jersey professional licensing boards.

(d) A committee or mechanism shall be established to be responsible for examining applications for appointment and reappointment to all categories of the medical staff. This committee shall recommend the conferring or withholding of all staff positions. It shall assure that all credentials are documented and verified.

(e) Medical staff privileges shall be specifically delineated and based on the practitioner's training, experience and demonstrations of clinical competence.

(f) The medical staff shall be divided into clinical departments. Each department shall be directed by a director, physician director, chairman or chief who is responsible for its administration and for taking or recommending action in those instances in which staff members fail to meet the department's standards of quality of care.

(g) There shall be an executive committee for the medical staff which performs supervisory functions, including reviewing patient care policies and procedures and serving as a forum for discussing patient care issues identified by the clinical departments.

(h) A medical staff meeting shall be held at least annually for all active staff members.

(i) The hospital and medical staff shall have a formal program addressing impaired practitioners. This program shall include the following components:

i. Policies and a mechanism which encourage the voluntary or informal identification or reporting of practitioner impairment to the hospital;

ii. A mechanism for monitoring physician performance and for the limitation of clinical privileges if appropriate; and

iii. A procedure for the referral of impaired practitioners to appropriate treatment.

(j) The clinical privileges of all individuals shall be fully reviewed periodically. Actions which result in reduction or restriction of staff privileges based on this review shall be reported to the New Jersey Board of Medical Examiners in accordance with *N.J.S.A. 26:2H-12.2*.

(k) The hospital shall notify the New Jersey State Board of Medical Examiners, or a medical practitioner review panel created by legislation and subordinate to the Board, if a practitioner who is employed by, under contract to render professional services to, or has privileges at the hospital:

1. Voluntarily resigns from the staff while the facility is reviewing the practitioner's conduct or patient care or has through any member of the medical or administrative staff expressed an intention to do so;

2. Voluntarily relinquishes any partial privileges to perform a specific procedure while the hospital is reviewing the practitioner's conduct or patient care or has, through any member of the medical or administrative staff, expressed an intention to do so;

3. Has full or partial privileges summarily or temporarily revoked or suspended, permanently reduced, suspended or revoked, has been discharged from the staff or has had a contract to render professional services terminated or rescinded for reasons relating to the practitioner's incompetency misconduct, or impairment;

4. Agrees to the placement of conditions or limitations on the exercise of clinical privileges or practice within the health care facility including, but not limited to: second opinion requirements, non-routine concurrent or retrospective review of admissions or care, non-routine supervision by one or more members of the staff, or the completion of remedial education or training;

5. Is granted a leave of absence pursuant to which he or she may not exercise clinical privileges or practice within the hospital if

the reasons provided in support of the leave relate to any physical, mental, or emotional condition or drug or alcohol use, which might impair the practitioner's ability to practice with reasonable skill and safety;

6. Is a party to a medical malpractice liability suit in which the hospital is also a party, in which there is a settlement, judgement, or arbitration award; or

7. Has privileges, conditions or limitations reinstated or a leave of absence concluded where the results of the investigation clear the practitioner from all allegations of misconduct, impairment, or incompetence.

(l) Notifications required by (k) above shall be provided within seven days of the reported event and shall be submitted on forms approved by the Department of Health for that purpose.

(m) The hospital shall provide upon request to the State Board of Medical Examiners, or to a practitioner review panel created by legislation and reporting to the board, such additional information on individual instances of loss or change of physician privileges, possible impairments, and medical malpractice liability as the board or panel requests in accordance with law.

(n) The hospital shall provide to the following:

Office of the Assistant Commissioner

Division of Health Facilities Evaluation

New Jersey State Department of Health

PO Box 367

Trenton, N.J. 08625-0367

copies of all reports regarding physician hospital privileges sent to the New Jersey State Board of Medical Examiners, or to the practitioner review panel created by legislation and reporting to the board. All records regarding such copies shall be made available to the Department of Health personnel for official purposes and, for each report, to the specific facility mentioned in the report.

(o) For the purposes of (k) through (n) above, "practitioner" means only a person licensed to practice: medicine and surgery under *N.J.S.A. 45:9-1* et seq. or a medical resident or intern; or podiatry under *N.J.S.A. 45:5-1* et seq.

HISTORY:

Amended by R.1992 d.72, effective February 18, 1992.

See: 23 New Jersey Register 2590(a), 24 New Jersey Register 590(a).

Notifications of practitioner status change required by (k) to be made in seven days.

CASE NOTES:

Members of medical peer review committees had immunity for actions, recommendations or statements. *Bundy v. Sinopoli, 243 N.J.Super. 563, 580 A.2d 1101 (L.1990).*

Privilege of self-critical evaluation protects from discovery opinions, criticisms, or evaluations contained within peer review committee files. *Bundy v. Sinopoli, 243 N.J.Super. 563, 580 A.2d 1101 (L.1990).*

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N.J.A.C. 8:43G-16.2 (2007)

§ 8:43G-16.2 Medical staff policies and procedures

(a) The medical staff shall have written policies, procedures, and bylaws that are reviewed at least once every three years; revised more frequently as needed, and implemented. They shall include at least:

1. Policies and procedures addressing the requirements for obtaining written informed consent from patients;

2. Requirements for the completeness and timing of the patient history and physical examination, including a listing of the minimum contents to be included in the medical record;

3. The minimum content of physician orders;

4. Specifications for verbal orders, including who may give verbal orders, who may receive them, and how soon they must be verified or countersigned in writing;

5. If applicable, policies and procedures related to the prescribing or ordering of medications or devices by certified nurse practitioners/clinical nurse specialists in accordance with New Jersey State Board of Nursing rules at N.J.A.C. 13:37-7; and

6. If applicable, the scope of practice, supervision, and record keeping requirements of licensed physician assistants in accordance with New Jersey State Board of Medical Examiners rules at N.J.A.C. 13:35-2B.

(b) All physician orders for medication, treatment, and restraints shall be in writing. All orders for restraints shall be made in accordance with requirements at *N.J.A.C. 8:43G-18.4(c)* through (e) and (i).

(c) The medical staff shall have a means to assess individual patient's competence to consent to treatment in conformance with current law. Measurement of patient competence may include such skills as ability to understand their medical condition and the consequences of procedures and treatments, and to communicate a

choice. The hospital and physician shall follow the procedures for appointment of a special medical guardian where required in accordance with the Civil Practice Rules at 4:83-12.

(d) Each time the attending physician visits the patient, the physician shall enter a note into the medical record describing the findings about the patient's condition. If issues have been raised in the record by other disciplines, this note shall respond to them.

(e) The hospital shall comply with the New Jersey State Board of Medical Examiners rules concerning the registration and permit requirements for graduate medical education programs and practice, *N.J.A.C. 13:35-1.5*.

(f) The hospital shall require that all prescriptions and orders issued by registered first-year residents in the inpatient setting be countersigned by a licensed physician or permit holder (a person authorized in the State of New Jersey to engage in the practice of medicine in the second year of a graduate medical education program or beyond).

HISTORY:

Amended by R.1992 d.72, effective February 18, 1992.

See: 23 New Jersey Register 2590(a), 24 New Jersey Register 590(a).

Reference changed at (b).

Amended by R.1995 d.124, effective March 20, 1995.

See: 26 New Jersey Register 4537(a), 27 New Jersey Register 1290(a).

Amended by R.1999 d.436, effective December 20, 1999.

See: *31 New Jersey Register 367(a), 31 New Jersey Register 614(a), 31 New Jersey Register 4293(c)*.

In (a), substituted "at least once every three years; revised more frequently" for "annually, revised" in the introductory paragraph.

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N.J.A.C. 8:43G-16.3 (2007)

§ 8:43G-16.3 Medical staff qualifications

(a) All physicians with clinical privileges shall be licensed or authorized to practice medicine by the New Jersey Board of Medical Examiners. All non-physicians with privileges shall be licensed or authorized to practice in the State of New Jersey, as required by law.

(b) In any subchapter of these rules requiring a practitioner to be Board-certified within his or her medical specialty, it shall be deemed acceptable to possess:

i. Board certification from one of the recognized boards of osteopathic medicine; or

ii. Board certification from a foreign Board within the specified medical specialty where the American Board offers reciprocity with or officially recognizes the foreign board certification credential.

CASE NOTES:

In action brought by physician challenging termination of staff privileges at hospital, regulation cited to support court's deference to decisions of hospitals to maintain a qualified medical staff. *Nanavati v. Burdette Tomlin Memorial Hospital, 107 N.J. 240, 526 A.2d 697 (1987).*

All hospital employees subject to regulatory supervision; restrictive staff admission policy invalid as not reasonably in furtherance of legitimate health objective. *Desai v. St. Barnabas Medical Center, 103 N.J. 79, 510 A.2d 662 (1986).*

Regulations require hospital to appoint organized medical staff responsible to governing board; hospitals must adopt rules concerning procedures for staff membership admission; qualified doctors may not be arbitrarily excluded from staff; exclusive contract for anesthesialogical services reasonable, not violative of public pol-

icy and not illegal tying arrangement under *Antitrust Act. Belmar v. Cipolla, 96 N.J. 199, 475 A.2d 533 (1984).*

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N.J.A.C. 8:43G-16.4 (2007)

§ 8:43G-16.4 (Reserved)

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N.J.A.C. 8:43G-16.5 (2007)

§ 8:43G-16.5 Medical staff time and availability

(a) The hospital shall establish policies and procedures for response times for emergencies.

(b) There shall be an on-call list of medical and surgical specialists that is available to personnel in all patient care units.

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N.J.A.C. 8:43G-16.6 (2007)

§ 8:43G-16.6. Medical staff patient services

(a) Each patient shall have an attending physician who has overall responsibility for the patient's care in the hospital.

(b) Each patient admitted to the hospital shall have a medical history and physical examination that includes a provisional diagnosis performed by a clinical practitioner within seven days prior to admission or within 24 hours after admission. If the history and physical were performed within seven days prior to admission, the patient's history and physical examination record completed by the attending physician, advanced practice nurse or physician assistant shall be included in the medical record, with any subsequent changes recorded at the time of admission.

(c) When there is a clinical consultant, he or she shall issue a report that states at least the assessment mechanisms used, findings, and opinion. This report shall be included in the medical record.

(d) The reason or reasons for requesting a clinical consultation shall be specified in the patient's medical record by the attending physician. The consultant shall provide consultation in accordance with the privileges accorded him or her by the hospital.

(e) Medical care shall be provided to all patients, regardless of their ability to pay.

(f) Every acute care patient shall receive a visit by a clinical practitioner every day unless there is a clinical basis to justify the patient not receiving such a visit that is documented in the medical record by the practitioner. In all cases a patient shall receive a visit by a practitioner at least once every two days.

HISTORY

Amended by R.1992 d.72, effective February 18, 1992.

See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).

Diagnosis to be provided seven days prior to or 24 hours after admission.

Amended by R.2005 d.279, effective September 6, 2005.

See: *37 N.J.R. 709(a), 37 N.J.R.3365(a).*

Rewrote (b).

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N.J.A.C. 8:43G-16.7 (2007)

§ 8:43G-16.7 Medical staff education

Requirements for the medical staff education program shall be as provided in *N.J.A.C. 8:43G-5.9(a)* and (b).

HISTORY:

Amended by R.1992 d.72, effective February 18, 1992.

See: 23 New Jersey Register 2590(a), 24 New Jersey Register 590(a).

Stylistic change.

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N.J.A.C. 8:43G-16.8 (2007)

§ 8:43G-16.8 Medical staff continuous quality improvement methods

There shall be a medical staff mechanism by which the quality of medical care is monitored, problems identified, solutions recommended and implemented, and follow-up conducted. Summary reports of these activities and problems in the quality of care shall be reviewed by the medical executive committee, or its equivalent.

HISTORY:

Amended by R.1999 d.436, effective December 20, 1999.

See: *31 New Jersey Register 367(a), 31 New Jersey Register 614(a), 31 New Jersey Register 4293(c).*

NOTES:
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APPENDIX B3

UTHCPC STAFF PROCEDURES

Staffing in Emergency Conditions

Introduction

Date of Last Review 4/2/07
SME: Director of Nursing

Introduction

UTHCPC is an acute-care inpatient hospital facility and must provide adequate staffing to meet patient care and operational requirements at all times, regardless of weather-related and other emergency conditions. During adverse conditions however, it may become necessary to officially suspend routine operations of UTHCPC and designate "Emergency Status". During Emergency Status, employees will be expected to work as needed in accordance with the procedures described.

Policy

UTHCPC remains open at all times. The closing of other operating units of the UTHSC-H does not automatically result in the closing of UTHCPC.

Authorization to Designate "Emergency Status"

UTHCPC assumes Emergency Status when routine operations are suspended. The following are the only people authorized to suspend any UTHCPC operations:

- Executive Director
- Hospital administrator or his/her designee

Monitoring Emergency Status

Employees have the responsibility for obtaining information about UTHCPC during adverse conditions to determine if Emergency Status has been designated, by using either of the following options:

- Call the UTHCPC-specific phone line at 713-741-5001 for a pre-recorded message
- Call his/her supervisor

Definitions

1. Adverse Conditions: conditions such as inclement whether or other factors which have an actual or potential harmful effect on the delivery of health care and other institutional operations.
2. Cascade Recall: A process initiated by the Executive Director, Hospital Administrator, or designee, after the designation of an Emergency Status, whereby employees who are not present at work at the time of the Emergency Status designation are called back into work.
3. Emergency Status: status of UTHCPC during which time routine operations are suspended because of Adverse Conditions.
4. Emergency Staffing Team: A pre-determined, designated team of Level I and Level II staff who are aware of the need to report to work immediately in the event of an "Emergency Status" unless instructed

by HCPC management. Level I and Level II are defined in this policy.

Staffing Resources During an "Emergency Status":

1. Emergency Staffing Team
2. Staff contacted via Cascade Recall System if Administration deems the Emergency Staffing team is not sufficient to provide coverage.

Employee Responsibilities

1. It is the responsibility of all employees to be familiar with:
   a. UTHCPC Emergency Preparedness Program
   b. Their Departmental Emergency Plans as well how these plans apply specifically to them

2. UTHCPC's Emergency Staff Team employees are expected to report to work as scheduled, regardless of where they live, even when operating units of UTHSC-H close. All Emergency Staff Team employees are expected to report for duty unless they are specifically released from duty by an appropriate authority of UTHCPC such as their supervisor.

Emergency Employee Classifications:

Emergency Staffing Team

An Emergency Staffing Team will be identified and designated at all times in order to be prepared to provide minimum staffing levels for continuous uninterrupted patient care based on formal staffing plans discussed below. UTHCPC Administration will maintain a list of the designated Emergency Staffing Team on the cascade recall list. Emergency Staffing Team members will remain on duty at the discretion of the Executive Director and Administrator throughout any emergency.

- The Emergency Staffing Team will be comprised of Level I and Level II staff
- The number of required team members will be designated by Department Heads and approved by Administration annually based on Formal Staffing Plans
- Team members will be selected by department heads primarily as a result of obtained staff volunteers and secondarily from appointed staff
- Team members will be appointed for a one year assignment on the Emergency Staffing Team

Level I

Employees with specific responsibilities for direct patient care in their regular jobs or who by licensure, are competent to provide direct patient care. Level I staff on duty at the time of the Emergency Status designation are expected to remain in their regular job duties throughout the Emergency Status and should contact their supervisor for additional instructions upon receiving notice of UTHCPC's designation of Emergency Status. During an emergency, Level I employees may not leave the hospital until released by a supervisor.

Level I includes all nursing department staff, all Nurses including UR Nurses, Patient Registration Nurses, PHP Nurses, HWE Nurses, Nursing Administration Nurses, Social Workers, Social Services Therapists and Chaplains, all Residential Unit staff, Administration, Patient Registration, Facilities Management, Dietary Staff, Pharmacy Staff, Housekeeping Staff, Lab Staff, Residents, Physicians and all Managers.

Level II

Employees who are not involved in provision of direct service to the patient in their usual job, but who are needed to perform defined roles throughout Emergency Status, i.e. answering phones in command center,

assisting with meal preparation, or providing assigned duties in patient care areas. Level II staff are expected to perform designated assigned duties upon reporting to work. During an emergency, Level II employees may not leave the hospital until released by a supervisor.

Level II includes COPES staff members, Reception/Switchboard, Medical Support Services, Health Information Management and Management Information Systems.

Employees that do not provide patient care are Level III staff. Level III staff are not required to assist in response to an Emergency Status unless requested to do so as a result of the engagement of the cascade recall list. In the event this should occur, Level III staff would then be considered to be reclassified to Level II staff and all information in this policy regarding Level II staff would apply. All employees are expected to report to work according to their schedule immediately following the completion of the Emergency Status.

Level III includes ancillary and administrative departments (Financial Operations, Personnel Systems Management, Hospital-Wide Education (except RN's), Patient Account Services, Reception/Switchboard, Performance Improvement (except RN's), Management Information Systems, Library, Public Information, PHP staff (except RN's and Social Workers)

Formal Staffing Plan Process

This table describes the responsibilities of maintaining the Formal Staffing Plans for UTHCPC:

Stage	Person Responsible	Description
1	Department Managers	Maintain a Formal Staffing Plan that identifies Emergency Classification (Level I, II or III) for all positions and enables all employees to reach appropriate supervisory personnel
2	Department Managers	Establish an Emergency Staffing Team if applicable. (This does not apply to Level III departments.)
3	Department Managers	Submit Formal Staffing Plans to Directors for approval
4	Directors	Finalize, Approve the Formal Staffing Plans
5	Directors	Submit approved Formal Staffing Plans to the Hospital Administrator
6	Department Managers	Notify employees of their Emergency Classification whenever changes occur

Compensation

Employees will receive emergency pay for hours actually worked during the period of time the hospital is under an "Emergency Status". Employees will not be reimbursed for designated sleep hours. Employees should address questions about their pay to their designated supervisor.Level I and Level II Essential will be compensated double time pay or granted regular pay and compensatory time equivalent to double time for hours actually worked during the designated emergency period. Departmental managers will determine how pay will be handled based on budgetary considerations. Compensatory time must be taken within 12 months of earning the compensatory time.Level III employees will be compensated administrative leave pay for hours scheduled to work during the designated emergency period.Level I and II employees who are not designated as an Emergency

Staffing Team member, or who are not called through the cascade recall, or who have been released from duty by a supervisor, will be compensated administrative leave pay for hours regularly scheduled to work during the designated emergency period.Employees who are expected to report to work either as a designated Emergency Staffing Team member or requested to report via engagement of the cascade recall system and who do not report to work must use appropriate personal leave time (vacation, sick leave, holiday accrued or leave without pay). Such employees may be subject to disciplinary action, at the discretion of their supervisor(s).Employees approved for personal leave time (vacation, sick leave, holiday accrued, leave of absence without pay) prior to the declaration of the emergency are not eligible for administrative pay during the designated emergency period.

Emergency Status Working Conditions

1. Employees must arrange to have the supplies they need during the emergency when they report to work. Examples include medications, personal hygiene products, clean clothing.
2. Employees should make necessary phone calls to family members before coming to their work assignment, informing the family as to their whereabouts and asking them not to call during the emergency. A telephone will be available should employees need to contact family.
3. All employees are encouraged to make prior arrangements for their family outside the UT system so that at the time of the emergency, the employee will know where they will be and who will be taking care of them. Planning ahead will help employees be available in the event the cascade recall system is engaged.
4. Employees who work during an emergency will be provided an assigned place to sleep. Arrangements will depend on available resources. Employees will not be compensated for designated sleep hours.
5. Employees may work under emergency conditions for an undetermined time and may be assigned other work shifts as needed.
6. Meals will be furnished free of charge to employees on duty
7. All employees are allowed to park their vehicle in designated parking free of charge during the emergency, depending on space availability. Employees assume all risk of damage or loss to such vehicles.

Failure to Comply with Policy

Failure of an employee to comply with this policy may result in disciplinary action, up to and including termination, in accordance with the provisions of the HOOP 2.35 and HCPC Attendance policies.

Volunteers

HCPC will accept the help of volunteers during a disaster. Volunteers will be assigned a specific job description including necessary qualifications. The identity of all volunteers who offer their service will be checked. Volunteers that will be providing professional medical services will require verification of licensure and assessment of competence within 72 hours. Personnel Systems Management will perform primary source verification of licensure, certification or registration of non-credentialed staff within 72 hours. Departmental management will perform assessments of competency and provide oversight of care, treatment and services provided during the initial 72 hours.

Related standards

HOOP 2.35; HOOP 18.01; HOOP 18.02
HCPC Emergency Preparedness Program
Departmental Emergency Plans

Related Forms

Emergency Preparedness & Staffing in Emergency Conditions

Related to regulatory standards

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HARRIS COUNTY PSYCHIATRIC CENTER

THE UNIVERSITY of TEXAS HEALTH SCIENCE CENTER at HOUSTON

University of Texas Harris County Psychiatric Center at Houston. UTHCPC Procedures. [Internet]. Houston (TX): University of Texas Harris County Psychiatric Center; 2007 April 2 [Date of last review; cited modification 2007 July 10]; Volume 1, Chapter 2, Staffing in Emergency Conditions. [about 15 p.]. Available from: http://www.uth.tmc.edu/uth_orgs/hcpc/procedures/volume1/chapter2/employee_staffing_and_training-03.htm

APPENDIX B4

DEPARTMENT STAFFING NEEDS WORKSHEET

DEPARTMENT STAFFING NEEDS CHECKLIST

Name: _____

Department: _____

Facility: _____

Identify the minimum number of staff required to maintain operations within your department.

Required	Number of Employees/Shift		
Skills	**7 -3**	**3-11**	**11-7**

Identify staff that could *possibly* work remotely.

Name	Title	Skills	Shift

Identify computer resources that would be required for employees to work remotely.

Name	Title	Hardware Needs	Software Needs

APPENDIX B5

MOU FOR PERSONNEL

This document was prepared by the Greater New York Hospital Association. This document was supported by Grant number U3RMC01549-01, 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 GNYHA 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, THEREFORE, 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.

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* This document was supported by Grant number U3RMC01549-01, 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 as 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 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:_____

Name of Designated Representative:_____

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:_____

Name of Designated Representative:_____

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:_____

12. **Governing Law**. This Agreement, and the rights, obligations and remedies of the parties hereto, shall be governed by and construed in accordance with the laws of the State of New York.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

_____(Hospital A)

By: _____

Title: _____

_____(Hospital B)

By: _____

Title: _____

APPENDIX B6

MODEL DISASTER PRIVLEDGES POLICY

This model policy has been prepared by the Greater New York Hospital Association. This document was supported by Grant number U3RMC01549-01, from the Health Resources and Services Administration (HRSA). Its contents are soley the responsibility of the authors and do not necessarily represent the official views of HRSA. Please note that as of July 2006, the Joint Commission standards regarding disaster privileging have been revised. Therefore, the standards reflected in this document have been revised since its distribution in 2004.

Prepared by GNYHA 2004

MODEL DISASTER PRIVILEGES POLICY*

POLICY:

It is the policy of _____ Hospital, to permit the Chief Executive Officer, Medical Staff President, or their designee(s), to grant disaster privileges on a case-by-case basis when the hospital's emergency management plan is activated and the hospital is unable to handle immediate patient care needs. This policy outlines _____ Hospital's plan to accept volunteer practitioners and to process the credentials of those practitioners who do not currently possess medical staff privileges to practice at _____ Hospital.

PURPOSE:

The purpose of this policy is to outline the process for granting disaster privileges to licensed independent practitioners (LIPs) during the time when the hospital's emergency management plan is activated and the hospital is unable to handle immediate patient care needs.

RESPONSIBILITY: The [insert title(s) of responsible individuals(s)]** is/are responsible for granting disaster privileges in accordance with this policy. The [insert title(s) of responsible individuals(s)] is not required to grant disaster privileges and will make such decisions on a case-by-case basis at his or her discretion.

PROCEDURE:

When the hospital's emergency management plan has been activated, the hospital will utilize the following process for any LIP who is not on the medical staff of _____ Hospital and who presents his/her self as a volunteer to render services:

1. The practitioner will be directed to _____,where he/she must present any one of the following, prior to the granting of disaster privileges:
    a. a current hospital photo identification card; or

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* This model policy, which has been prepared by GNYHA, is based upon JCAHO Standard MS.4110. The New York State Department of Health has endorsed MS.4.110. This document was supported by Grant number U3RMC01549-01, 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.

** While JCAHO Standard MS.4110 indicates that the Chief Executive Officer, Medical Staff President, or their designee(s) have the ultimate responsibility for granting disaster privileges, MS. 4.110 indicates that the hospital should identify in writing the individual(s) responsible for granting disaster privileges.

b. a current license to practice and a valid picture identification card issued by a state, federal, or regulatory agency; or identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); or
c. identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal , state, or municipal entity); or
d. presentation by current hospital or medical staff member(s) with personal knowledge regarding the LIP's identity.

2. Once a practitioner obtains approval for disaster privileges, _____ Hospital will issue appropriate identification. The practitioner will then report to and practice under the auspices of the chairman/designee of the department to which he/she is assigned.

3. The medical staff will begin the verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control. The verification process is identical to the process established under the medical staff bylaws for granting temporary privileges to meet an important patient care need, and is a high priority. ***

4. All disaster privileges will immediately terminate once the emergency management plan is no longer activated. However, the hospital may choose to terminate disaster privileges prior to that time. The practitioner must return the temporary ID card to _____.

5. The medical staff will maintain a list of all volunteer practitioners who received disaster privileges during the emergency management/disaster event.

REFERENCES:

JCAHO Standard MS.4.110.

*** *JCAHO Standard MS.4.110 assumes that hospitals have a procedure for granting temporary privileges to meet an important patient care need.*

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APPENDIX B7

CRS REPORT ON ISOLATION/QUARANTINE

Order Code RL33201

CRS Report for Congress

Federal and State Quarantine and Isolation Authority

Updated January 23, 2007

Kathleen S. Swendiman and Jennifer K. Elsea
Legislative Attorneys
American Law Division

Prepared for Members and
Committees of Congress

Federal and State Quarantine and Isolation Authority

Summary

In the wake of recent terrorist attacks and increasing fears about the spread of highly contagious diseases, such as severe acute respiratory syndrome (SARS) and pandemic influenza, federal, state, and local governments have become increasingly aware of the need for a comprehensive public health response to such events. An effective response could include the quarantine of persons exposed to infectious biological agents that are naturally occurring or released during a terrorist attack, the isolation of infected persons, and the quarantine of certain cities or neighborhoods.

The public health authority of the states derives from the police powers reserved to them by the Tenth Amendment to the U.S. Constitution. The authority of the federal government to prescribe quarantine and other health measures is based on the Commerce Clause, which gives Congress exclusive authority to regulate interstate and foreign commerce. Thus, state and local governments have the primary authority to control the spread of dangerous diseases within their jurisdictions, and the federal government has authority to quarantine and impose other health measures to prevent the spread of diseases from foreign countries and between states. In addition, the federal government may assist state efforts to prevent the spread of communicable diseases if requested by a state or if state efforts are inadequate to halt the spread of disease. Some state laws are antiquated and, until recently, have not been reviewed to address the spread of disease resulting from a biological attack. Other state laws do not cover newly emerging diseases such as SARS or pandemic influenza. In light of recent events, however, many states are reevaluating their public health emergency authorities and are expected to enact more comprehensive laws relating to quarantine and isolation. Public health experts have developed a Model State Emergency Health Powers Act to guide states as they reevaluate their emergency response plans.

This report provides an overview of federal and state public health laws as they relate to the quarantine and isolation of individuals, a discussion of constitutional issues that may be raised should individual liberties be restricted in a quarantine situation, and federalism questions that may arise where federal and state authorities overlap. In addition, the possible role of the armed forces in enforcing public health measures is discussed, specifically whether the Posse Comitatus Act would constrain any military role, and other statutory authorities that may be used for the military enforcement of health measures.

Contents

Federal and State Quarantine and Isolation Authority

> One very simple principle [justifies state coercion]. That principle is, that the sole end for which mankind are warranted, individually or collectively, in interference with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. John Stuart Mill (1856)

Introduction

The practice of avoiding persons with contagious diseases may be found in the oldest of writings, including Leviticus and Numbers in the Old Testament, wherein specific instructions are given for the inspection and sequestration of lepers.[1] The term "quarantine" is derived from the Italian words *quaranta giorni*, which refer to the 40-day period during which certain ships arriving at the port of Venice during the Black Death plague outbreaks of the 14th century were obliged to sit at anchor before any persons or goods were allowed to go ashore.[2] Following a plague epidemic in London in 1664, England passed rigorous quarantine laws. All quarantined vessels were required to show a solid yellow flag to indicate they were under quarantine. As late as 1721, some ships coming to England from infected areas were burned at sea.[3] The earliest evidence of quarantine in colonial America occurred in the Massachusetts Bay Colony in 1647, when vessels from the West Indies were forbidden to land or discharge passengers and cargo during a plague outbreak. The first federal quarantine law was passed in 1796 in response to continued yellow fever epidemics.[4]

In the event of a biological attack or the introduction of a highly contagious disease affecting the public, the U.S. health system may take measures to prevent those people infected with or exposed to a disease or a disease-causing biological agent from infecting others.[5] The terms used to describe these measures, *quarantine*

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[1] *Leviticus* 14:4-8 and *Numbers* 5:2. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 204-5 (2002).

[2] Centers for Disease Control and Prevention (CDC), History of Quarantine, at [http://www.cdc.gov/ncidod/dq/history.htm].

[3] 1911 Encyclopedia Britannica, available at [http://www.1911encyclopedia.org/quarantine].

[4] An Act Relative to Quarantine, ch. 31, 1 Stat. 474 (1796).

[5] See, generally, CRS Report RL33145, *Pandemic Influenza: Domestic Preparedness* (continued...)

and *isolation*, generally apply to distinct groups of persons but are often used interchangeably. Quarantine typically refers to the "(s)eparation of individuals who have been exposed to an infection but are not yet ill from others who have not been exposed to the transmissible infection."[6] Isolation refers to the "(s)eparation of infected individuals from those who are not infected."[7] Varying degrees of quarantine exist, and the authority to order quarantine or isolation is generally very broad.

> First, both complete quarantine and isolation usually involve the confinement of contagious individuals to their residences pursuant to orders from the state health department. Health officials post a public notice forbidding anyone from entering or exiting the dwelling. Alternatively, health authorities may confine an infected person to either a hospital or a prison. Second, health authorities may order a modified quarantine, which selectively restricts an individual from participation in certain activities, e.g. jobs involving food preparation, school attendance, or particularly hazardous activities. The quarantine power also includes the authority to place a contagious individual under surveillance to insure strict compliance with quarantine orders. Finally, the health department may issue segregation orders which require the separation of an entire group of people from the general population. Quarantine orders may extend to any persons who come into contact with the infected individual.[8]

Primary quarantine authority typically resides with state health departments and health officials; however, the federal government has jurisdiction over interstate and foreign quarantine. In addition, the federal government may assist with or take over the management of an intrastate incident if requested by a state or if the federal government determines local efforts are inadequate.[9] This report examines federalism and other constitutional issues related to quarantines, discusses current federal and state statutes and regulations, and explains the military's role in enforcing quarantines.

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[5] (...continued)
Efforts, by Sarah A. Lister. See also Homeland Security Council, *National Strategy for Pandemic Influenza*, (GPO November 2005), and Homeland Security Council, *National Strategy for Pandemic Influenza: Implementation Plan* (GPO May 2006).

[6] Homeland Security Council, *National Strategy for Pandemic Influenza: Implementation Plan* 209 (GPO May 2006).

[7] *Id.* at n. 207.

[8] Edward A. Fallone, *Preserving the Public health: A Proposal to Quarantine Recalcitrant AIDS Carriers*, 68 B.U.L. REV. 441, 460 - 461 (1988). During the 2003 outbreak of SARS, U.S. patients were isolated until they were no longer infectious, allowing them to receive medical care and helping to contain the spread of the illness. However, there were no individual or population-based quarantines of persons who may have been in contact with infected persons. The CDC advised persons who were exposed but not symptomatic to monitor themselves for symptoms and advised home isolation and medical evaluation if symptoms appeared. CDC, Isolation and Quarantine Fact Sheet, 2004, available at [http://www.cdc.gov/ncidod/dq/sars_facts/isolationquarantine.pdf].

[9] 42 U.S.C. § 264(e) and 42 C.F.R. § 70.2.

Constitutional Issues

The preservation of the public health has historically been the responsibility of state and local governments.[10] Although the federal government has the authority to authorize quarantine under certain circumstances, the primary authority exists at the state level as an exercise of the state's police power. The 4th Congress appears to have recognized this principle when, in 1796, it debated whether to authorize the President to establish regulations to impose quarantines at ports of entry.[11] After opponents argued that the authority belonged to the states, Congress passed a law authorizing the President to assist states in enforcing their health laws,[12] which it soon replaced with a law requiring certain federal officials to observe restraints and quarantines imposed by state laws and to aid state officials in their execution.[13]

In 1824, the Supreme Court alluded to a state's authority to enact quarantine laws in *Gibbons v. Ogden*.[14] In *Gibbons*, the Court noted that although quarantine laws may affect commerce, they are, by nature, health laws, and thus fall under the authority of state and local governments. Courts have noted that the duty to ensure that the public health is preserved is inherent to the police power of a state and cannot be surrendered.[15] However, the Supreme Court has recognized that state health laws that intrude on a matter within Congress's power to legislate must give way under the Supremacy Clause.[16]

The federal or state origin of quarantine laws may influence the means and methods of their enforcement. The Constitution does not expressly vest the executive branch with the authority to execute state laws, and the federal government has no authority to order state officials to execute federal law.[17] Article IV, § 4, guarantees federal assistance to states only in cases of invasion or insurrection, or at the request of the state legislature (or the executive, if the legislature cannot be convened) in the case of "domestic violence." The Tenth Amendment provides that powers not

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[10] *People ex rel. Barmore v. Robertson*, 134 N.E. 815, 817 (Ill. 1922); see, generally, James G. Hodge, *The Role of New Federalism and Public Health Law*, 12 J.L. & HEALTH 309 (1998) (Hereafter cited as, Hodge).

[11] 5 *Annals of Congress* 1349-59 (1796).

[12] 1 Stat. 474 (1796).

[13] Act of Feb. 23, 1799, ch. 12, § 1, 1 Stat. 619 (presently codified at 42 U.S.C. 97). This section applies to maritime quarantines. Federal officials include customs officials, the Coast Guard, and "military officers commanding in any fort or station upon the seacoast."

[14] 22 U.S. 1, 25 (1824).

[15] 134 N.E. at 817.

[16] U.S. CONST. art. VI, par. 2 ("[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof; ... shall be the supreme Law of the Land; ..."). See *Morgan's Steamship Company v. Louisiana Board of Health*, 118 U.S. 455, 464 (1886).

[17] *United States v. Printz*, 521 U.S. 898, 935 (1997).

expressly vested in the federal government are retained by the states or the people.[18] It may be argued that a distinctly federal interest must exist before Congress can legislate with respect to public health and that, although the Constitution does not expressly say so, federal law enforcement officers may not ordinarily enforce state laws without the permission of the state government.[19]

Federal and state quarantine laws are also subject to constitutional due process constraints. The Fifth and Fourteenth Amendments prohibit governments at all levels from depriving individuals of any constitutionally protected liberty interest without due process of law.[20] What process may be due under certain circumstances is generally determined by balancing the individual's interest at stake against the governmental interest served by the restraints, determining whether the measures are reasonably calculated to achieve the government's aims,[21] and deciding whether the least restrictive means have been employed to further that interest. In addition, some have suggested that military enforcement of quarantines raises additional civil liberties concerns. These aspects are discussed more fully below.

Federal Quarantine Authority

Current Law and Regulations

Federal quarantine authority derives from the Commerce Clause, which states that Congress shall have the power "(t)o regulate Commerce with foreign Nations, and among the several States...."[22] Thus, under section 361 of the Public Health Service (PHS) Act, 42 U.S.C. § 264, the Secretary of Health and Human Services (HHS) has the authority to make and enforce regulations necessary "to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any

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[18] In practice, the Tenth Amendment has not barred Congress from enacting legislation, and the boundaries of federal and state powers are neither clear nor static. See S. DOC. NO. 108-17 at 1611 *et seq.*; Hodge, note 9, at 319 (discussing federalism in the context of public health law).

[19] U.S. CONST. art. II (vesting in the President the obligation to see that the laws are executed, *Id.* art. I, § 8, cl. 15 (empowering the Congress to provide for calling forth the militia to execute the *laws of the Union*) (emphasis added).

[20] It is well settled that freedom from physical restraint is a "liberty interest" protected by the due process clause of the Fourteenth Amendment. *Kansas v. Hendricks*, 521 U.S. 346, 356 (1997).

[21] See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 27 (1905) (enforcement of public health laws must have some "real or substantial relation to the protection of the public health and the public safety"); *Jew Ho v. Williamson*, 103 F. 10 (C.C.N.D. Cal. 1900) (quarantine of San Francisco district inhabited primarily by Chinese immigrants purportedly to control the spread of bubonic plague; invalidated because the measure was found to increase the risk of spreading the disease).

[22] U.S. CONST. art I, § 8.

other State or possession."[23] While providing the Secretary with broad authority to promulgate regulations "as in his judgement may be necessary," this law limits the Secretary's authority to the communicable diseases published in an Executive Order of the President.[24] The list of communicable diseases in Executive Order 13295 currently includes cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, SARS, and influenza caused by novel or reemergent influenza viruses that are causing or have the potential to cause a pandemic.[25]

Generally, federal regulations authorizing the apprehension, detention, examination, or conditional release of individuals are applicable only to individuals coming into a state or possession from a foreign country or possession.[26] Thus, federal regulations require the reporting of ill passengers on international conveyances such as airplanes and boats.[27] During the 2003 response to the SARS epidemic, federal officials provided health alert information to air travelers returning to the United States from areas with SARS outbreaks, boarded airplanes with travelers reported to be ill to assess their symptoms, and facilitated transport of ill passengers to hospitals. Federal officials also provided updates to the public and worked with state and local public health agencies to investigate possible SARS cases.[28]

In addition, section 361 of the PHS Act authorizes the apprehension and examination of "any individual reasonably believed to be infected with a communicable disease in a qualifying stage[29] and (A) to be moving or about to move from a State to another State; or (B) to be a probable source of infection to individuals who, while infected with such disease in a qualifying stage, will be

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[23] 42 U.S.C. § 264(a). Subsection (a) also authorizes other public health measures, including destruction of animals or articles determined to be sources of communicable disease. Originally, the statute conferred this authority on the Surgeon General; however, pursuant to Reorganization Plan No. 3 of 1966, all statutory powers and functions of the Surgeon General were transferred to the Secretary of Health, Education, and Welfare (now Secretary of HHS). In 2000, the Secretary of HHS transferred authority under this provision to the Director of the Centers for Disease Control and Prevention (CDC). CDC's Division of Global Migration and Quarantine carries out quarantine and related activities. [http://www.cdc.gov/ncidod/dq/index.htm].

[24] 42 U.S.C. § 264(b).

[25] Executive Order 13295, as amended by Executive Order 13375, on April 1, 2005. See [http://www.whitehouse.gov/news/releases/2005/04/20050401-6.html].

[26] 42 U.S.C. § 264(c).

[27] 42 C.F.R. § 71.21.

[28] See Mark A. Rothstein et al., Quarantine and Isolation: Lessons Learned From SARS: A Report to the Centers for Disease Control and Prevention (2003), at [http://www.instituteforbioethics.com] (hereinafter, Quarantine and Isolation).

[29] "Qualifying stage" means that such a disease is (1) in a communicable stage or (2) in a precommunicable state, if the disease would likely cause a public health emergency if transmitted to other individuals. 42 U.S.C. § 264(d)(2).

moving from a State to another State."[30] If found to be infected, such individuals may be detained for such time and in such manner as may be reasonably necessary.[31] During times of war, the authority to apprehend and examine individuals extends to any individual "reasonably believed (1) to be infected with such disease [as specified in an Executive order of the President] and (2) to be a probable source of infection to members of the armed forces of the United States" or to individuals engaged in the production or transportation of supplies for the armed forces.[32]

Regulations promulgated pursuant to this authority under the PHS Act may be found in Parts 70 and 71 of Title 42 of the Code of Federal Regulations. Part 70 deals with interstate matters; Part 71 deals with foreign arrivals.[33] Following a transfer of authority from the Secretary of HHS to the Director of the CDC in 2000, the Director of the CDC is authorized to take measures as may be necessary to prevent the spread of a communicable disease from one state or possession to any other state or possession if he or she determines that measures taken by local health authorities are inadequate to prevent the spread of the disease.[34] To prevent the spread of diseases between states, the regulations also prohibit infected persons from traveling from one state to another without a permit from the health officer of the state, possession, or locality of destination, if such a permit is required under the law applicable to the place of destination.[35] Additional requirements apply to persons who are in the "communicable period of cholera, plague, smallpox, typhus or yellow fever, or who having been exposed to any such disease, is in the incubation period thereof."[36]

The PHS Act and related statutes also authorize measures to aid or enforce a quarantine in the event of a public health emergency. Section 322(a) of the PHS Act[37] authorizes the PHS to care for and treat persons under quarantine. Such persons may also receive care and treatment at the expense of the PHS from public or private medical facilities when authorized by the officer in charge of the PHS station at which the application is made.[38] Section 311 of the PHS Act[39] provides for federal-state cooperative activities to enforce quarantines. The federal government may help states and localities enforce their quarantines and other health regulations and, in turn, may accept state and local assistance in enforcing federal quarantines. Under the

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[30] 42 U.S.C. § 264(d)(1).

[31] *Id.*

[32] 42 U.S.C. § 266.

[33] In response to the SARS epidemic, the Secretary of HHS in 2003 amended 42 C.F.R. §§ 70.6 and 71.3 to incorporate by reference Executive Order 13295, thus eliminating rulemaking delays for the publication of new diseases.

[34] 42 C.F.R. § 70.2.

[35] 42 CFR § 70.3.

[36] 42 CFR § 70.5.

[37] 42 U.S.C. § 249(a).

[38] 42 U.S.C. § 249(c).

[39] 42 U.S.C. § 243.

authority of 42 U.S.C. § 97, the Secretary of HHS may request the aid of Customs, Coast Guard, and military officers in the execution of quarantines imposed by states on vessels coming into ports.

Criminal sanctions are prescribed for violations of federal regulations issued pursuant to section 361 of the PHS Act.[40] Violation of a federal quarantine or isolation order is a criminal misdemeanor, and individuals may be subject to a fine of up to $250,000, one year in jail, or both. Organizational violations may be subject to fines of up to $500,000 per event. Federal district courts may enjoin individuals and organizations from violation of CDC quarantine regulations.[41]

Proposed CDC Regulations

Responding to the possible threat of an influenza pandemic, the CDC on November 22, 2005, announced proposed changes to its quarantine regulations.[42] If adopted, these changes would constitute the first significant revision of the regulations in Parts 70 and 71 in 25 years. The proposed changes are an outgrowth of the CDC's experience during the spread of SARS in 2003, when the agency experienced difficulties locating and contacting airline passengers who might have been exposed to the SARS virus during their travels. In announcing the proposed regulations, CDC Director Julie Gerberding said, "These updated regulations are necessary to expedite and improve CDC operations by facilitating contact tracing and prompting immediate medical follow up of potentially infected passengers and their contacts."[43]

The proposed regulations would expand reporting requirements for ill passengers[44] on board flights and ships arriving from foreign countries. They would also require airlines and ocean liners to maintain passenger and crew lists with detailed contact information and to submit these lists electronically to CDC upon request.[45] The lists would be used to notify passengers of their suspected exposure

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[40] 42 U.S.C. § 271, 18 U.S.C. §§ 3559 and 3571(c).

[41] 28 U.S.C. § 1331.

[42] The proposed regulations may be viewed at [http://www.cdc.gov/ncidod/dq/nprm/] and are published at 70 *Fed. Reg.* 71892 (Nov. 30, 2005). These proposed regulations were available for a 60-day comment period, and later extended for an additional 30 days, closing on March 1, 2006. See 71 *Fed. Reg.* 4544 (January 27, 2006).

[43] *CDC Proposes Modernizing Control of Communicable Disease Regulation, USA*, Medical News Today, November 23, 2005, at [http://www.medicalnewstoday.com/medicalnews.php?newsid=34042]. Since the SARS outbreak, the CDC has increased its quarantine stations nationwide from 8 to 18.

[44] The definition of ill person would be expanded to include anyone who has a fever of at least 100.4 degrees plus one of the following: severe bleeding, jaundice, or severe, persistent cough accompanied by bloody sputum, or respiratory distress. (Section 70.1 of proposed regulations).

[45] *Id.* The lists, in electronic format, would have to be kept for 60 days after arrival, and be able to be submitted within 12 hours of a CDC request. The lists would include names,

(continued...)

if a sick person were not identified until after the travelers had dispersed from an arriving carrier. The proposed regulations address the due process rights of passengers who might be subjected to quarantine after suspected exposure to disease; the regulations also provide for an appeal process.[46]

State Police Powers and Quarantine Authority

Although every state has the authority to pass and enforce quarantine laws as an exercise of their police powers, these laws vary widely by state. Generally, state and local quarantines are authorized through public health orders, though some states may require a court order before an individual is detained.[47] For example, in Louisiana, the state health officer is not authorized to "confine any person in any institution unless directed or authorized to do so by the judge of the parish in which the person is located."[48] Diseases subject to quarantine may be defined by statute, with some statutes addressing only a single disease, or the state health department may be granted the authority to decide which diseases are communicable and therefore subject to quarantine.[49] States also employ different methods for determining the duration of the quarantine or isolation period. Generally, "release is accomplished when a determination is made that the person is no longer a threat to the public health, or no longer infectious."[50]

One common characteristic of many state quarantine laws is their "overall antiquity," with many statutes being between 40 and 100 years old.[51] The more antiquated laws "often do not reflect contemporary scientific understandings of

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[45] (...continued)
contact information and seat assignments.

[46] Proposed section 70.20 and 71.23 of 42 CFR.

[47] Paula Mindes, Note, *Tuberculosis Quarantine: A Review of Legal Issues in Ohio and Other States*, 10 J.L. & HEALTH 403, 409 (1995).

[48] LA. REV. STAT. ANN. § 40:17(A) (West 2005). Exceptions are provided for certain diseases, including smallpox, cholera, yellow fever, bubonic plague, and tuberculosis.

[49] 10 J.L. & HEALTH at 409. See e.g., MD. CODE ANN., [Health] § 18-324 (2005), which formerly addressed only quarantine in tuberculosis cases. However, recent 2004 amendments grant the governor quarantine power during a "catastrophic health emergency" involving "deadly agents," which include "anthrax, ebola, plague, smallpox, tularemia, or other bacterial, fungal, rickettsial, or viral agent, biological toxin, or other biological agent capable of causing extensive loss of life or serious disability." MD. CODE ANN., [Public Safety] § 14-3A-01 (2005).

[50] *Id.* at 410.

[51] Lawrence O. Gostin, et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 102 (1999). For a recent 50-state survey of quarantine provisions, see *State Quarantine and Isolation Laws*, compiled by Trust for America's Health, 2004, at [http://healthyamericans.org/reports/bioterror04/Quarantine.pdf].

disease, [or] current treatments of choice."[52] In the past, state laws were often enacted with a focus on a particular disease, such as tuberculosis or typhoid fever, leading to inconsistent approaches in addressing other diseases.[53]

Until recently, despite the inconsistencies and perceived problems with such laws, state legislatures have not been forced to reevaluate their quarantine and isolation laws due to a decline in infectious diseases and advances in public health and medicine.[54] However, in light of recent threats and security concerns, many states have begun to reconsider their emergency response systems, including the state's authority to quarantine.[55] A review of quarantine authority was listed as a priority for state governments in the President's 2002 *National Strategy for Homeland Security*.[56]

Federal authority over interstate and foreign travel is clearly delineated under constitutional and statutory provisions. Less clear, however, is whether the state police powers may be used to restrict interstate travel to prevent the spread of disease.[57] In a public health emergency, federal, state, and local authorities may overlap. For example, both federal and state agencies may have quarantine authority over an aircraft arriving in a large city from a foreign country. Thus, coordination between the various levels of government would be essential during a widespread public health emergency.[58] Bioterrorism exercises such as TOPOFF 2 in May 2002 have highlighted the legal issues that may arise when federal, state, and local authorities respond simultaneously to a public health emergency. One author's comments on lessons learned from TOPOFF 2 are instructive:[59]

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[52] *Id.* at 106.

[53] *Id.* Following the SARS outbreak, some states had to quickly amend their public health laws to deal with that disease under their authorities.

[54] But see Edward A. Fallone, *Preserving the Public Health: A Proposal to Quarantine Recalcitrant AIDS Carriers*, 68 B.U.L. REV. 441, 448 (1988); 10 J.L. & HEALTH at 413, citing Wendy E. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53, 54-55 (1985). No large-scale human quarantine has been implemented within the United States since the 1918 influenza pandemic. G. A. Gernhart, *Forgotten Enemy: PHS's Fight Against the 1918 Influenza Pandemic*. PUBLIC HEALTH REP. 559-561 (1999).

[55] Justin Gillis, "States Weighing Laws to Fight Bioterrorism," *Washington Post*, Nov. 19, 2001, at A01. See the Model State Emergency Health Powers Act discussed, *infra*.

[56] Office of Homeland Security, *National Strategy for Homeland Security*, June 2002. [http://www.whitehouse.gov/homeland/book/nat_strat_hls.pdf].

[57] Rothstein, et al., Quarantine and Isolation, *supra* note 28, at 7-8 (discussing restrictions on travel to combat the spread of disease).

[58] *Id.* at 13 (suggesting that memoranda of understanding be developed between federal and state health officials setting forth responsibilities in cases of concurrent quarantine jurisdiction).

[59] John D. Blum, *Too Strange to Be Just Fiction: Legal Lessons from a Bioterrorist Simulation, the Case of TOPOFF 2*, 54 LA. L. REV. 905, 916 (summer 2004).

> Perhaps the most significant lesson in reference to the law and TOPOFF 2 is the most obvious, namely the fact that the law at the intersection of public health and bioterrorism is extremely unsettled. There is not a lack of law to draw upon in addressing specific questions, but rather a myriad of laws that must be considered, most of which were developed to address more mundane public health matters, or designed to respond to more traditional emergency situations. It is critical for the legal responders to be sensitive to the rights of affected individuals and the public at large, because in the heat of the moment concern for individual rights may be seen as a secondary matter. In particular, heightened sensitivity to human rights must be exhibited in areas where physical imposition or restraint come into question, such as isolation, quarantine, and mandated medical examinations. While considerable progress is being made in coordinating approaches to the age-old practices of isolation and quarantine, other rights issues in this context remain open questions, such as the need to be sensitive to post-deprivation rights, the right to legal counsel, the nature of clinical evidence required to justify such measures, and the policies concerning the application of isolation and quarantine to populations.

Model State Emergency Health Powers Act

The Model State Emergency Health Powers Act (the Model Act) was drafted by The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities.[60] The Model Act seeks to "grant public health powers to state and local public health authorities to ensure a strong, effective, and timely planning, prevention, and response mechanism to public health emergencies (including bioterrorism) while also respecting individual rights."[61] It is important to note that the act is intended to be a model for states to use in evaluating their emergency response plans; passage of the Model Act in its entirety is not required, so state legislatures may select the entire model, parts of it, or none at all. Many states have used parts of the Model Act while tailoring their statutes and regulations to respond to unique or novel situations that may arise in their jurisdiction.

The Model Act provides a comprehensive framework for state emergency health powers, including statutory authority for quarantine[62] and isolation.[63] Section 604 of the Model Act authorizes the quarantine or isolation of an individual or groups of

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[60] The text of the Center's Model State Emergency Health Powers Act from 2001 is available at [http://www.publichealthlaw.net/Resources/Modellaws.htm]. The Center has also developed a Turning Point Model State Public Health Act, which addresses public health issues more broadly and is available at the same website.

[61] *Id.*

[62] For purposes of the Model Act, quarantine is defined as "the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possibly contagious disease and who do not show signs or symptoms of a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals."

[63] Isolation is defined as "the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals."

individuals during a public health emergency.[64] The Model Act encourages the public health authority to adhere to specific conditions and principles when exercising quarantine or isolation authority.[65] These conditions and principles include ensuring that the measures taken are the least restrictive means necessary to prevent the spread of the disease; monitoring the condition of quarantined or isolated individuals; and providing for the immediate release of individuals when they no longer pose a substantial risk of transmitting the disease to others.[66] The Model Act provides that a failure to obey the rules and orders concerning quarantine and isolation shall be treated as a misdemeanor.[67]

The Model State Emergency Health Powers Act sets forth procedures for quarantine and isolation under two different sets of circumstances. Section 605(a) addresses procedures for temporary quarantine and isolation without notice if a "delay in imposing the isolation or quarantine would significantly jeopardize the public health authority's ability to prevent or limit the transmission of a contagious or possibly contagious disease to others." The quarantine or isolation must be ordered through a written directive specifying the identity of the individuals subject to the order, the premises subject to the order, the date and time at which the quarantine or isolation are to commence, the suspected contagious disease, and a copy of the provisions set forth in the act relating to isolation and quarantine.[68] The public health authority is required to petition within 10 days after issuing the directive for a court order authorizing the continued isolation or quarantine if needed.[69]

Apart from the emergency procedures outlined above, the public health authority may petition a court for an order authorizing the quarantine or isolation of an individual or groups of individuals, with notice of the petition given to the individuals or groups of individuals in question within 24 hours.[70] The public health authority's petition must include the same information as required in the emergency directive discussed above, in addition to "a statement of the basis upon which

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[64] A public health emergency is defined to include "an occurrence or imminent threat of an illness or health condition" that is believed to be caused by bioterrorism or the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin, and that poses a high probability of a large number of deaths, a large number of serious or long-term disabilities, or a significant risk of substantial future harm to a large number or people.

[65] For a complete list of the conditions and principles, see Section 604(b) of the Model Act.

[66] The SARS epidemic highlights the need to take into account possible political and social reactions to stringent public health measures. "Officials in Taiwan now believe that its aggressive use of quarantine contributed to public panic and thus proved counterproductive." Rothstein, et al., Quarantine and Isolation, *supra*, note 28 at 9.

[67] Section 604(c).

[68] Section 605(a)(2).

[69] Section 605(a)(4).

[70] Section 605(b).

isolation and quarantine is justified in compliance with this Article."[71] A hearing must be held within five days of the petition being filed, and the court "shall grant the petition if, by a preponderance of the evidence, isolation or quarantine is shown to be reasonably necessary to prevent or limit the transmission of a contagious or possibly contagious disease to others."[72] An order authorizing quarantine or isolation may not do so for a period exceeding 30 days, though the public health authority may move to continue quarantine or isolation for additional periods not exceeding 30 days.[73]

The Model Act provides procedures that allow individuals subject to quarantine or isolation to challenge their detention and obtain release, and it provides remedies where established conditions were not met.[74] Individuals subject to quarantine or isolation would be appointed counsel if they are not otherwise represented in their challenge.[75]

Legal Challenges to State Quarantine Authority

Public health measures in emergency situations, including quarantine, involve balancing the rights of individuals with the state's police power to protect the needs of the public health, safety, and general welfare. Historically, this balance can be seen in public health crises over the past century or so:[76]

> It is well known that public health raises conflicts between individual and societal interests. The context may vary, but the essential tension of balancing individual and group interests is largely the same. For example, at the beginning of the twentieth century, a key issue was vaccination against smallpox. In the 1980s, a contentious issue was the reporting of human immunodeficiency virus ("HIV") test results by name to public health authorities. After September 11, 2001, and the anthrax episode shortly thereafter, there has been a debate about whether broad emergency powers to protect public health should be given to governors and state health departments and, if so, whether special new legislation is needed. Many of the same issues arise in the use of large-scale quarantine measures, such as those used to combat SARS. [Footnotes omitted.]

The Supreme Court in *Gibbons v. Ogden*, in 1824, alluded to a state's authority to quarantine under the police powers. In 1902, the Court directly addressed a state's power to quarantine an entire geographic area in *Compagnie Francaise de Navigation a Vapeur v. Louisiana State Board of Health*,[77] where both the law and its implementation were upheld as valid exercises of the state's police power. A

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[71] Section 605(b)(2).

[72] Section 605(b)(5).

[73] Section 605(b)(6).

[74] Section 605(c).

[75] Section 605(e).

[76] Mark A. Rothstein, *Are Traditional Public Health Strategies Consistent with Contemporary American Values?*, 77 TEMPLE L. REV. 175 (Summer, 2004).

[77] 186 U.S. 380 (1902).

shipping company in this case challenged an interpretation of a state statute that conferred upon the state board of health the authority to exclude healthy persons, whether they came from without or within the state, from a geographic area infested with a disease.[78] The shipping company alleged that the statute as interpreted interfered with interstate commerce, and thus was an unconstitutional violation of the Commerce Clause. The Court rejected this argument, holding that although the statute may have had an effect on commerce, it was not unconstitutional.[79]

When a quarantine is established in a geographic area due to adverse conditions in the area, courts are thus likely to uphold the restrictions. The Supreme Court has stated that the right to travel "does not mean that areas ravaged by flood, fire or pestilence cannot be quarantined when it can be demonstrated that unlimited travel to the area would directly and materially interfere with the safety and welfare of the area."[80] In *Miller v. Campbell City*,[81] an order to evacuate an area was issued due to leaking methane and hydrogen gases. After some residents from a subdivision in the area became ill, the County Commissioners declared the subdivision uninhabitable. The plaintiff was arrested when he crossed the roadblock enforcing the quarantine in an attempt to return home. The court upheld a finding that the evacuation order was substantially related to the public health and safety, and found no evidence that the quarantine action was taken in bad faith or maliciously.[82] The county needed to act quickly because of the potential danger, so no liability was found.

Courts have recognized an individual's right to challenge his or her quarantine or isolation by petitioning for a writ of habeas corpus.[83] Although the primary function of a writ of habeas corpus is to test the legality of the detention,[84] petitioners often seek a declaration that the statute under which they were quarantined is unconstitutional or violative of due process. Due process is a concern, though courts are reluctant to interfere with a state's exercise of police powers with regard to public health matters "except where the regulations adopted for the protection of the public

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[78] 186 U.S. at 384.

[79] *Id.* at 387. See also, *Morgan's Steamship Company v. Louisiana Board of Health*, 118 U.S. 455 (1886).

[80] *Zemel v. Rusk*, 381 U.S. 1, 15 (1965).

[81] 945 F.2d 348 (10th cir. 1991).

[82] *Id.*at 354.

[83] *Ex parte Hardcastle*, 208 S.W. 531(Tex. Crim. App. 1919).

[84] *Habeas corpus* is "the name given to a variety of writs, having for their object to bring a party before a court or judge. In common usage, and whenever these words are used alone, they are usually understood to mean the *habeas corpus ad subjiciendum*." Specifically, *habeas corpus ad subjiciendum* is "a writ directed to the person detaining another, and commanding him to produce the body of the prisoner, or person detained. This is the most common form of *habeas corpus* writ, the purpose of which is to test the legality of the detention or imprisonment; not whether he is guilty or innocent." Black's Law Dictionary, 6th Edition, 1990.

health are arbitrary, oppressive and unreasonable."[85] The courts appear to defer to the determinations of state boards of health and generally uphold such detentions as nonviolative of due process and as valid exercises of a state's duty to preserve the public health. Thus, the court in *United States v. Shinnick*[86] upheld the Public Health Service's medical isolation of an arriving passenger because she had been in Stockholm, Sweden, a city declared by the World Health Organization to be a smallpox-infected area, and she could not show proof of vaccination.

In *People ex rel. Barmore v. Robertson*,[87] the court refused to grant a habeas corpus petition for a woman who ran a boarding house where a person infected with typhoid fever had boarded. The woman was not herself infected with the disease, but she was a carrier and had been quarantined in her home. She argued that her quarantine was unwarranted because she was not "actually sick," though the court noted that "[i]t is not necessary that one be actually sick, as that term is usually applied, in order that the health authorities have the right to restrain his liberties by quarantine regulations."[88] In justifying quarantine under these circumstances, the court explained that because disease germs are carried by human beings, and as the purpose of an effective quarantine is to prevent the spread of the disease to those who are not infected, anyone who carries the germs must be quarantined.[89] The court found that in the case of a person infected with typhoid fever, anyone who had come into contact with that person must be quarantined to prevent the spread of the disease.[90]

However, some courts have refused to uphold the quarantine of an individual in cases where the state is unable to meet its burden of proof concerning that individual's potential danger to others, or if a restriction is viewed as unreasonable or oppressive.[91] In *Wong Wai v. Williamson*,[92] the San Francisco Board of Health ordered all Chinese residents to be inoculated against bubonic plague and restricted their right to leave the city, citing nine deaths allegedly from plague. The inoculations were tainted, causing severe consequences. The court inferred that the regulations were properly authorized, but nevertheless struck them down as "not based on any established distinction in the conditions that are supposed to attend the

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[85] *People ex. rel. Barmore v. Robertson*, 134 N.E. 815, 817 (citations omitted) (Ill.1922).

[86] 219 F. Supp. 789 (E.D.N.Y. 1963).

[87] 134 N.E. 815 (Ill.1922).

[88] *Id.*at 819.

[89] *Id.*at 819-820.

[90] *Id.*at 820.

[91] See *State v. Snow*, 324 S.W.2d 532 (Ark. 1959), where the court found insufficient evidence to show a person who had tuberculosis was in an active and communicable stage so that he could be involuntarily isolated. On the other hand, see *City of New York v. Antoinette, R..*, 630 N.Y.S.2d 1008 (N.Y. Sup. Ct. 1995), wherein the court upheld detaining a tuberculosis patient in a hospital setting until the patient completed an appropriate course of medication.

[92] 103 F. Rep. 10 (1900).

plague, or the persons exposed to its contagions."[93] Shortly after, in *Jew Ho v. Williamson*, the same court held that the quarantine requirements applied only to Chinese and questioned whether bubonic plague actually caused the reported deaths. It invalidated the quarantine as "unreasonable, unjust and oppressive."[94]

Additional legal issues might be raised if quarantine, isolation, and other public health measures were used to deal with a widespread public health emergency such as a biological terror attack or an influenza pandemic. If government agencies requisition private facilities for quarantine purposes, such as in the case of overburdened medical facilities, the legal questions regarding eminent domain power may arise.[95] If a person with symptoms of a contagious disease is involuntarily isolated in a hospital for a period of days or weeks, who pays for the person's hospital stay? What if medical personnel or hospital employees refuse to come to work because of a medical emergency?[96] Discrimination issues may arise if health care providers refuse to treat infected patients or individuals who appear to be from an area of the world where a disease outbreak originates, or if persons discriminate against health care providers who treat individuals with infectious conditions.[97] The legality concerning mandatory vaccinations as a health measure may arise during an infectious disease outbreak,[98] and health authorities may face the related issue of rationing limited supplies of available vaccines.[99]

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[93] *Id. at* 15.

[94] *Id.* at 26.

[95] Compelled public use of private property in a public health emergency is not unheard of. "In Paris, in August 2003, after 11,000 deaths were caused by a heat wave, the government took over refrigerated warehouses and similar facilities to use them as temporary morgues." Rothstein, *et al.*,Quarantine and Isolation, *supra*, note 28 at 42. Compensation may be appropriate in some circumstances, but following a volcanic eruption, the state of Washington successfully argued that continued restricted access to a town near the volcano was a permissible exercise of police power and did not require compensation. *Cougar Business Owners Assn. v. State of Washington*, 647 P.2d 481, 486 (Sup. Ct. Wash. 1982). See David G. Tucker and Alfred O. Bragg, III, *Florida's Law of Storms: Emergency Management, Local Government, and the Police Power*, 30 STETSON L. REV. 837 (2001).

[96] See Section 502(b) of the Model State Emergency Health Powers Act, discussed *supra*, which provides that a health care facility could face loss of its license if it is not able to provide services during a public health emergency.

[97] Rothstein, et al., Quarantine and Isolation, *supra*, note 28 at 118-119 (discussing antidiscrimination legislation). For information on the possible applicability of the Americans with Disabilities Act to persons with contagious diseases see CRS Report RS22219, *The Americans with Disabilities Act (ADA) Coverage of Contagious Diseases*, by Nancy Lee Jones.

[98] See CRS Report RS21414, *Mandatory Vaccination: Precedent and Current Laws*, by Kathleen S. Swendiman.

[99] See CRS Report RL32655, *Influenza Vaccine Shortages and Implications*, by Sarah A. Lister and Erin D. Williams.

The application of statutes such as the Emergency Medical Treatment and Active Labor Act (EMTALA)[100] to a public health emergency situation may need to be assessed. EMTALA requires hospitals to evaluate all patients who come to an emergency room and to stabilize patients needing emergency care prior to any transfer. Compliance with EMTALA during a health emergency may be compromised if hospitals are overwhelmed by large numbers of persons seeking treatment.[101] The Health Insurance Portability and Accountability Act (HIPAA),[102] and its implementing regulations at 45 C.F.R. Parts 160 and 164 (Privacy Rule), may also need to be assessed. While HIPAA requirements do not include broad waivers that would exempt hospitals from compliance during an emergency situation, there are provisions in the Privacy Rule that may be relaxed under emergency circumstances.

A new development in the law relating to quarantine is the possible use of self-imposed or home quarantines. States may need to consider whether their ability to impose quarantine also includes the authorities necessary to support a population asked to voluntarily stay at home for a period of time.[103] Such authority may include the ability to offer legal immunity to businesses asked to provide facilities for quarantine. Compliance with public health measures such as quarantine or isolation may also be affected by employment-related issues, because individuals may fear losing their jobs or benefits while staying at home for social distancing measures such as "snow days" or voluntary quarantines, or for caring for a sick relative.[104]

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[100] 42 U.S.C. § 1395dd. See also Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. Med. & Ethics 590-601 (2003).

[101] After Hurricane Katrina, HHS Secretary Michael Leavitt waived sanctions under EMTALA for the redirection of an individual to another location to receive a medical screening pursuant to a state emergency preparedness plan. The Secretary also waived sanctions for transfers of individuals who had not been stabilized if the transfer arose out of hurricane-related emergency circumstances. HHS, "Waiver Under Section 1135 of the Social Security Act," Sept. 4, 2005. See, generally, James G. Hodge, Jr., *Legal Triage during Public Health Emergencies and Disasters*, 58 Admin. L. Rev. 627 (2006).

[102] 42 U.S.C. §§ 300gg *et seq*. See Rothstein, et al., Quarantine and Isolation, *supra*, note 28 at 8 (noting that misunderstanding HIPAA requirements can lead to a failure to report infectious disease cases to public health officials).

[103] Federal and state authorities generally provide for the care of persons mandatorily quarantined (see 42 U.S.C. § 249, and Section 604 of the Model State Emergency Health Powers Act, discussed *infra*), but voluntary home-quarantine situations may pose new issues. See Steven D. Gravely, et al., *Emergency Prepared ness and Response: Legal Issues in a Changing World*, 17 THE HEALTH LAWYER 1 (June 2005).

[104] See CRS Report RL33609, *Quarantine and Isolation: Selected Legal Issues Relating to Employment*, by Nancy Lee Jones and Jon O. Shimabukuro.

Military Enforcement of Health Measures

In light of recent concerns that a strain of avian influenza could mutate to cause a pandemic, President Bush has suggested that Congress should authorize him to employ military forces to enforce any quarantine that might become necessary in the event of an outbreak in the United States.[105] President Bush also suggested that the National Guard might be employed under federal rather than state control to carry out measures to contain such an outbreak.[106] Critics of the proposal have expressed concern that an additional exception to the Posse Comitatus Act,[107] which prohibits active military personnel from carrying out certain law enforcement activities without express statutory authority,[108] would lead to a form of martial law, with the attendant threats to civil liberties.[109] The 109th Congress passed a measure that may enhance the President's authority to use military forces to restore law and order in the event of a "natural disaster, epidemic, or other serious public health emergency," possibly including the enforcement of health measures.[110]

Posse Comitatus Act

The Posse Comitatus Act, 18 U.S.C. § 1385, punishes those who, "except in cases and under circumstances expressly authorized by the Constitution or Act of Congress, willfully use any part of the Army or the Air Force as a posse comitatus or otherwise to execute the laws."[111] Some view the act as the embodiment of the American tradition that abhors the use of soldiers to compel citizens to obey the law.[112] Yet the Constitution does not explicitly bar the use of military forces in

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[105] See David Brown, "Military's Role in a Flu Pandemic; Troops Might Be Used to 'Effect a Quarantine,' Bush Says," *Washington Post*, Oct. 5, 2005, p. A5 (noting that "the [P]resident gave no details on the specific role troops might play or what sort of quarantine might be invoked").

[106] *Id.*

[107] 18 U.S.C. § 1385.

[108] See CRS Report RS22266, *The Use of Federal Troops for Disaster Assistance: Legal Issues*, by Jennifer Elsea.

[109] See John Reichard, *Critics Argue Use of Military to Enforce Flu Quarantine Would Undermine Compliance, Civil Liberties*, CQ Healthbeat, Oct. 5, 2005, [http://www.cq.com/display.do?docid=1900272&prod=5&binderName=healthbeat-20051005].

[110] Defense Authorization bill for FY2007, P.L. 109-364, § 1076.

[111] See CRS Report 95-964, *The Posse Comitatus Act and Related Matters: The Use of the Military to Execute Civilian Law*, by Charles Doyle.

[112] See Gary Felicetti and John Luce, *The Posse Comitatus Act: Setting the Record Straight on 124 Years of Mischief and Misunderstanding Before Any More Damage Is Done*, 175 MIL. L. REV. 86, 91 (2003)(arguing that "courts analyzing the act [have written] about the law as if it was the only law or principle that limited the use of the armed forces in a law enforcement role. Some, therefore, have claimed to discern a broader policy or 'spirit' behind the act that is not supported by the historical record or the statute's text. While these wider policies are sound, they are embodied in federalism, the law concerning federal arrest

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civilian situations or in matters of law enforcement; in fact, it empowers Congress to provide for calling forth the militia to execute federal law.[113]

Courts have held that, absent a recognized exception, the Posse Comitatus Act is violated when (1) civilian law enforcement officials make "direct active use" of military investigators, (2) the use of the military "pervades the activities" of the civilian officials, or (3) the military is used to subject citizens to the exercise of military power that is "regulatory, prescriptive, or compulsory in nature."[114] To the extent that quarantine enforcement measures involve the compulsion of civilians to remain in or leave an area, for example, it appears that the Posse Comitatus Act would be implicated. Thus, unless a pandemic were to lead to significant civil unrest or call for other military activity already authorized pursuant to existing exceptions,[115] Congress would have to enact a law to authorize military enforcement of health measures.

The act does not prohibit activities conducted for a military purpose, which could encompass restrictions implemented on bases or to control a communicable disease affecting service members. The Posse Comitatus Act does not apply to the National Guard unless it is employed in federal service as a reserve force of the armed forces. If the National Guard is called up to enforce U.S. laws, however, it is not subject to the Posse Comitatus Act.[116]

Possible Military Enforcement Under Other Statutes

The President may be authorized by the Constitution or by statute to use the military to enforce a quarantine or conduct other law enforcement activities as needed during an epidemic. Prior to the Civil War, Congress was generally reluctant to involve itself with any type of disaster assistance,[117] and health measures, except in

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[112] (...continued)
authority, election law, and especially fiscal law. The ... Posse Comitatus Act ... doesn't have to do all the work, a view that even the act's original proponents appeared to recognize. Trying to force-fit all these other principles into the surviving part of the act has only created a need to 'discover' a number of implied exceptions and has sowed a great deal of confusion."); Sean J. Kealy, *Reexamining the Posse Comitatus Act: Toward a Right to Civil Law Enforcement*, 21 YALE L. & POL'Y REV. 383 (2003).

[113] U.S. CONST. art. I § 8 cl. 15.

[114] See, e.g., *United States v. Yunis*, 924 F.2d 1086, 1094 (D.C.Cir. 1991); *United States v. McArthur*, 419 F.Supp. 186 (D.N.D. 1975), *aff'd*, 541 F.2d 1275 (8th Cir. 1976); *United States v. Bacon*, 851 F.2d 1312, 1313-14 (11th Cir. 1988).

[115] See, generally, CRS Report RS20590, *The Posse Comitatus Act and Related Matters: A Sketch*, by Jennifer K. Elsea; and CRS Report 95-964, *The Posse Comitatus Act and Related Matters: The Use of the Military to Execute Civilian Law*, by Charles Doyle.

[116] 10 U.S.C. § 12406 (The President may call National Guard units or members into federal service to repel an invasion, suppress a rebellion, or execute federal laws when he is unable to execute them using the regular forces.)

[117] See GAINES M. FOSTER, THE DEMANDS OF HUMANITY: ARMY MEDICAL DISASTER (continued...)

areas under exclusive federal jurisdiction, were generally left to the regulation of the states. However, Congress has given the President, through the Secretary of HHS, the authority to help states enforce quarantine laws with respect to any vessels arriving in or bound to any of their ports or districts, including the use of the military.[118] This authority, which originated in a law passed in 1796,[119] does not extend to the control of movement of persons within the United States.

In 1866, when issues involving military government and states' rights figured prominently in the nation's political discourse, the Senate considered a bill that would have given the Secretary of War the responsibility, "with the cooperation of the Secretary of the Navy and the Secretary of the Treasury ... to cause a rigid quarantine against the introduction into this country of the Asiatic cholera through its ports of entry."[120] The bill would have further authorized the Secretary of War to "use the means at [his] command" to enforce "sanitary cordons to prevent the spread of said disease from infected districts adjacent to or within the limits of the United States." After the bill's sponsor affirmed that the power could extend to the declaration of martial law,[121] the questioner responded, "I would rather have the cholera than such a proposition as this."[122] Most of the ensuing debate centered around Congress's power to legislate, either under the Commerce Clause, the Guarantee Clause, or the "war power" and on whether the legislation would impermissibly intrude on the police powers of the states.[123] The power to regulate foreign commerce appears to have attracted the most support; as finally passed, the bill gave authority to the Secretary of the Treasury, until January of 1867, to make and enforce quarantine regulations deemed necessary to help state and municipal authorities guard against cholera.[124]

Outside of the Coast Guard's role in enforcing CDC health regulations with respect to foreign passengers and cargo,[125] the armed forces have not historically played a major role in enforcing quarantines during epidemics.[126] The Army Medical

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[117] (...continued)
RELIEF 8-13 (1983) (describing the emergence of federal disaster assistance during the 19th century).

[118] 42 U.S.C. § 97.

[119] See notes 10-12, *supra*.

[120] H.J.Res. 116, 39th Cong. (1866) as reported from the Senate Committee on Commerce, CONG. GLOBE, 39th Cong., 1st sess. 2444 (1866).

[121] CONG. GLOBE, 39th Cong., 1st Sess. 2445 (1866)(Sen. Chandler responded, "they may use any power requisite to stop the cholera").

[122] *Id.* (Sen. Anthony).

[123] *Id.* pp. 2483-85, 2521-22, 2548-50, 2581-87.

[124] 14 Stat. § 357 (1866).

[125] 42 U.S.C. § 97.

[126] Military governments established in the South during and after the Civil War may have had occasion to order quarantines. According to one account, the Commanding General in (continued...)

Corps has provided medical assistance to victims of yellow fever and other epidemics and contributed extensively to medical research,[127] but it does not appear that an outbreak of disease has ever overwhelmed state and local authorities to the point where federal military intervention was required. It is, however, conceivable that in a major epidemic, opposition to quarantine measures could lead to civil disorder and significant numbers of state and local law enforcement officials could themselves fall victim to the disease, in each case to such an extent that federal assistance or intervention would be needed to ensure the execution of federal or state laws. In such circumstances, the President could invoke the Insurrection Act, 10 U.S.C. §§ 331-335, to employ the National Guard or regular armed forces to execute federal law or state law (if requested by the state legislature).

Section 331 of title 10, U.S. Code, authorizes the President to use the military to suppress an insurrection at the request of a state government. This authorization is meant to fulfill the federal government's responsibility to protect states against "domestic violence." Section 332 delegates Congress's power under the Constitution, art. I, § 8, cl. 15, to the President, authorizing him to determine that "unlawful obstructions, combinations, or assemblages, or rebellion against the authority of the United States make it impracticable to enforce the laws of the United States" and to use the armed forces as he considers necessary to enforce the law or to suppress the rebellion. Section 333 permits the President to use the armed forces to suppress any "insurrection, domestic violence, unlawful combination, or conspiracy" if law enforcement is hindered within a state and local law enforcement is unable to protect individuals' rights guaranteed by the Constitution, or if the unlawful action "obstructs the execution of the laws of the United States or impedes the course of justice under those laws." This section was enacted to implement the Fourteenth Amendment and does not require the request or even the permission of the governor of the affected state. The Insurrection Act has been used to send the armed forces to quell civil disturbances a number of times during U.S. history, most recently during the 1992 Los Angeles riots and during Hurricane Hugo in 1989.[128]

The President could use the Insurrection Act, now titled "Enforcement of the Laws to Restore Public Order," to enforce health measures in the event that civil

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[126] (...continued)
New Orleans established a quarantine to prevent ships from carrying yellow fever upriver in 1862, although no cases of the disease had yet appeared, mainly because troops occupying the city were thought to be more susceptible than the local "acclimated" population. See Benjamin F. Butler, *Some Experiences with Yellow Fever and its Prevention*, 147 NORTH AM. REV. 530 (1888).

[127] See FOSTER, *supra* note 115, at 16 (noting that "[s]oldiers served primarily as administrators; they estimated needs, purchased supplies, delivered them in bulk, and left to local authorities the actual distribution to the needy"); MARY C. GILLETT, THE ARMY MEDICAL DEPARTMENT 1865-1917, at 39-49 (1995).

[128] President Bush reportedly considered invoking the Insurrection Act to take federal control of Louisiana National Guard units during the aftermath of Hurricane Katrina, but the Louisiana governor had resisted the proposal and no proclamation was issued. See Manuel Roig-Franzia and Spencer Hsu, "White House Shifts Blame to State and Local Officials," *Washington Post*, Sept. 4, 2005, p. A01.

officials were overwhelmed during a pandemic and unable to enforce those laws. The 109th Congress included in the Defense Authorization bill for FY2007 (P.L. 109-364), a provision that amended 10 U.S.C. § 333 explicitly to cover instances of "domestic violence" where public order is disrupted due to a "natural disaster, epidemic, or other serious public health emergency, terrorist attack or incident, or other condition." (Section 1076). Section 333, as amended, authorizes the President to employ federal troops to "restore public order and enforce the laws of the United States," without a request from the governor or legislature of the state involved, in the event he determines that local authorities are unable to maintain public order, where, as before, either the enjoyment of equal protection of the laws is impeded or the execution of federal law and related judicial process is obstructed.

On exercising the authority, the President is required to notify Congress as soon as practicable and every 14 days until ordinary law enforcement is restored. The authority to employ military force in section 333 remains unchanged, except that the President's recourse to "any other means" is eliminated, and the relevant state is to be deemed to have denied constitutional equal protection any time the authority is exercised outside of the newly described disaster scenario, rather than when "any part or class of [the state's] people is deprived of a right, privilege, immunity, or protection named in the Constitution and secured by law," although this remains one of the alternative prerequisites for invoking the authority even under disaster conditions. The amendment has been criticized as encouraging recourse to federalization of National Guard troops and employment of other military troops in the event of a natural disaster, even if the governor of the affected state does not believe the situation calls for federal troops.

APPENDIX B8

NEW JERSEY REGULATIONS REGARDING DISABILITIES

*** THIS FILE INCLUDES ALL REGULATIONS ADOPTED AND PUBLISHED THROUGH THE ***
*** NEW JERSEY REGISTER, VOL. 40, NO. 8, APRIL 21, 2008 ***

TITLE 13. LAW AND PUBLIC SAFETY
CHAPTER 13. REGULATIONS PERTAINING TO DISCRIMINATION ON THE BASIS OF DISABILITY
SUBCHAPTER 1. GENERAL PROVISIONS

N.J.A.C. 13:13-1.1 (2008)

§ 13:13-1.1. Purpose

This chapter is designed to implement the Law Against Discrimination, N.J.S.A. 10:5-1 et seq. ("the act" or "the statute"), as it pertains specifically to discrimination on the basis of physical and mental disability.

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SUBCHAPTER 1. GENERAL PROVISIONS

N.J.A.C. 13:13-1.2 (2008)

§ 13:13-1.2 Construction

(a) Consistent with the public policy underlying the Law Against Discrimination and with firmly established principles for the interpretation of such remedial legislation, the remedial provisions of the statute will be given a broad construction and its exceptions construed narrowly.

(b) The provisions of these regulations are severable. If any provision or the application of any provisions of these regulations to any person or circumstances is invalid, such invalidity shall not affect other provisions or applications which can be given effect without the invalid provision or application.

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SUBCHAPTER 1. GENERAL PROVISIONS

N.J.A.C. 13:13-1.3 (2008)

§ 13:13-1.3. Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Covered multifamily dwellings" means buildings covered by the provisions of the Barrier-Free Subcode of the State Uniform Construction Code Act, N.J.S.A. 52:27D-119 et seq. and N.J.A.C. 5:23-7.

"Disability" as used in this chapter will have the same meaning as the term "disability" is given by N.J.S.A. 10:5-5(q). "A person with a disability" also means:

1. A person who is perceived as or believed to be a person with a disability, whether or not that individual is actually a person with a disability; and

2. A person who has been a person with a disability at any time.

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SUBCHAPTER 2. EMPLOYMENT

N.J.A.C. 13:13-2.1 (2008)

§ 13:13-2.1. Job advertising and solicitation

(a) It is unlawful to print or cause to be printed any advertisement which has the effect of discouraging people with disabilities from applying for a job for which they are qualified, despite a particular disability or which contains the words "able-bodied persons wanted," or their equivalent. An employer may include a statement of the particular physical or mental abilities reasonably necessary for the performance of the essential functions of the job.

(b) The publication by any communications medium of any notice of advertisement relating to employment, or to membership in a labor organization, indicating any preference, limitation, specification, or discrimination based on disability is unlawful unless such notice or advertisement falls within one of the exceptions enumerated by N.J.A.C. 13:13-2.8.

(c) All employers, labor organizations and employment agencies should conduct job vacancy, membership recruitment and employment referral programs in such a manner as to assure that all persons, including people with disabilities, are given fair and adequate notice of job vacancies, membership opportunities and employment referral opportunities:

1. Employers and labor organizations are encouraged to place notices or advertisements relating to employment, or to membership in a labor organization, in the newspaper having the largest circulation in the relevant labor market, unless the position sought to be filled requires specialized training, education, experience or licensing of a type not commonly found among members of the workforce in the relevant labor market.

2. Employers should encourage their referral sources to seek and refer qualified individuals with disabilities.

3. Employers are encouraged to list all job openings and requests for referrals with institutions, agencies, and organizations of or serving people with disabilities including the Division of Vocational Rehabilitation Services in the New Jersey Department of Labor.

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SUBCHAPTER 2. EMPLOYMENT

N.J.A.C. 13:13-2.2 (2008)

§ 13:13-2.2 Job referrals

(a) The knowing use by an employer of any employment agency or recruitment source which does not refer people with disabilities or which discriminates against people with disabilities is an unlawful act of discrimination.

(b) The failure or refusal of any employment agency or labor organization to refer for employment any individual because that individual is a person with a disability is an unlawful employment practice. It is unlawful for an employment agency or labor organization to comply with an employer's request for referrals if such a request indicates either directly or indirectly that the employer will discriminate against people with disabilities.

(c) It is an unlawful employment practice for any employment agency or labor organization to classify people with disabilities in any way which would deprive or have the effect of depriving people with disabilities of employment opportunities or otherwise affect employee status.

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N.J.A.C. 13:13-2.3 (2008)

§ 13:13-2.3. Employment criteria

(a) It is an unlawful employment practice for any employer, employment agency or labor organization to make use of any employment test or other selection criterion that screens out or has the effect of screening out people with disabilities unless:

1. That test score or other selection criterion is shown to be job related for the position in question; and

2. Alternative job-related tests or criteria that do not screen out or have the effect of screening out fewer people with disabilities are not available.

(b) An employer, employment agency or labor organization shall select and administer tests concerning employment which accurately reflect, with the benefit of reasonable accommodation, the applicant's or employee's job skills, aptitude or competency, rather than reflecting the applicant's or employee's impaired sensory, manual or speaking skills (except where those skills are the factors that the test purports to measure, and are necessary to perform the essential functions of the job in question).

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N.J.A.C. 13:13-2.4 (2008)

§ 13:13-2.4. Pre-employment inquiries

(a) It shall be an unlawful practice for an employer, employment agency or labor organization to elicit or attempt to elicit, either verbally or through the use of an application form or request for documentation, any information which would tend to divulge the existence of a disability or health condition, unless required or necessitated by Federal law or regulation. An employer, employment agency or labor organization may inquire whether an applicant is precluded from satisfactorily performing the essential functions of the job in question.

(b) It is not unlawful for an employer to invite applicants for employment to identify themselves as a person with a disability:

1. To satisfy the affirmative action requirements of Federal law;

2. To implement a court ordered or other bona fide affirmative action plan to promote the employment of people with disabilities; or

3. To implement a special program which is designed to benefit people with disabilities when a condition for a person's participation in the program is that he or she is a person with a disability.

(c) Employers who request such information must observe requirements under Section 503 of the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq., regarding the manner in which the information is requested and used, and the procedure for maintaining such information as a separate, confidential record, apart from regular personnel records.

(d) The act does not prohibit any officially recognized agency from keeping necessary records in order to provide services to individuals requiring rehabilitation or employment assistance.

(e) It is not unlawful for an employer to condition an offer of employment on the results of a medical examination held subsequent to such offer and prior to the employee's entrance on duty, provided that:

1. All entering employees are subjected to such examination; and

2. The results of such an examination are used in accordance with these regulations and are not used to disqualify an applicant except to the extent that any disability discovered would, even with reasonable accommodation, preclude the safe or adequate performance of the essential functions of the job in question, as defined in N.J.A.C. 13:13-2.8. An examination should consider the degree to which the person has compensated for his limitations and the rehabilitation services he has received or is receiving.

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N.J.A.C. 13:13-2.5 (2008)

§ 13:13-2.5. Reasonable accommodation

(a) All employers shall conduct their employment procedures in such a manner as to assure that all people with disabilities are given equal consideration with people who do not have disabilities for all aspects of employment including, but not limited to, hiring, promotion, tenure, training, assignment, transfers, and leaves on the basis of their qualifications and abilities. Each individual's ability to perform a particular job must be assessed on an individual basis.

(b) An employer must make a reasonable accommodation to the limitations of an employee or applicant who is a person with a disability, unless the employer can demonstrate that the accommodation would impose an undue hardship on the operation of its business. The determination as to whether an employer has failed to make reasonable accommodation will be made on a case-by-case basis.

1. Under circumstances where such accommodation will not impose an undue hardship on the operation of an employer's business, examples of reasonable accommodation may include:

i. Making facilities used by employees readily accessible and usable by people with disabilities;

ii. Job restructuring, part-time or modified work schedules or leaves of absence;

iii. Acquisition or modification of equipment or devices; and

iv. Job reassignment and other similar actions.

2. An employer shall consider the possibility of reasonable accommodation before firing, demoting or refusing to hire or promote a person with a disability on the grounds that his or her disability precludes job performance.

3. In determining whether an accommodation would impose undue hardship on the operation of an employer's business, factors to be considered include:

i. The overall size of the employer's business with respect to the number of employees, number and type of facilities, and size of budget;

ii. The type of the employer's operations, including the composition and structure of the employer's workforce;

iii. The nature and cost of the accommodation needed; and

iv. The extent to which accommodation would involve waiver of an essential requirement of a job as opposed to a tangential or non-business necessity requirement.

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N.J.A.C. 13:13-2.6 (2008)

§ 13:13-2.6 Wages and fringe benefits

(a) An employer's wage scale must be unrelated to the disability of its employees, except where permitted by State or Federal law.

(b) Occupational training and retraining programs, including, but not limited to, guidance programs, apprentice training programs and executive training programs, shall not be conducted in such a manner as to discourage or otherwise discriminate against people with disabilities.

(c) It is an unlawful practice for any employer to discriminate against people with disabilities, with regard to fringe benefits provided either directly by an employer or through contracts with insurance carriers. Fringe benefits as used in this section include, but are not limited to, medical, hospital, accident and life insurance, retirement benefits, profit sharing and bonus plans, and leave. This subsection does not, for example, prohibit any employer from providing medical insurance which does not cover the cost of any medical condition arising out of preexisting illnesses, which costs are incurred following an employee's date of hire. Rather, whatever medical insurance is made available to non-disabled employees must be equally available to employees with disabilities.

(d) Regulations promulgated pursuant to the Law Against Discrimination shall supersede any inconsistent term of a collective bargaining agreement.

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N.J.A.C. 13:13-2.7 (2008)

§ 13:13-2.7 Labor organizations

(a) It is unlawful for any labor organization to exclude or expel any individual from membership or from any apprenticeship program because that individual is a person with a disability.

(b) It is an unlawful employment practice for any labor organization to discriminate on the basis of disability with respect to hiring, tenure, promotion, transfer, compensation, terms, conditions or privileges of employment, representation, grievances or any other matter directly or indirectly related to membership in or employment by such an organization.

(c) It is unlawful for a labor organization to cause or to attempt to cause an employer to discriminate against an individual because that individual is a person with a disability.

(d) It is unlawful to engage in any activity proscribed by (a), (b), or (c) above notwithstanding that activity is authorized or required by the constitution or by-laws of a labor organization or by a collective bargaining agreement or other contract to which the labor organization is a party.

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N.J.A.C. 13:13-2.8 (2008)

§ 13:13-2.8. Exception

(a) It shall be lawful to take any action otherwise prohibited under this section where it can reasonably be determined that an applicant or employee, as a result of the individual's disability, cannot perform the essential functions of the job even with reasonable accommodation.

1. Refusal to refer, admit to membership, hire, or transfer a person with a disability may be lawful where the nature or extent of the individual's disability reasonably precludes the performance the essential functions of the particular employment. Such a decision, however, must be based upon an objective standard supported by factual evidence rather than on the basis of general assumptions that a particular disability would interfere with the individual's ability to perform the essential functions of the job.

2. Refusal to select a person with a disability may be lawful where it can be demonstrated that the employment of that individual in a particular position would be hazardous to the safety or health of such individual, other employees, clients or customers. Such a decision must be based upon an objective standard supported by factual or scientifically validated evidence, rather than on the basis of general assumptions that a particular disability would create a hazard to the safety or health of such individual, other employees, clients or customers. A "hazard" to the person with a disability is a materially enhanced risk of serious harm.

3. The burden of proof is upon the employer, employment agency or labor organization to demonstrate in each case that the exception relied upon is based upon an objective standard supported by factual evidence, but no exception shall be based on:

i. A refusal to select a person with a disability because of the preferences of co-workers, clients, customers or the employer.

ii. A refusal to select a person with a disability because of the increased cost of insurance whether actual or anticipated, under a group or employee insurance plan provided in accordance with the law or as a fringe benefit.

iii. A refusal to select a person with a disability because of an assumption not supported by factual documented proof that such individual will incur a high rate of absenteeism in the future.

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SUBCHAPTER 3. REAL PROPERTY

N.J.A.C. 13:13-3.1 (2008)

§ 13:13-3.1. Application

This subchapter on discrimination in real property applies to vendors and lessors of property and their agents, real estate brokers, agents and salespersons, lending institutions and other persons. For the purpose of this subchapter, lending institutions include banks, building and loan associations, insurance companies and any other enterprise whose business consists in whole or in part in the making or purchasing of any loan or extension of credit, for whatever purpose, whether secured by residential real estate or not, including, but not limited to, financial assistance for the purchase, acquisition, construction, rehabilitation, repair or maintenance of any real property or part or portion thereof, or any agent or employee thereof.

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N.J.A.C. 13:13-3.2 (2008)

§ 13:13-3.2. Advertising and solicitation

(a) This section applies to real property, public housing and the rental of:

1. A single apartment or flat in a two-family dwelling, the other occupancy unit of which is occupied by the owner as a residence at the time of such rental; and

2. A room or rooms to another person or persons by the owner or occupant of a one-family dwelling occupied by the owner or occupant as a residence at the time of such rental.

(b) It is unlawful for any person to make, print, circulate, issue, display, post, utter, disseminate or publish or cause to be made, printed, circulated, issued, displayed, posted, uttered, disseminated or published any notice, listing, statement, sign or advertisement with respect to the sale, rental, sublease, assignment or lease of real property which expresses, overtly or subtly, directly or indirectly, any preference, limitation, specification, or discrimination based upon disability.

(c) It is unlawful for any real estate broker, agent or salesperson to accept for listing any housing accommodation when the seller or lessor or his or her agent has expressed, directly or indirectly, an intention to discriminate against people with disabilities.

(d) It is not unlawful for any person to make, print or publish or cause to be made, printed or published any notice, listing, statement, or advertisement which indicates that barrier free accommodations are available for sale, rent, lease or occupancy.

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N.J.A.C. 13:13-3.3 (2008)

§ 13:13-3.3 Inquiries

It is unlawful for any person to make or cause to be made any written or oral inquiry or record concerning the disability of any prospective purchaser, tenant or prospective occupant of any real property, or the disability of any other person associated with a prospective purchaser, tenant or prospective occupant, unless such information is required by an agency of local, State or Federal government and the person states clearly that the information requested is intended for use solely by the government agency.

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N.J.A.C. 13:13-3.4 (2008)

§ 13:13-3.4 Sale or rental

(a) It is unlawful for any person to discriminate on the basis of disability in the actual showing, sale, rental or lease of available real property. For example, a representation to any person, because that person is a person with a disability, that real property is not available for inspection, sale or rental when such real property is in fact so available is a violation of the act.

(b) It is unlawful for any person to misrepresent the price of real property listed for sale, rent or lease or to fail to communicate to the seller or lessor any offer made by a prospective buyer or lessor because the applicant or prospective occupant is a person with a disability, or because of any other person associated with the applicant or prospective occupant is a person with a disability.

(c) It is unlawful for any person to fail or refuse to show, rent or lease any real property to a person because he or she is a person with a disability who is accompanied by a guide or service dog or animal. Policies which restrict the availability of housing accommodations to persons without pets shall be void with respect to the above-mentioned segment of this protected class.

(d) It is unlawful for any person to fail or refuse to show, rent or lease any real property because a person with a disability will be residing or intends to reside in a dwelling or because of the disability of any person associated with a buyer or renter.

(e) It is unlawful for any person to discriminate against any individual because of disability in the price, terms, conditions or privileges of the sale, rental or lease of real property or in the provision of services for facilities in connection therewith. People with disabilities shall not be required to pay extra compensation or additional security deposits as a result of their maintaining or requiring special practices or accessories though such persons may be liable for any specific damage which may be done to the premises by virtue of their requirement.

1. This provision does not require a landlord to install or bear the expense of any such special accessories or practices. Apart from requiring payment for specific damage which may be done to the premises, however, a landlord may not charge a person with a disability an extra fee, for example, for keeping a guide or service dog or animal or maintaining special equipment such as a shower bar.

(f) It is unlawful for any person to:

1. Refuse to permit, at the expense of the person with a disability, reasonable modifications of existing premises occupied or to be occupied by the person with a disability, if the modifications may be necessary to afford the person with a disability full enjoyment of the premises, except that, in the case of a rental, the landlord may:

i. Where it is reasonable to do so, condition permission for a modification on the renter's agreeing to restore the interior of the premises to the condition that existed before the modification, reasonable wear and tear excepted;

ii. Where it is necessary in order to ensure with reasonable certainty that funds will be available to pay for the restorations at the end of the tenancy, negotiate as part of such a restoration agreement a provision requiring that the tenant pay into an interest bearing escrow account, over a reasonable period, a reasonable amount of money not to exceed the cost of the restorations and, the interest in such account shall accrue to the benefit of the tenant; and

iii. Condition permission for a modification on the renter providing a reasonable description of the proposed modifications as well as reasonable assurances that the work will be done in a workmanlike manner and that any required building permits will be obtained; and

2. Refuse to make reasonable accommodations in rules, policies, practices or services, when such accommodations may be necessary to afford a person with a disability equal opportunity to use and enjoy a dwelling.

(g) It is unlawful for any person to fail or refuse to rent to, or to impose different terms of tenancy upon, any person with a disability because that individual is a recipient of Federal, State or local assistance, including medical assistance or housing subsidies.

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N.J.A.C. 13:13-3.5 (2008)

§ 13:13-3.5 Eviction

It is an unlawful act of discrimination for any person to evict a tenant because the tenant is a person with a disability, or because that person is associated with another person who is a person with a disability.

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N.J.A.C. 13:13-3.6 (2008)

§ 13:13-3.6 Financing

It is unlawful for any lending institution or person to discriminate against an individual seeking a loan or other form of financial assistance whether in the initial extension of credit or in the terms and conditions of the obligation because that individual or an intended occupant of real property is a person with a disability, or because that individual or intended occupant is associated with another person who is a person with a disability. An application for loans or other forms of financial assistance means and extends to the purchase of an existing property, the construction of new buildings and the rehabilitation, repair or maintenance of existing property.

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N.J.A.C. 13:13-3.7 (2008)

§ 13:13-3.7 Covered multifamily dwellings

In connection with the design and construction of covered multifamily dwellings for first occupancy after March 13, 1991, it shall be unlawful to fail to design and construct dwellings which comply with the standards set forth in the Barrier-Free subcode of the State Uniform Construction Code Act, N.J.S.A. 52:27D-119 et seq., and N.J.A.C. 5:23-7.

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SUBCHAPTER 4. ACCESS TO PUBLIC ACCOMMODATIONS

N.J.A.C. 13:13-4.1 (2008)

§ 13:13-4.1 Purpose

The purpose of this subchapter is to implement the provisions of the New Jersey Law Against Discrimination, N.J.S.A. 10:5-1 to 49, as it pertains to unlawful discrimination against people with disabilities by the owners, lessees, proprietors, managers, superintendents, agents or employees of any place of public accommodation.

*** THIS FILE INCLUDES ALL REGULATIONS ADOPTED AND PUBLISHED THROUGH THE ***
*** NEW JERSEY REGISTER, VOL. 40, NO. 8, APRIL 21, 2008 ***

TITLE 13. LAW AND PUBLIC SAFETY
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N.J.A.C. 13:13-4.2 (2008)

§ 13:13-4.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings:

"LAD" means the New Jersey Law Against Discrimination, N.J.S.A. 10:5-1 to 49.

"Path of travel" means a continuous, unobstructed means of pedestrian passage by which the facilities may be approached, entered, and exited, and which connects the facility to an exterior approach (including sidewalks, streets, and parking areas), an entrance to the facility, and to other parts of the facility, and includes a continuous, unobstructed means of pedestrian passage to the areas of the facility where goods or services are made available to the general public, and to the restrooms, telephones, and drinking fountains.

"Person with a disability" and "people with disabilities" shall have the same meaning as the term "handicapped" or "disabled" as defined in N.J.S.A. 10:5-5(q), and explained in N.J.S.A. 10:5-4.1, and shall include people who are perceived as having a disability.

"Place of public accommodation" shall include the places set forth in N.J.S.A. 10:5-5(l), and shall also specifically include organizations that make membership available to the general public and entities that offer examinations or courses related to applications, licensing, certification or credentialing for secondary or post-secondary education, professional, or trade purposes.

"Qualified interpreter" means an interpreter who is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary.

"Service animal" means any animal individually trained to do work or perform tasks for the benefit of a person with a disability, including, but not limited to, guiding people with impaired vision, alerting people with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or retrieving dropped items.

"Service dog" means any guide dog, signal dog, or other dog individually trained to do work or perform tasks for the benefit of a person with a disability, including, but not limited to, guiding people with impaired vision, alerting people with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or retrieving dropped items.

"Smoking" means the burning of a lighted cigar, cigarette, pipe, or any other matter or substance which contains tobacco.

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N.J.A.C. 13:13-4.3 (2008)

§ 13:13-4.3 Unlawful practices

(a) It shall be unlawful for an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation to refuse, withhold from or deny an individual, either directly or indirectly, on account of that person's disability or perceived disability, access to any of the accommodations, advantages, facilities or privileges of a place of public accommodation. It shall also be unlawful for an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation to discriminate against a person with a disability in the price, eligibility criteria, methods of administration, standards, terms, or conditions upon which access to such accommodations, advantages, facilities or privileges may depend.

(b) It shall be unlawful for an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation, directly or indirectly, such as through contractual, licensing, or other arrangements, to accord a person with a disability differential terms, conditions or privileges of a place of public accommodation, or to accord a person with a disability differential opportunity to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation otherwise offered to the general public.

1. Separate goods, services, privileges, facilities, or terms and conditions of enjoyment shall be deemed differential unless such action is necessary to provide a person with a disability with a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is as effective as that offered to the general public, and provided the separate accommodation comports with the standards set forth in N.J.A.C. 13:13-4.4.

(c) It shall be unlawful for an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation to refuse, withhold, or deny, either directly or indirectly, the right of people with disabilities to be accompanied in any place of public accommodation by guide or service dogs, specially trained by a service animal trainer as that term is defined in the LAD. This subsection shall also apply to trainers of service or guide dogs engaged in the actual training process and activities of such animals, and to service animal trainers and people with disabilities accompanied by service animals other than dogs, provided the use of such other service animals in the place of public accommodation is deemed to be a reasonable accommodation under all of the circumstances. Service animal trainers or people with disabilities accompanied by service or guide dogs or service or guide animals shall be liable for any damage done to the premises or facilities by such dogs or animals.

(d) It shall be unlawful for an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation to publish, circulate, issue, display, post or mail or cause to be printed, circulated, issued, displayed, posted or mailed any written, printed or broadcast notice indicating directly or indirectly that the right of a person with a disability to have equal access to a place of public accommodation will be denied or abridged.

(e) It shall be unlawful for any person to refuse to buy from, sell to, lease from or to, license, contract with, or trade with, provide goods, services or information to, or otherwise do business with any other person on the basis of

that person's disability or on the disability of such other person's spouse, partners, members, stockholders, directors, officers, managers, superintendents, agents, employees, business associates, suppliers, or customers, except as provided by N.J.S.A. 10:5-12(l) with respect to collective bargaining, labor disputes, and actions to protest unlawful discrimination or unlawful employment practices.

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N.J.A.C. 13:13-4.4 (2008)

§ 13:13-4.4 Integrated settings

(a) An owner, lessee, proprietor, manager, superintendent, agent or employee of a place of public accommodation shall, to the extent reasonable, afford goods, services, facilities, privileges, advantages, and accommodations to a person with a disability in the most integrated setting appropriate to the needs of that person.

(b) Notwithstanding the existence of separate or different programs or activities provided in accordance with this subchapter, an owner, lessee, proprietor, manager, superintendent, agent or employee of a public accommodation shall not deny a person with a disability the opportunity to participate in programs or activities that are not separate or different, in accordance with N.J.A.C. 13:13-4.8.

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N.J.A.C. 13:13-4.5 (2008)

§ 13:13-4.5 Examinations

An owner, lessee, proprietor, manager, superintendent, agent or employee of a place of public accommodation that offers examinations or courses related to applications, licensing, certification or credentialing for secondary or post-secondary education, professional, or trade purposes shall assure that examinations are selected and administered to best ensure that when an examination is administered to a person with a disability that impairs sensory, manual, or speaking skills, the examination results accurately reflect the individual's aptitude or achievement level or whatever other factor the examination purports to measure, rather than reflecting the individual's impaired sensory, manual, or speaking skills, except where those skills are the factors that the examination purports to measure.

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N.J.A.C. 13:13-4.6 (2008)

§ 13:13-4.6 Prohibited charges

It shall be unlawful for an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation to impose a surcharge on a particular person with a disability or any group of people with disabilities to cover the costs of measures, such as the provision of auxiliary aids, barrier removal, alternatives to barrier removal, and reasonable modifications in policies, practices, or procedures, that may be required by law.

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N.J.A.C. 13:13-4.7 (2008)

§ 13:13-4.7 Retaliation or coercion

(a) It shall be unlawful for any person to discriminate against any individual because that individual has opposed any act or practice prohibited by the LAD or because that individual filed a complaint, testified, assisted, or participated in any investigation or proceeding under the LAD.

(b) It shall be unlawful for any person to coerce, intimidate, threaten, or interfere with any person in the exercise or enjoyment of, or on account of that person having exercised or enjoyed, or on account of that person having aided or encouraged any other person in the exercise or enjoyment of any right granted or protected by the LAD.

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N.J.A.C. 13:13-4.8 (2008)

§ 13:13-4.8 Reasonable probability of serious harm

(a) Nothing in this subchapter shall be construed as requiring an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation to permit a person with a disability to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of that public accommodation if to do so creates a reasonable probability of serious harm to the person with a disability, or to others, that cannot be eliminated with reasonable accommodation.

(b) In determining whether providing a person with a disability with access to a public accommodation poses a reasonable probability of serious harm to that individual, or to others, that cannot be eliminated with reasonable accommodation, an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain the probability that the serious harm will actually occur and whether reasonable modifications of policies, practices, or procedures will eliminate the probability of serious harm.

(c) An owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation may impose legitimate safety requirements that are necessary for the safe operation of the facility. Such safety requirements shall be based on actual risks and not on mere speculation, stereotypes, or generalizations about people with disabilities.

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N.J.A.C. 13:13-4.9 (2008)

§ 13:13-4.9 Smoking

Nothing in this subchapter shall be construed as making it unlawful to prohibit or impose restrictions on smoking in places of public accommodation.

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N.J.A.C. 13:13-4.10 (2008)

§ 13:13-4.10 Insurance

(a) Nothing in the LAD or this subchapter shall be construed as interfering with the operation of the terms or conditions and administration of any bona fide insurance plan or program.

(b) It shall be unlawful for an owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation to refuse to serve a person with a disability because its insurance company conditions coverage or rates on the absence of people with disabilities.

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N.J.A.C. 13:13-4.11 (2008)

§ 13:13-4.11. Reasonable accommodation

(a) An owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation shall make reasonable accommodations to the limitations of a patron or prospective patron who is a person with a disability, including making such reasonable modifications in policies, practices, or procedures, as may be required to afford goods, services, facilities, privileges, advantages, or accommodations to a person with a disability, unless the owner, lessee, proprietor, manager, superintendent, agent or employee of the place of public accommodation demonstrates that making the accommodations would impose an undue burden on its operation.

(b) In determining whether an accommodation is unreasonable because it will impose an undue burden on the operation of a place of public accommodation, factors to be considered include:

1. The overall size of the business which runs the place of public accommodation with respect to the number of employees, number and type of facilities, and size of budget;

2. The nature and cost of the accommodation sought;

3. Whether the accommodation sought will result in a fundamental alteration to the goods, services, program or activity offered; and

4. Whether the accommodation sought involves an alteration that will threaten or destroy the historic significance of a building or facility that is eligible for listing in the National Register of Historic Places under the National Historic Preservation Act (16 U.S.C. §§ 470 et seq.) or designated as historic under State or local law.

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N.J.A.C. 13:13-4.12 (2008)

§ 13:13-4.12 Examples of reasonable accommodation

(a) Accommodations that may be reasonable in a particular situation include, but are not limited to:

1. Permitting the use of service or guide animals, other than dogs, that are individually trained to do work or perform tasks for the benefit of a person with a disability;

2. Making reasonable structural alterations such as:

i. Repositioning shelves or telephones;

ii. Rearranging furniture and equipment;

iii. Installing accessible door hardware;

iv. Adding raised markings on elevator control buttons;

v. Installing flashing alarm lights;

vi. Widening doors and installing offset hinges to widen doorways; and/or

vii. Installing an accessible paper cup dispenser at an existing inaccessible water fountain;

3. Providing at least one accessible restroom for each sex or an accessible single unisex restroom, and making alterations such as the following to ensure accessibility:

i. Installing grab bars in toilet stalls;

ii. Rearranging toilet partitions to increase maneuvering space;

iii. Insulating lavatory pipes under sinks to prevent burns;

iv. Installing a raised toilet seat;

v. Installing a full-length bathroom mirror; and/or

vi. Repositioning the paper towel dispenser in a bathroom;

4. Creating designated accessible parking spaces;

5. Installing vehicle hand controls;

6. Providing an accessible check-out aisle or modifying policies and practices to ensure that an equivalent level of convenient service is provided to a person with a disability as is provided to others;

7. Providing auxiliary aids and services to ensure effective communication, such as:

i. Qualified, effective interpreters, notetakers, computer-aided transcription services, written materials, accessible telephones, including telephone handset amplifiers, assistive listening devices or systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, "telecommunications devices for deaf persons" (TDD's), and videotext displays or

alternate effective means for decoding captions to facilitate television use by people with impaired hearing;

ii. Qualified readers, Brailled materials and versions of books, books and materials on audio cassettes, and large print materials; and/or

iii. Other specialized equipment or devices;

8. Providing wheelchair seating spaces and seats with removable aisle-side arm rests that permit people who use wheelchairs to sit with family members or other companions and that are located so that the seats:

i. Are dispersed throughout the seating area;

ii. Provide lines of sight and choice of admission prices comparable to what is available to members of the general public; and

iii. Adjoin an accessible route that also serves as a means of egress in case of emergency;

9. Offering examinations or courses in a place and manner accessible to people with disabilities or offering alternate accessible arrangements; such accommodations shall include making reasonable modifications to the time permitted for completion of an examination or course; and/or

10. To the extent reasonable, ensuring that the path of travel to the areas of the facility where goods or services are made available to the general public, and to the restrooms, telephones, and drinking fountains, are readily accessible to and useable by people with disabilities, including people who use wheelchairs; this may include, but shall not be limited to:

i. Providing accessible entrances, walks and sidewalks, curb ramps and other interior or exterior pedestrian ramps, clear floor paths through lobbies, corridors, rooms, and other areas, parking access aisles, and accessible elevators and lifts;

ii. Remodeling merchandise display areas in a department store;

iii. Replacing an inaccessible floor surface and/or removing high pile, low density carpeting; and/or

iv. Eliminating a turnstile or providing an alternative accessible path.

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N.J.A.C. 13:13-4.13 (2008)

§ 13:13-4.13 Referrals

An owner, lessee, proprietor, manager, superintendent, agent or employee of any place of public accommodation may refer a person with a disability to another place of public accommodation, if that person is seeking, or requires, treatment or services outside of the referring entity's area of specialization, and if, in the normal course of its operations, the referring entity would make a similar referral for an individual who is not a person with a disability and who seeks or requires the same treatment or services.

APPENDIX B9

FEDERAL AND NEW JERSEY MEDICAL LEAVE REQUIREMENTS

Employment Law Guide
Chapter: Family and Medical Leave

Related Information

Compliance Assistance By Law
- The Family and Medical Leave Act (FMLA)

DOL Agency Assistance
- Wage and Hour Division FMLA Page

Updated: September 2005

Family and Medical Leave Act of 1993 (FMLA)
(29 USC §2601 et seq.; 29 CFR Part 825)

Who is Covered

The Family and Medical Leave Act (FMLA) provides a means for employees to balance their work and family responsibilities by taking unpaid leave for certain reasons. The Act is intended to promote the stability and economic security of families as well as the nation's interest in preserving the integrity of families.

The FMLA applies to any employer in the private sector who engages in commerce, or in any industry or activity affecting commerce, and who has 50 or more employees each working day during at least 20 calendar weeks in the current or preceding calendar year.

The law covers all public agencies (state and local governments) and local education agencies (schools, whether public or private). These employers do not need to meet the "50 employee" test. Title II of FMLA covers most federal employees, who are subject to regulations issued by the Office of Personnel Management.

To be eligible for FMLA leave, an individual must (1) be employed by a covered employer and work at a worksite within 75 miles of which that employer employs at least 50 people; (2) have worked at least 12 months (which do not have to be consecutive) for the employer; and (3) have worked at least 1,250 hours during the 12 months immediately before the date FMLA leave begins.

Basic Provisions/Requirements

**** The Family and Medical Leave Act was amended on January 28, 2008. Please visit Wage and Hour's Web page for additional information.***

The FMLA provides an entitlement of up to 12 weeks of job-protected, unpaid leave during any 12-month period for the following reasons:

- Birth and care of the employee's child, or placement for adoption or foster care of a child with the employee;
- Care of an immediate family member (spouse, child, parent) who has a serious health condition; or
- Care of the employee's own serious health condition.

If an employee was receiving group health benefits when leave began, an employer must maintain them at the same level and in the same manner during periods of FMLA leave as if the employee had continued to work. Usually, an employee may elect (or the employer may require) the use of any accrued paid leave (vacation, sick, personal, etc.) for periods of unpaid FMLA leave.

Employees may take FMLA leave in blocks of time less than the full 12 weeks on an intermittent or reduced leave basis when medically necessary. Taking intermittent leave for the placement, adoption, or foster care of a child is subject to the employer's approval. Intermittent leave taken for the birth and care of a child is also subject to the employer's approval except for pregnancy-related leave that would be leave for a serious health condition.

When the need for leave is foreseeable, an employee must give the employer at least 30 days notice, or as much notice as is practicable. When the leave is not foreseeable, the employee must provide such notice as soon as possible.

An employer may require medical certification of a serious health condition from the employee's health care provider. An employer may also require periodic reports during the period of leave of the employee's status and intent to return to work, as well as "fitness-for-duty" certification upon return to work in appropriate situations.

An employee who returns from FMLA leave is entitled to be restored to the same or an equivalent job (defined as one with equivalent pay, benefits, responsibilities, etc.). The employee is not entitled to accrue benefits during periods of unpaid FMLA leave, but the employer must return him or her to employment with the same benefits at the same levels as existed when leave began.

Employers are required to post a notice for employees outlining the basic provisions of FMLA and are subject to a $100 civil money penalty per offense for willfully failing to post such notice. Employers are prohibited from discriminating against or interfering with employees who take FMLA leave.

Employee Rights

The FMLA provides that eligible employees of covered employers have a right to take up to 12 weeks of job-protected leave in any 12-month period for qualifying events without interference or restraint from their employers. The FMLA also gives employees the right to file a complaint with the Wage and Hour Division of the Department of Labor's Employment Standards Administration, file a private lawsuit under the Act (or cause a complaint or lawsuit to be filed), and testify or cooperate in other ways with an investigation or lawsuit without

being fired or discriminated against in any other manner.

Compliance Assistance Available

The Wage and Hour Division of the Employment Standards Administration administers FMLA. More detailed information, including copies of explanatory brochures, may be obtained by contacting your local Wage and Hour Division office. In addition, the Wage and Hour Division has developed the *eLaws* Family and Medical Leave Act Advisor, which is an online resource that answers a variety of commonly asked questions about FMLA, including employee eligibility, valid reasons for leave, notification responsibilities of employers and employees, and rights and benefits of employees. Compliance assistance information is also available from the Wage and Hour Division's Web site. For additional assistance, contact the Wage and Hour Division at 1-866-4USWAGE.

Penalties/Sanctions

Employees and other persons may file complaints with the Employment Standards Administration (usually through the nearest office of the Wage and Hour Division). The Department of Labor may file suit to ensure compliance and recover damages if a complaint cannot be resolved administratively. Employees also have private rights of action, without involvement of the Department of Labor, to correct violations and recover damages through the courts.

Relation to State, Local, and Other Federal Laws

A number of states have family leave statutes. Nothing in the FMLA supersedes a provision of state law that is more beneficial to the employee, and employers must comply with the more beneficial provision. Under some circumstances, an employee with a disability may have rights under the Americans with Disabilities Act.

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Federal vs. New Jersey Family and Medical Leave Laws

	FEDERAL ELEMENTS	STATE ELEMENTS
Employer Covered	Private Employers of 50 or more Employees in at least 20 weeks of the current or preceding year Public agencies, including state, local, and Federal Employers Local education agencies covered under special provisions	Public and private Employers of 50 or more Employees each working day during each of 20 or more calendar workweeks in the then current or immediately preceding calendar year; includes the State, any political subdivision thereof, and all public offices, agencies, boards or bodies No special provision for education agencies
Employees Eligible	Worked for Employer for at least 12 months - which need not be consecutive; worked at least 1,250 hours for Employer during 12 months preceding leave; and employed at Employer worksite with 50 or more Employees or within 75 miles of Employer worksites with a total of 50 or more Employees	12 months with an Employer for not less than 1000 base hours during the immediately preceding 12 months No worksite proviso
Leave Amount	Up to a total of 12 weeks during a 12-month period; however, leave for birth, adoption, foster care, or to care for a parent with a serious health condition must be shared by spouses working for same Employer	12 weeks in any 24-month period No provision requiring spouses to share leave
Type of Leave	Unpaid leave for birth, placement of child for adoption or foster care, to provide care for Employee's own parent (including individuals who exercise parental responsibility under state law), child, or spouse with serious health condition, or Employee's own serious health condition	Birth, adoption placement, serious health condition of child, parent, parent-in-law, or spouse, but not for an employee's own health condition.
Serious Health Condition	Illness, injury, impairment, or physical or mental condition involving incapacity or treatment connected with inpatient care in	Similar to Federal provision

	hospital, hospice, or residential medical-care facility; or, continuing treatment by a health care provider involving a period of incapacity: (1) requiring absence of more than 3 consecutive calendar days from work, school, or other activities; (2) due to a chronic or long-term condition for which treatment may be ineffective; (3) absences to receive multiple treatments (including recovery periods) for a condition that if left untreated likely would result in incapacity of more than 3 days; or (4) due to any incapacity related to pregnancy or for prenatal care	
Health Care Provider	Doctors of medicine or osteopathy authorized to practice medicine or surgery; podiatrists, dentists, clinical psychologists, clinical social workers, optometrists, chiropractors (limited to manual manipulation of spine to correct subluxation shown to exist by x-ray), nurse practitioners, and nurse-midwives, if authorized to practice under State law and consistent with the scope of their authorization; Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, MA; any provider so recognized by the Employer or its group health plan's benefits manager; and any health provider listed above who practices and is authorized to practice in a country other than the United States	No specific provision
Intermittent Leave	Permitted for serious health condition when medically necessary. Not permitted for care of newborn or new placement by adoption or foster care unless Employer agrees	Similar to Federal provision
Substitution of Paid Leave	Employees may elect or Employers may require accrued paid leave to be substituted in some cases. No limits on substituting paid vacation or personal leave. An Employee may not substitute paid sick, medical, of family leave for any situation not covered by any Employers' leave plan	Family leave required by this Act may be paid, unpaid, or a combination of paid and unpaid leave. If an employer provides paid family leave for fewer than 12 weeks, the additional weeks of leave added to attain the 12-workweek total required by this Act may be unpaid.
Reinstatement Rights	Must be restored to same position or one equivalent to it in all benefits and other terms and conditions of employment	Similar to Federal provision
Key Employee	Limited exception for salaried Employees if	Similar to Federal

Exception	among highest paid 10%, within 75 miles of worksites, restoration would lead to grievous economic harm to Employer, and other conditions met	provision, except limited to Employees who are among the highest paid 5% or the seven highest paid Employees, whichever is greater
Maintenance of Health Benefits During Leave	Health insurance must be continued under same conditions as prior to leave	Similar to Federal provision
Leave Requests	To be made by Employee at least 30 days prior to date leave is to begin where need is known in advance or, where not foreseeable, as soon as practicable. If due to a planned medical treatment or for intermittent leave, the Employee, subject to health care provider's approval, shall make a reasonable effort to schedule it in a way that does not unduly disrupt Employer's operation	Employee shall provide the employer notice of the expected leave in a manner which is reasonable and practicable
Medical Certification May Be Required by Employer for:	Request for leave because of serious health condition To demonstrate Employee's fitness to return to work from medical leave where Employer has a uniformly applied practice or policy to require such certification	Request may be made for circumstances of birth, adoption placement or because of serious health condition of family member. No provision relating to certification of fitness to return to work.
Executive, Administrative, and Professional Employees	Such individuals are entitled to FMLA benefits. However, their use of FMLA leave does not change their status under the Fair Labor Standards Act (FLSA), i.e., an Employer, does not lose its exemption from the FLSA's minimum wage and overtime requirements.	No specific provision

U.S. Department of Labor
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1-866-4-USWAGE
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Contact Us

APPENDIX B I O

NEW JERSEY MANDATORY OVERTIME RESTRICTIONS

New Jersey Department of Labor & Workforce Development

To be posted in a conspicuous place

New Jersey Mandatory Overtime Restrictions for Health Care Facilities

N.J.S.A. 34:11-56a31, et seq.

Conditions

- A health care facility shall not require an hourly employee who provides direct patient care to work in excess of an agreed to, predetermined and regularly scheduled daily work shift, not to exceed 40 hours per week.

  "Direct patient care activities" are activities in which an employee provides direct services to patients in a clinical setting–including the emergency department, in-patient bedside, operating room or other clinical specialty treatment areas.

- Mandatory overtime cannot be used to compensate for "chronic short staffing."
- An hourly wage employee may agree to work overtime strictly on a voluntary basis or volunteer to be on call.
- An hourly wage employee's refusal to accept overtime shall not be grounds for retaliatory action, workplace discrimination, dismissal, discharge or any other penalty or adverse employment decision.

Exemptions

Overtime may be mandated in the case of unforeseeable, emergent circumstances only as a last resort and where the employer has exhausted reasonable efforts to obtain staffing as follows:

- Seeks individuals to volunteer to work extra time from all available, qualified staff who are working at the time of the unforeseeable, emergent circumstance;
- Contacts qualified employees who have made themselves available to work extra time;
- Seeks and makes use of per diem staff; and
- Seeks personnel from a contracted temporary agency when such staffing is permitted by law, regulation, or an applicable collective bargaining agreement.

Exhaustion of reasonable efforts is not required as follows:

- In the event of any declared, national, state or municipal emergency including, but not limited to, an act of terrorism, a disease outbreak, adverse weather conditions or natural disaster;
- When a health care facility disaster plan is activated; or
- In the event of any unforeseen disaster, natural or man-made, or other catastrophic event which substantially affects or increases the need for health care services.

The prohibition against mandatory overtime does not apply when an employee is participating in a procedure in progress and it would be detrimental to the patient's health if the employee was not in attendance. However, this exemption does not apply for elective procedures scheduled such that the length of time ordinarily required to complete the procedure would exceed the employee's scheduled end of shift.

Penalties

- Any employer who violates any provisions of this Act shall be guilty of a disorderly persons offense and, upon conviction, shall be punished by a fine of not less than $100 nor more than $1,000.
- As an alternative to, or in addition to, any other sanctions provided by law for violations, the Commissioner of Labor and Workforce Development is authorized to assess and collect administrative penalties, up to a maximum of $250 for a first violation and up to a maximum of $500 for each subsequent violation.
- Each incident during which any violation of this provision occurs shall constitute a separate and distinct offense.

Enforced by:

NJ Department of Labor & Workforce Development
Division of Wage and Hour Compliance
P.O. Box 389
Trenton, New Jersey 08625-0389

Working Together to Keep New Jersey Working

Additional copies of this poster or any other required posters may be obtained by contacting the New Jersey Department of Labor & Workforce Development, Office of Constituent Relations, PO Box 110, Trenton, New Jersey 08625-0110, (609) 777-3200.

New Jersey Department of Labor and Workforce Development is an equal opportunity employer with equal opportunity programs. Auxiliary aids and services are available upon request to individuals with disabilities.

If you need this document in Braille or large print, call (609) 292-2305. TTY users can contact this department through New Jersey Relay: 7-1-1.

APPENDIX B11

SAMPLE TELECOMMUTING POLICY

Software
Alternative Staffing
Empl. Law Basics
FMLA Guide
Unempl. Insur. Guide
Wage and Hour Guide

Resources / Files
Workplace Policies
Forms
Free Software / Files

Government Info
EEOC INS IRS
U.S. Dep't of Labor
Tex. Workf. Comm.
TWCC

Statutes and Regs
Wage and Hour Laws
Misc. Federal Laws
Texas Laws

Services
Seminars / Training
Consult an Attorney
List of Attorneys
List of Consultants

Features
Workplace Weirdness
Newsletter
Links

Participate

Employment Law Advisory Network

Telecommuting Policy

Important disclaimer: The policy available on this page is only an example and is furnished merely as an illustration of its category. It is not meant to be taken and used without consultation with a licensed employment law attorney. If you are in need of a policy for a particular situation, you should keep in mind that any sample policy such as the one available below would need to be reviewed, and possibly modified, by an employment law attorney in order to fit your situation and to comply with the laws of your state. Downloading, printing, or reproducing any of these policies in any manner constitutes your agreement that you understand this disclaimer and that you will not use the policy for your company or individual situation without first having it approved and, if necessary, modified by an employment law attorney of your choice.

TELECOMMUTING

For some positions within our organization, working away from the office, or telecommuting, may be possible. Telecommuting can be a privilege, or a necessity, or a combination of both, depending upon the circumstances. No particular positions have been designated as "telecommuting positions"; rather, certain positions may from time to time be suitable for performance outside the workplace, and in such a case, a supervisor may allow all or part of the duties of the position to be performed away from the office on a temporary or ongoing basis. However, no such arrangement is promised or guaranteed, and no particular duration of telecommuting is guaranteed. If telecommuting is allowed for a position, it will last as long as it is appropriate for both the employee and the organization.

Employees wishing to be considered for working by telecommuting must apply for such consideration. The request may be granted or denied. If granted, the supervisor and the employee will work out the arrangement. Such arrangement must be set forth in writing and signed by both the employee and the supervisor. The arrangement must at a minimum cover the following:

1. the duties that will be performed away from the office;
2. how deadlines will be handled;
3. hours to be worked;
4. how hours worked will be recorded;
5. if overtime is to be handled any differently than in the office, how it will be handled;
6. the amount of notice to be given of any change in the arrangement;
7. how much time the employee should spend in the office and when the employee should report back to the office;
8. how the employee and the organization will be able to contact each other during the workday;
9. any changes in workplace policies that may be necessary due to the telecommuting arrangement; and
10. the employee's understanding and agreement that the telecommuting arrangement is at the will of the organization and may be altered or terminated at any time.

**** **** **** ****

Again, it is not recommended to simply adopt this sample policy for your situation without first seeking the advice of an employment law attorney. There is almost an infinite variety of policies for various kinds of workplaces and different kinds of situations. Moreover, the

laws vary widely from state to state in some areas of employee relations. Thus, it is very important to make sure that what you have in your policy handbook not only truly meets your needs, but also complies with your state's law.

Don't know an attorney? Contact ELANet for information on how to find an attorney concerning the design or review of employment policies for your situation: elaninc@employmentlawadvisors.com

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U.S. General Services Administration (GSA)

APPENDIX A: SAMPLE TELECOMMUTING AGREEMENTS

This section currently contains three examples of Telecommuting Agreements and other materials used by the GSA and other agencies to involve employees in the telecommuting pilot project. Other examples and materials will be added as they become available.

EXAMPLE 1: Sample Agreement Between Agency and Employee Approved for Telecommuting on a Continuing Basis

The supervisor and the employee should each keep a copy of this agreement for reference.

(Agency)_____(Employee)

_____

Voluntary Participation

Employee voluntarily agrees to work at the agency-approved alternative workplace indicated below and to follow all applicable policies and procedures. Employee recognizes that the flexiplace arrangement is not an employee benefit but an additional method the agency may approve to accomplish work.

Trial Period

Employee and agency agree to try out the arrangement for at least [specify number] months unless unforeseeable difficulties require earlier cancellation.

Salary and Benefits

Agency agrees that a telecommuting arrangement is not a basis for changing the employee's salary or benefits.

Duty Station and Alternative Workplace

Agency and employee agree that the employee's official duty station is: [indicate duty station for main office] and that the employee's approved alternative workplace: [specify street and number, city, and State]

Note: All pay, leave and travel entitlements are based on the official duty station.

Official Duties

Unless otherwise instructed, employee agrees to perform official duties only at the main office or agency-approved alternative workplace. Employee agrees not to conduct personal business while in official duty status at the alternative workplace, for example, caring for dependents or making home repairs.

Work Schedule and Tour of Duty

Agency and employee agree the employee's official tour of duty will be: [specify days, hours, and location, i.e., the main office or the alternative workplace].

Time and Attendance

Agency agrees to make sure the telecommuting employee's timekeeper has a copy

of the employee's work schedule. The supervisor agrees to certify biweekly the time and attendance for hours worked at the main office and the alternative workplace. (Note: agency may require employee to complete self certification form.)

Leave
Employee agrees to follow established office procedures for requesting and obtaining approval of leave.

Overtime
Employee agrees to work overtime only when ordered and approved by the supervisor in advance and understands that working overtime without such approval may result in termination of the flexiplace privilege and/or other appropriate action.

Equipment\Supplies
Employee agrees to protect any Government-owned equipment and to use the equipment only for official purposes. The agency agrees to install, service and maintain any Government-owned equipment issued to the telecommuting employee. The employee agrees to install, service, and maintain any personal equipment used. The agency agrees to provide the employee with all necessary office supplies and also reimburse the employee for business-related long distance telephone calls.

Security
If the Government provides computer equipment for the alternative workplace, employee agrees to the following security provisions: [insert agency-specific language]

worksite.

Cancellation
Agency agrees to let the employee resume his or her regular schedule at the main office after notice to the supervisor. Employee understands that the agency may cancel the telecommuting arrangement and instruct the employee to resume working at the main office. The agency agrees to follow any applicable administrative or negotiated procedures.

Other Action
Nothing in this agreement precludes the agency from taking any appropriate disciplinary or adverse action against an employee who fails to comply with the provisions of this agreement.

(Employee's Signature and Date)

_____

(Supervisor's Signature and Date)

_____

EXAMPLE 2: Telecomuting (Flexiplace) Pilot Program Work Agreement

Type of Telecommuting (Flexiplace) Request: Medical ___ Non-Medical ___

The following constitutes an agreement between:

Name of Organization _____
and

Employee's Name (print) _____

Terms and conditions of the Telecommuting (Flexiplace) program.

1. Employee agrees to participate in this program on a voluntary basis and to adhere to the applicable guidelines and policies.

2. The agreement is made for a specified period of time not to exceed 6 months. The employee may work at the alternate duty station a maximum of 1 day per week during the agreement period. Employee agrees to participate in this program for the period of time:

beginning: (month/day/year)_____

and ending: (month/day/year) _____

3. Employee's official duty station is:

_____

Complete Address

4. Employee is allowed to participate in any type of work schedule authorized for use by his/her immediate organization. Normal rules and procedures apply for authorizing, approving, earning, and using of leave, overtime, credit hours, compensatory time, etc. Failure to obtain prior approval for overtime work or earning of credit hours may result in the employee's removal from the flexiplace program or other appropriate action.

Management reserves the right to alter the employee's established work schedule to accommodate work demands or for any other official purpose.

5. Employee's time and attendance will be recorded as performing official duties at the official duty station. The normal duty day must be accounted for by hours worked, some form of authorized leave, or any combination thereof. All leave and travel entitlement will be based on the employee's official duty station.

6. Employee will meet the supervisor or others as necessary, appropriate, or requested in order to perform assigned duties or to fulfill organizational requirements. This includes such activities as attending required training programs, receiving assignments, reviewing completed work, attending meetings, providing progress

reports etc.

7. If the employee requires Government property at the alternate duty station, the employee may request a loan of such items. The loan, use, security, and protection of Government property must be in accordance with established policies and procedures. The employee is responsible for immediately notifying his/her supervisor if Government-owned property fails to operate properly or is damaged. Employee-owned property, computer equipment, software, etc. is the sole responsibility of the employee.

Government-owned computer equipment and software will be serviced and maintained by the Government at a location of its choosing. The employee agrees to follow the terms of computer software license and copyright agreements, as well as computer virus and protecti The agreement may be renewed or extended at the end of the originally agreed upon period.

Supevisor's Signature: _____ Date:_____

Employee's Signature: _____ Date:_____

Approving Official's Signature: _____ Date:_____

EXAMPLE 3. FLEXIPLACE TEST: APPLICATION FORM

Bargaining Unit_____

Non-Bargaining Unit_____

Please complete, sign, and return this form to your supervisor by _____.

If you fail to return this form by the requested date, we will assume that you do not wish to participate in the Telecommuting Program. If you choose not to participate in this program, you will continue to work at your official workstation.

1. Mark your choice:

I wish to work at home. ____

I wish to work at a satellite facility (Telecommuting Center). ____

2. Place the number "1" next to the day you would most like to work at home as your first choice. Next, place the number "2" next to the day you would like to work at home as your second choice.

HOME: Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___

3. Place the number "1" next to the day you would most like to work at the satellite facility or telecommuting center as your first choice. Next, place the number "2" next to the day you would like to work at the satellite facility or telecommuting center as your second choice.

CENTER: Monday ___ Tuesday ___ Wednesday ___ Thursday___ Friday ___

4. For your information only, attached is a list of available satellite facilities or telecommuting centers. Select the one that you are most interested in and list it here. DO NOT contact the center yourself.

I am interested in working at the _____ facility.

_____

EMPLOYEE'S NAME/DATE

_____

ORGANIZATION

INFORMATION

For more information contact Dr. Wendell Joice on (202) 273-4664 or email at wendell.joice@gsa.gov

APPENDIX C I

DEPARTMENT DIRECTOR CHECKLIST

DEPARTMENT DIRECTOR'S CHECKLIST

Name: _____

Department: _____

Facility: _____

PREPARATIONS	DATE COMPLETED
Review and revise individual department staffing plan. Submit copy to: _____	
Update phone roster.	
Complete, if applicable, Department Volunteer List. Submit to: _____	
Identify and document, if applicable, any special needs for equipment or supplies, i.e., computer resources for remote employees.	
Review facility and department pandemic plans with department employees.	
Review Employee Staffing Worksheet with department employees.	

APPENDIX D I

HHS INFLUENZA PLAN

Department of Health & Human Services (US), HHS Pandemic Influenza Plan. [Internet]. Washington (DC): Health & Human Services, 2005 July 19 [Last Revised 2007 May 15]. Appendix D, Table D-1: Vaccine Priority Group Recommendations. [about 17 p.]. Available from: http://www.hhs.gov/pandemicflu/plan/appendixd.html.

HHS Pandemic Influenza Plan

Home: HHS Pandemic Influenza Plan

Visit PandemicFlu.gov for one-stop access to U.S. Government avian and pandemic flu information. HHS is responsible for Pandemic Influenza Planning, outlined below.

Advisory Committee recommendations are presented in this report to provide guidance for planning purposes and to form the basis for further discussion of how to equitably allocate medical countermeasures that will be in short supply early in an influenza pandemic.

Two federal advisory committees, the Advisory Committee on Immunization Practices (ACIP) and the National Vaccine Advisory Committee (NVAC), provided recommendations to the Department of Health and Human Services on the use of vaccines and antiviral drugs in an influenza pandemic.

Although the advisory committees considered potential priority groups broadly, the main expertise of the members was in health and public health. The primary goal of a pandemic response considered was to decrease health impacts including severe morbidity and death; secondary pandemic response goals included minimizing societal and economic impacts. However, as other sectors are increasingly engaged in pandemic planning, additional considerations may arise. The advisory committee reports explicitly acknowledge the importance of this, for example highlighting the priority for protecting critical components of the military. Finally, HHS has recently initiated outreach to engage the public and obtain a broader perspective into decisions on priority groups for pandemic vaccine and antiviral drugs. Though findings of the outreach are preliminary, a theme that has emerged is the importance of limiting the effects of a pandemic on society by preserving essential societal functions.

Based on this guidance, state, local, and tribal implementation plans should be developed to 1) include more specific definitions of the priority groups (e.g., which functions are indeed critical to maintaining continuity) and their size; 2) define how persons in these groups will be identified; and 3) establish strategies for effectively and equitably delivering vaccines and antiviral drugs to these populations. The committees acknowledged that further work is needed, in particular, to identify the functions that must be preserved to maintain effective services and critical infrastructures and to identify the groups that should be protected to achieve this goal. The committees also acknowledge that the specific composition of some priority groups may differ between states or localities based on their needs and that priority groups should be reconsidered when a pandemic occurs and information is obtained on its epidemiology and impacts.

On July 19, 2005, ACIP and NVAC voted unanimously in favor of the vaccine priority recommendations summarized in Table D-1. These votes followed deliberations of a joint Working Group of the two committees, which included as consultants representatives of public and private sector stakeholder organizations and academic experts. There was limited staff level participation from DoD, DHS, and VA. Several ethicists also served as consultants to the Working Group.

A. Critical assumptions

The recommendations summarized in Table D-1 were based on the following critical assumptions:

- Morbidity and mortality. The greatest risk of hospitalization and death—as during the 1957 and 1968 pandemics and annual influenza—will be in infants, the elderly, and those with underlying health conditions. In the 1918 pandemic, most deaths occurred in young adults, highlighting the need to reconsider the recommendations at the time of the pandemic based on the epidemiology of disease.

- Healthcare system. The healthcare system will be severely taxed if not overwhelmed due to the large number of illnesses and complications from influenza requiring hospitalization and critical care. CDC models estimate increases in hospitalization and intensive care unit demand of more than 25% even in a moderate pandemic.

- Workforce. During a pandemic wave in a community, between 25% and 30% of persons will become ill during a 6 to 8 week outbreak. Among working-aged adults, illness attack rates will be lower than in the community as a whole. A CDC model suggests that at the peak of pandemic disease, about 10% of the workforce will be absent due to illness or caring for an ill family member. Impacts will likely vary between communities and work sites and may be greater if significant absenteeism occurs because persons stay home due to fear of becoming infected.

- Critical infrastructure. Only limited information was available from which to assess potential impacts on critical infrastructure sectors such as transportation and utility services. Because of changes in business practices and the complexity of networks, information from prior pandemics was not considered applicable.

- Vaccine production capacity. The U.S.-based vaccine production capacity was assumed at 3 to 5 million 15 µg doses per week with 3 to 6 months needed before the first doses are produced. Two doses per person were assumed to be required for protection. Subsequent results of an NIH clinical trial of influenza A (H5N1) vaccine suggest that higher doses of antigen will be needed to elicit a good immune response; thus, the assumptions made by the committee could potentially substantially exceed the amount of vaccine that would be produced.

Table D-1: Vaccine Priority Group Recommendations*

Tier	Subtier	Population	Rationale
1	A	• Vaccine and antiviral manufacturers and others essential to manufacturing and critical support (~40,000) • Medical workers and public health workers who are involved in direct patient contact, other support services essential for direct patient care, and vaccinators (8-9 million)	• Need to assure maximum production of vaccine and antiviral drugs • Healthcare workers are required for quality medical care (studies show outcome is associated with staff-to-patient ratios). There is little surge capacity among healthcare sector personnel to meet increased demand
	B	• Persons > 65 years with 1 or more influenza high-risk conditions, not including	• These groups are at high risk of hospitalization and death. Excludes

		essential hypertension (approximately 18.2 million) • Persons 6 months to 64 years with 2 or more influenza high-risk conditions, not including essential hypertension (approximately 6.9 million) • Persons 6 months or older with history of hospitalization for pneumonia or influenza or other influenza high-risk condition in the past year (740,000)	elderly in nursing homes and those who are immunocompromised and would not likely be protected by vaccination
	C	• Pregnant women (approximately 3.0 million) • Household contacts of severely immunocompromised persons who would not be vaccinated due to likely poor response to vaccine (1.95 million with transplants, AIDS, and incident cancer x 1.4 household contacts per person = 2.7 million persons) • Household contacts of children <6 month olds (5.0 million)	• In past pandemics and for annual influenza, pregnant women have been at high risk; vaccination will also protect the infant who cannot receive vaccine. • Vaccination of household contacts of immunocompromised and young infants will decrease risk of exposure and infection among those who cannot be directly protected by vaccination
	D	• Public health emergency response workers critical to pandemic response (assumed one-third of estimated public health workforce=150,000) • Key government leaders	• Critical to implement pandemic response such as providing vaccinations and managing/monitoring response activities • Preserving decision-making capacity also critical for managing and implementing a response
2	A	• Healthy 65 years and older (17.7 million) • 6 months to 64 years with 1 high-risk condition (35.8 million) • 6-23 months old, healthy (5.6 million)	• Groups that are also at increased risk but not as high risk as population in Tier 1B
	B	• Other public health emergency responders (300,000 = remaining two-thirds of public health work force) • Public safety workers including police, fire, 911 dispatchers, and correctional facility staff (2.99 million) • Utility workers essential for maintenance of power, water, and sewage system functioning (364,000) • Transportation workers transporting fuel, water, food, and medical supplies as well as public ground public transportation (3.8 million) • Telecommunications/IT for essential network operations and maintenance (1.08	• Includes critical infrastructure groups that have impact on maintaining health (e.g., public safety or transportation of medical supplies and food); implementing a pandemic response; and on maintaining societal functions

	million)	
3	• Other key government health decision-makers (estimated number not yet determined) • Funeral directors/embalmers (62,000)	• Other important societal groups for a pandemic response but of lower priority
4	• Healthy persons 2-64 years not included in above categories (179.3 million)	• All persons not included in other groups based on objective to vaccinate all those who want protection

*The committee focused its deliberations on the U.S. civilian population. ACIP and NVAC recognize that Department of Defense needs should be highly prioritized. DoD Health Affairs indicates that 1.5 million service members would require immunization to continue current combat operations and preserve critical components of the military medical system. Should the military be called upon to support civil authorities domestically, immunization of a greater proportion of the total force will become necessary. These factors should be considered in the designation of a proportion of the initial vaccine supply for the military.

Other groups also were not explicitly considered in these deliberations on prioritization. These include American citizens living overseas, non-citizens in the U.S., and other groups providing national security services such as the border patrol and customs service.

B. Definitions and rationales for priority groups

1. **Healthcare workers and essential healthcare support staff**

a) Definition

Healthcare workers (HCW) with direct patient contact (including acute-care hospitals, nursing homes, skilled nursing facilities, urgent care centers, physician's offices, clinics, home care, blood collection centers, and EMS) and a proportion of persons working in essential healthcare support services needed to maintain healthcare services (e.g. dietary, housekeeping, admissions, blood collection center staff, etc.). Also included are healthcare workers in public health with direct patient contact, including those who may administer vaccine or distribute influenza antiviral medications, and essential public health support staff for these workers.

b) Rationale

The pandemic is expected to have substantial impact on the healthcare system with large increases in demand for healthcare services placed on top of existing demand. HCW will be treating influenza-infected patients and will be at risk of repeated exposures. Further, surge capacity in this sector is low. To encourage continued work in a high-exposure setting and to help lessen the risk of healthcare workers transmitting influenza to other patients and HCW family members, this group was highly prioritized. In addition, increases in bed/nurse ratios have been associated with increases in overall patient mortality. Thus, substantial absenteeism may affect overall patient care and outcomes.

2. **Groups at high risk of influenza complications**

a) Definition

Persons 2-64 years with a medical condition for which influenza vaccine is recommended and all persons 6-23 months and 65 years and older. Excludes nursing home residents and severely immunocompromised persons who would not be expected to respond well to vaccination.

b) Rationale

These groups were prioritized based on their risk of influenza-related hospitalization and death and also their likelihood of vaccine response. Information from prior pandemics was used whenever possible, but information from interpandemic years was also considered. Nursing home residents and severely immunocompromised persons would be prioritized for antiviral treatment and/or prophylaxis and vaccination of healthcare workers and household contacts who are most likely to transmit influenza to these high risk groups.

3. **Critical infrastructure**

a) Definitions and rationale

Those critical infrastructure sectors that fulfill one or more of the following criteria: have increased demand placed on them during a pandemic, directly support reduction in deaths and hospitalization; function is critical to support the healthcare sector and other emergency services, and/or supply basic necessities and services critical to support of life and healthcare or emergency services. Groups included in critical infrastructure are needed to respond to a pandemic and to minimize morbidity and mortality, and include the following sectors:

- Persons directly involved with influenza vaccine and antiviral medication manufacturing and distribution and essential support services and suppliers (e.g., growers of pathogen-free eggs for growth of vaccine virus) production activities
- Key government leaders and health decision-makers who will be needed to quickly move policy forward on pandemic prevention and control efforts
- Public safety workers (firefighters, police, and correctional facility staff, including dispatchers) are critical to maintaining social functioning and order and will contribute to a pandemic response, for example by ensuring order at vaccination clinics and responding to medical emergencies
- Utility service workers (water, power, and sewage management) are prioritized as the services they provide are also essential to the healthcare system as well as to preventing additional illnesses from lack of these services unrelated to a pandemic.
- Transportation workers who maintain critical supplies of food, water, fuel, and medical equipment and who provide public transportation, which is essential for provision of medical care and transportation of healthcare workers to work and transportation of ill persons for care
- Telecommunication and information technology services critical for maintenance and repairs of these systems are also essential as these systems are now critical for accessing and delivering medical care and in support of all other critical infrastructure
- Mortuary services will be substantially impacted due to the increased numbers of deaths from a pandemic and the fact that impact will be high in the elderly, a growing segment of the population

4. **Public health emergency response workers**

a) Definition

This group includes persons who do not have direct patient care duties, but who are essential for surveillance for influenza, assessment of the pandemic impact, allocation of public health resources for the pandemic response, development and implementation of public health policy as part of the response, and development of guidance as the pandemic progresses.

b) Rationale

Persons in this sector have been critical for past influenza vaccine pandemics and influenza vaccine shortages and little surge capacity may be available during a public health emergency such as a pandemic.

5. **Persons in skilled nursing facilities**

a) Definition

Patients residing in skilled nursing facilities. Not included in this group are persons in other residential settings (e.g., assisted living) who are more likely to be mobile, in a setting that is less closed, and have decentralized healthcare.

b) Rationale

This group was not prioritized for vaccine because of the medical literature finding poor response to vaccination and occurrence of outbreaks even in the setting of high vaccination rates. Other studies have suggested that vaccination of healthcare workers may be a more effective strategy to prevent influenza in this group. Further, surveillance for influenza can be conducted in this group and antiviral medications used widely for prophylaxis and treatment. Ill visitors and staff should also be restricted from visiting nursing home facilities during outbreaks of pandemic influenza. This strategy for pandemic influenza vaccine differs from the interpandemic vaccination strategy of aggressively vaccinating nursing home residents. The rationale considers several factors: 1) these populations are less likely to benefit from vaccine than other groups who are also at high risk; 2) other prevention strategies feasible for this group are not possible among other high-risk groups; 3) the overall morbidity and mortality from pandemic is likely to severely impact other groups of persons who would be expected to have a better response to the vaccine; and 4) a more severe shortage of vaccine is anticipated.

6. **Severely immunocompromised persons**

a) Definition

Persons who are undergoing or who have recently undergone bone marrow transplantation and others with severe immunodeficiency (e.g., AIDS patients with CD4 counts <50, children with SCID syndrome, recent bone marrow transplant patients). The numbers of persons in these categories is likely much smaller than the anticipated number assumed in tiering above, but sources for more specific estimates have not been identified.

b) Rationale

These groups have a lower likelihood of responding to influenza vaccination. Thus, strategies to prevent severe influenza illness in this group should include vaccination of healthcare workers and

household contacts of severely immunocompromised persons and use of antiviral medications. Consideration should be given to prophylaxis of severely immunocompromised persons with influenza antivirals and early antiviral treatment should they become infected.

7. **Children <6 months of age**

a) Rationale

Influenza vaccine is poorly immunogenic in children <6 months and the vaccine is currently not recommended for this group. In addition, influenza antiviral medications are not FDA-approved for use in children <1 year old. Thus, vaccination of household contacts and out-of-home caregivers of children <6 months is recommended to protect this high-risk group.

C. Other discussion

There was substantial discussion on priority for children. Four potential reasons were raised for making vaccination of children a priority:

- At the public engagement session, many participants felt that children should have high priority for vaccination.
- Children play a major role in transmitting infection, and vaccinating this group could slow the spread of disease and indirectly protect others.
- Children have strong immune systems and will respond well to vaccine whereas vaccination of the elderly and those with illnesses may be less effective.
- Some ethical frameworks would support a pediatric priority.

ACIP and NVAC did not make children a priority (other than those included in tiers, because of their underlying diseases [Tiers 1B and 2A] or as contacts of high-risk persons [Tier 1C]) for several reasons:

- Healthy children have been at low risk for hospitalization and death in prior pandemics and during annual influenza seasons.
- It is uncertain whether vaccination of children will decrease transmission and indirectly protect others. Studies that show this impact or mathematical models that predict it rely on high vaccination coverage that may not be possible to achieve given limited supplies in a pandemic.
- The committees recognize that this is an area for further scientific work; that children may be a good target population for live-attenuated influenza vaccine (FluMist®) if it is available; and that education of the public will be needed to provide the rationale for the recommendations.

NVAC RECOMMENDATIONS ON PANDEMIC ANTIVIRAL DRUG USE

On July 19, 2005, NVAC voted unanimously in favor of the antiviral drug use priority recommendations described here and summarized in Table D-2. These votes followed deliberations of a Working Group, which included as consultants representatives of public and private sector stakeholder organizations and academic experts. There was limited staff level participation from DoD, DHS, and VA. Several ethicists also served as consultants to the Working Group.

The recommendations were made considering pandemic response goals, assumptions on the impacts of a pandemic, and after thorough review of past pandemics, annual influenza disease, data on antiviral drug impacts, and recommendations for pandemic vaccine use.

Recommendations were made to guide planning needed for effective implementation at state and local levels. The committee recognizes that recommendations will need to be reconsidered at the time of a pandemic when information on the available drug supply, epidemiology of disease, and impacts on society are known.

The committee considered the primary goal of a pandemic response to decrease health impacts including severe morbidity and death. Minimizing societal and economic impacts were considered secondary and tertiary goals.

A. Critical assumptions

Assumptions regarding groups at highest risk during a pandemic and impacts on the healthcare system and other critical infrastructures are the same as those underlying the vaccine priority recommendations. Additional assumptions specific for antiviral drugs included:

- Treatment with a neuraminidase inhibitor (oseltamivir [Tamiflu®] or zanamivir [Relenza®]) will be effective in decreasing risk of pneumonia, will decrease hospitalization by about half (as shown for interpandemic influenza), and will also decrease mortality.
- Antiviral resistance to the adamantanes (amantadine and rimantadine) may limit their use during a pandemic.
- The primary source of antiviral drugs for a pandemic response will be the supply of antiviral drugs that have been stockpiled. Before annual influenza seasons about 2 million treatment courses of oseltamivir are available in the U.S. U.S.-based production of oseltamivir is being established; expected capacity is projected at about 1.25 million courses per month.
- Treating earlier after the onset of disease is most effective in decreasing the risk of complications and shortening illness duration. Generally, treatment should be given within the first 48 hours.
- Assumptions for the amount of antiviral drug needed for defined priority groups is based on the population in those groups and assumptions that 35% of persons in the priority groups will have influenza-like illness and 75% will present within the first 48 hours and be eligible for treatment. For persons admitted to the hospital, the committee assumed that 80% would be treated, as the 48-hour limit may sometimes be relaxed in more ill patients.
- Unlike vaccines, where each tier would be protected in turn as more vaccine is produced, for antiviral drugs, the number of priority groups that can be covered would be known at the start of the pandemic based on the amount of drug that is stockpiled. Additional supply that would become available during the pandemic could provide some flexibility.

Table D-2: Antiviral Drug Priority Group Recommendations*

	Group	Estimated population (millions)	Strategy**	# Courses (millions)		Rationale
				For target group	Cumulative	
1	Patients admitted to hospital***	10.0	T	7.5	7.5	Consistent with medical practice and ethics to treat those with serious illness and who are most likely to

						die.
2	Health care workers (HCW) with direct patient contact and emergency medical service (EMS) providers	9.2	T	2.4	9.9	Healthcare workers are required for quality medical care. There is little surge capacity among healthcare sector personnel to meet increased demand.
3	Highest risk outpatients—immunocompromised persons and pregnant women	2.5	T	0.7	10.6	Groups at greatest risk of hospitalization and death; immunocompromised cannot be protected by vaccination.
4	Pandemic health responders (public health, vaccinators, vaccine and antiviral manufacturers), public safety (police, fire, corrections), and government decision-makers	3.3	T	0.9	11.5	Groups are critical for an effective public health response to a pandemic.
5	Increased risk outpatients—young children 12-23 months old, persons >65 yrs old, and persons with underlying medical conditions	85.5	T	22.4	33.9	Groups are at high risk for hospitalization and death.
6	Outbreak response in nursing homes and other residential settings	NA	PEP	2.0	35.9	Treatment of patients and prophylaxis of contacts is effective in stopping outbreaks; vaccination priorities do not include nursing home residents.
7	HCWs in emergency departments, intensive care units, dialysis centers, and EMS providers	1.2	P	4.8	40.7	These groups are most critical to an effective healthcare response and have limited surge capacity. Prophylaxis will best prevent absenteeism.
8	Pandemic societal responders (e.g., critical infrastructure groups as defined in the vaccine priorities) and HCW without direct patient contact	10.2	T	2.7	43.4	Infrastructure groups that have impact on maintaining health, implementing a pandemic response, and maintaining societal functions.

9	Other outpatients	180	T	47.3	90.7	Includes others who develop influenza and do not fall within the above groups.
10	Highest risk outpatients	2.5	P	10.0	100.7	Prevents illness in the highest risk groups for hospitalization and death.
11	Other HCWs with direct patient contact	8.0	P	32.0	132.7	Prevention would best reduce absenteeism and preserve optimal function.

*The committee focused its deliberations on the domestic U.S. civilian population. NVAC recognizes that Department of Defense (DoD) needs should be highly prioritized. A separate DoD antiviral stockpile has been established to meet those needs. Other groups also were not explicitly considered in deliberations on prioritization. These include American citizens living overseas, non-citizens in the U.S., and other groups providing national security services such as the border patrol and customs service.

**Strategy: Treatment (T) requires a total of 10 capsules and is defined as 1 course. Post-exposure prophylaxis (PEP) also requires a single course. Prophylaxis (P) is assumed to require 40 capsules (4 courses) though more may be needed if community outbreaks last for a longer period.

***There are no data on the effectiveness of treatment at hospitalization. If stockpiled antiviral drug supplies are very limited, the priority of this group could be reconsidered based on the epidemiology of the pandemic and any additional data on effectiveness in this population.

B. Definitions and rationale for draft priority groups

1. **Persons admitted to hospital with influenza infection**

a) Definition

Persons admitted to acute care facilities (traditional or non-traditional with a clinical diagnosis of influenza; laboratory confirmation not required). Excludes persons admitted for a condition consistent with a bacterial superinfection (e.g., lobar pneumonia developing late after illness onset) or after viral replication and shedding has ceased (e.g., as documented by a negative sensitive antigen detection test)

b) Strategy

Treatment within 48 hours of symptom onset.

c) Rationale

This group is at greatest risk for severe morbidity and mortality. Although there are no data to document the impacts of antiviral drug treatment among persons who already suffer more severe influenza illness, benefit is biologically plausible in persons with evidence of ongoing virally mediated pathology (e.g., diffuse pneumonia, ARDS). Providing treatment to those who are most ill is also consistent with standard medical practices, would be feasible to implement, and would be acceptable to the public.

d) Population size

The number of persons admitted to hospital in an influenza pandemic would vary substantially depending on the severity of the pandemic and on the ability to expand inpatient capacity, if needed.

e) Unresolved issues

More specific guidance should be provided to healthcare workers on implementing antiviral treatment, including when and when not to treat. In some persons with severe illness, the ability to take oral medication or its absorption may be important issues. For infants <1 year old admitted to hospital, decisions about whether to treat with antiviral drugs may depend on the child's age and potential risk versus benefit as the neuraminidase inhibitors are not licensed for use in infants. If possible, data on time from symptom onset to hospital admission, current use of antiviral drug treatment among inpatients, and its impacts should be collected during interpandemic influenza seasons.

2. **Healthcare workers and emergency medical service providers who have direct patient contact**

a) Definition

Persons providing direct medical services in inpatient and outpatient care settings. Includes doctors, nurses, technicians, therapists, EMS providers, laboratory workers, other care providers who come within 3 feet of patients with influenza, and persons performing technical support functions essential to quality medical care.

b) Strategy

Treatment within 48 hours of symptom onset.

c) Rationale

Maintaining high quality patient care is critical to reduce health impacts of pandemic disease and to prevent adverse outcomes from other health conditions that will present for care during the pandemic period. Treatment of healthcare providers will decrease absenteeism due to influenza illness and may decrease absenteeism from fear of becoming ill, given the knowledge that treatment can prevent serious complications of influenza. Good data exist documenting the impacts of early treatment on duration of illness and time off work, and on the occurrence of complications such as lower respiratory infections. Treating healthcare providers is feasible to implement, especially for inpatient care providers who can be provided drugs through the occupational health clinic. It also would be acceptable to the public, who would recognize the importance of maintaining quality healthcare and would understand that persons with direct patient contact are putting themselves at increased risk.

d) Population size

There are about 12.6 million persons designated as healthcare workers by the Bureau of Labor Statistics and about 820,000 EMS providers. Among HCWs, two-thirds are estimated to provide direct patient care services.

e) Unresolved issues

Further work is needed to hone definitions and estimate population sizes. Implementation issues include the approach to identifying healthcare providers who would be eligible for treatment and where the treatment would be provided, particularly for outpatient care providers.

3. **Outpatients at highest risk for severe morbidity or mortality from influenza infection**

a) Definition
The Advisory Committee on Immunization Practices defines groups at high risk (or increased risk) of complications from influenza infection during annual outbreaks based on age (6-23 months and >65 years) and underlying illnesses. Among this population of about 88 million persons, some can be identified who are at highest risk of severe disease and death. These include persons with hematopoetic stem cell transplants (HSCT) and solid organ transplants; those with severe immunosuppression due to cancer therapy or hematological malignancy; persons receiving immunosuppressive therapy for other illnesses (e.g., rheumatoid arthritis); persons with HIV infection and a CD4 count <200; persons on dialysis; and women who are in the second or third trimester of pregnancy.

b) Strategy
Treatment within 48 hours of symptom onset.

c) Rationale
Of the large group of persons who are at increased risk of severe disease or death from influenza, these groups represent the population at highest risk and who are least likely to be protected by vaccination. Studies show that neuraminidase inhibitor therapy decreases complications and hospitalizations from influenza in high-risk persons and one unpublished study shows a significant decrease in mortality among patients who have undergone a hematopoteic stem cell transplant.

d) Population size
About 150,000 persons have had an HSCT or solid organ transplant. Assuming that the period of severe immunosuppression after a cancer diagnosis lasts for 1 year, the population targeted with non-skin, non-prostate cancers would equal the incidence of about 1.35 million persons. Based on a birth cohort of 4.1 million, a 28-week risk period during the second and third trimesters, and an 8-week pandemic outbreak in a community, there would be about 400,000 pregnant women included in this risk group. Further work is needed to estimate the size of other immunosuppressed groups.

e) Unresolved issues
Specific definition of included groups and population sizes.

4. **Pandemic health responders, public safety workers, and key government decision-makers**

a) Definition
Public health responders include those who manufacture vaccine and antiviral drugs; persons working at health departments who are not included as healthcare workers; and those who would be involved in implementing pandemic vaccination or other response components. Public safety

workers include police, fire, and corrections personnel. Key government decision-makers include chief executives at federal, state, and local levels.

b) Strategy
Treatment within 48 hours of symptom onset.

c) Rationale
Preventing adverse health outcomes and social and economic impacts in a pandemic depend on the ability to implement an effective pandemic response. Early treatment of pandemic responders will minimize absenteeism and ensure that vaccination and other critical response activities can be maintained. Implementing early treatment for public health workers and vaccine manufacturers is feasible at workplace settings. Public safety workers prevent intentional and unintentional injuries and death, are critical to maintaining social functioning, and will contribute to a pandemic response, for example by ensuring order at vaccination clinics. A small number of decision-makers at federal, state, and local levels are needed to for an effective pandemic response.

d) Population size
An estimated 40,000 workers who produce pandemic vaccine and antiviral drugs in the U.S.; ~300,000 public health workers who would not be included in the HCW category; 3 million public safety workers; and a small number of government decision-makers.

e) Unresolved issues
Need to define the exact composition and size of this group.

5. **Outpatients at increased risk of severe morbidity or mortality from influenza**

a) Definition
For planning purposes, this group would include those currently designated as high-risk groups, except for those who have been categorized as being at highest-risk and included in a separate category. This increased-risk group includes persons 6-23 months and >>65 years old, or who have underlying illnesses defined by the ACIP as associated with increased risk. Definition of this group may change based on the epidemiology of the pandemic.

b) Strategy
Treatment within 48 hours of symptom onset.

c) Rationale
Early treatment has been shown to significantly decrease lower respiratory infections and to reduce the rate of hospitalization in elderly and high-risk populations. By extrapolation and based on the results of one small uncontrolled study, significant reductions of mortality can be expected as well. As these risk groups are familiar to the public given recommendations for annual vaccination, communication would be easy and acceptability high.

d) Population size
About 85.5 million persons are included in this group. Although all are at increased risk of annual

influenza compared with the healthy under-65 year old population, there are different levels of increased risk for severe complications and death within this category. Further stratification may be possible based on several parameters including number of underlying conditions; recent hospitalization for a high-risk condition, pneumonia, or influenza; and age.

e) Unresolved issues
Stratifying this group into those at greater and lesser risk may be important if antiviral supplies are limited. Implementing treatment will be challenging given that it should be provided at the initial point of care to accrue the greatest benefit from early therapy.

6. **Outbreak control**

a) Definition
Use of antiviral drugs to support public health interventions in closed settings where an outbreak of pandemic influenza is occurring.

b) Strategy
Treatment of cases and post-exposure prophylaxis of contacts (once daily antiviral medication for 10 days).

c) Rationale
Influenza outbreaks in nursing homes are associated with substantial mortality and morbidity. Nursing home residents also are less likely to respond to vaccination. Post-exposure prophylaxis has been shown to be effective in stopping influenza outbreaks in closed settings.

d) Population size
The number of outbreaks that may occur during a pandemic is unclear. Measures should be implemented to prevent outbreaks including limiting visitors, vaccination of staff, furloughing non-critical staff, and screening and exclusion for illnesses consistent with influenza.

e) Unresolved issues
Should this policy also be implemented in prisons or other settings where explosive spread of illness may occur but the risk for severe complications is not high?

7. **Healthcare workers in ER, ICU, EMS, and dialysis settings**

a) Definition
Includes all staff in these settings who are required for effective functioning of these health care units.

b) Strategy
Prophylaxis

c) Rationale
Optimally effective functioning of these units is particularly critical to reducing the health impacts of a pandemic. Prophylaxis will minimize absenteeism in these critical settings.

d) Population size
Need to obtain population estimates.

e) Unresolved issues
Population sizes

8. **Pandemic societal responders and healthcare workers who have no direct patient contact**

a) Definition
This group includes persons who provide services that must be sustained at a sufficient level during a pandemic to maintain public well-being, health, and safety. Included are workers at healthcare facilities who have no direct patient contact but are important for the operation of those facilities; utility (electricity, gas, water), waste management, mortuary, and some transport workers.

b) Strategy
Treatment within 48 hours of symptom onset.

c) Rationale
Maintaining certain key functions is important to preserve life and decrease societal disruption. Heat, clean water, waste disposal, and corpse management all contribute to public health. Ensuring functional transportation systems also protects health by making it possible for people to access medical care and by transporting food and other essential goods to where they are needed.

d) Population size
Within these broad categories, there are about 2 million workers at healthcare facilities who have no direct patient contact; 730,000 utility workers; 320,000 waste management workers; 62,000 in mortuary services; and 2.3 million in transportation. Not all occupations within these categories would be classified as pandemic societal responders. Estimates are that 35% of this population will develop illness and present within 48 hours of onset regardless of pandemic severity.

e) Unresolved issues
Need to stratify within these groups to identify who fills specific pandemic societal response functions and to assess whether those functions could still operate if a substantial proportion of the workforce became ill during a 6-8 week pandemic outbreak within a community. Implementation issues need to be addressed, especially with respect to how persons would be identified as falling within this priority group when presenting for treatment and where that treatment would be provided.

9. **Other outpatients**

a) Definition
Includes persons not in one of the earlier priority groups.

b) Strategy
Treatment within 48 hours of illness onset.

c) Rationale
Treatment reduces the risk of complications and mortality, reduces duration of illness and shortens time off work, and decreases viral shedding and transmission. If sufficient antiviral supplies are available, providing treatment to all who are ill achieves equity and will be most acceptable to the public.

d) Population size
There are an estimated 180 million persons who are not included in previously targeted groups.

e) Unresolved issues
Consider whether there are any strata that can be defined within this population.

C. Additional NVAC recommendations on antiviral drugs for pandemic influenza

In addition to recommendations for priority groups, NVAC unanimously adopted the following recommendations:

- Sufficient drugs should be stockpiled to address top priorities. NVAC recommends that the minimum stockpile size be about 40 million courses, allowing coverage of the top 7 priority groups.
- Oseltamivir should be the primary drug stockpiled, but some zanamivir also should be obtained as it is effective against some oseltamivir-resistant strains, may be preferred for treatment of pregnant women, and supporting two manufacturers enhances security against supply disruptions. Approximately 10% of the stockpile should be zanamivir if feasible and cost effective. No additional adamantanes should be stockpiled.
- Antiviral drugs can also be used as part of an international effort to contain an initial outbreak and prevent a pandemic. Use to slow disease spread early in a pandemic may be useful but requires large amounts of drug.
- Critical research should be conducted to support development and implementation of recommendations for pandemic influenza antiviral drug use, including:
  - Impact of treatment at hospital admission on outcome
  - Optimal treatment dose for H5N1 and other potential pandemic strains
  - Sensitivity and use of rapid diagnostic tests for H5N1 and other influenza strains with pandemic potential
  - Safety and pharmacokinetics of oseltamivir among infants <1 year old
  - Investigation of the impact of other drugs (new antiviral agents and other classes such as statins) on influenza
- Additional work with public and private sector groups should be done to further hone definitions of target groups and their estimated population sizes, and to provide further guidance on antiviral drug distribution and dispensing.

Last revised: May 15, 2007

APPENDIX D2

PROPHYLAXSIS WORKSHEET

PROPHYLAXIS WORKSHEET

❒ List and estimate the number of patients and healthcare personnel that may be targeted for influenza vaccinations or anti-viral prophylaxis has been developed.

- ✓ Number of first priority personnel _____ based upon availability.
- ✓ Number of second priority personnel _____ based upon availability.
- ✓ Number of remaining personnel _____ based upon availability.
- ✓ Number of first priority patients _____ based upon availability.
- ✓ Number of second priority patients _____ based upon availability.
- ✓ Number of immediate family members of employees _____ based upon availability.

APPENDIX D3

SECRETARY LEAVITT STATEMENT

United States Department of Health & Human Services

News Release

FOR IMMEDIATE RELEASE
Tuesday, April 17, 2007

Contact: HHS Press Office
(202) 690-6343

Statement by Mike Leavitt
Secretary of Health and Human Services
On the Approval of the First U.S. Vaccine for Humans Against the Avian Influenza Virus H5N1

The approval by the Food and Drug Administration (FDA) of the first U.S. H5N1 influenza vaccine for use in humans is a sign of progress in our ongoing efforts to protect the American people from a pandemic. We have the opportunity to be the first generation that prepares for a pandemic, and we are working to that meet that challenge.

To date, H5N1 avian influenza has remained primarily an animal disease, but should the virus acquire the ability for sustained transmission among humans, the potential for an influenza pandemic would have grave consequences for global public health. Pandemics happen, and we must minimize the impact of the next pandemic when it comes.

HHS has been making significant investments in vaccines, antivirals, and research. In 2006 we awarded $1 billion in contracts to develop cell-based vaccines against both seasonal and pandemic influenza with the goal of having sufficient domestic vaccine production capacity to vaccinate all Americans within six months of the declaration of a pandemic. Also, we are working on dose-sparing measures to enable us to produce more treatment courses for more people and are developing a library of live virus vaccine candidates against all known influenza strains with pandemic potential. In addition, we have developed rapid diagnostic testing for H5 strains that shorten testing time. We have also developed community mitigation strategies should a pandemic break out and continue to encourage vigorous state and local planning.

Today's announcement is the result of a collaborative effort between FDA and the National Institutes of Health, which funded the vaccine research through its National Institute of Allergy and Infectious Diseases. To date, HHS has purchased 13 million doses of this vaccine, enough to cover 6.5 million people.

It is our collective resources and cooperation that will help make our pandemic preparedness efforts succeed and position us to better prepared tomorrow than we are today.

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APPENDIX D4

SAMPLE STANDING ORDERS

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Robert Wood Johnson University Hospital
at Rahway
865 Stone Street
Rahway, NJ 07065

PNEUMOCOCCAL & INFLUENZA EVALUATION & STANDING ORDER FORM

Apply Patient Sticker

Influenza vaccinations are offered October 1 through the end of February each year.
Pneumococcal Polysaccharide vaccinations are offered all year.

PATIENT EVALUATION CRITERIA

PNEUMOCOCCAL VACCINE

High Risk Patients – Criteria to Receive Vaccine

- ☐ Adults 65 years old or older
- ☐ Adults with chronic illness such as chronic cardiovascular disease (i.e., congestive heart failure or cardiomyopathies), chronic pulmonary disease (e.g., COPD or emphysema, but not asthma), diabetes mellitus, alcoholism, chronic liver disease (cirrhosis), or CSF leaks.
- ☐ Adults who have functional or anatomic aspleenia (e.g., sickle cell disease or splenectomy).
- ☐ Adults who have conditions associated with decreased immunological function (e.g., HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or organ or bone marrow transplantation).
- ☐ Adults receiving immunosuppressive therapy, including long-term systemic corticosteroids, chemotherapy, etc.

Exclusion Criteria PNEUMOCOCCAL VACCINE

Do not vaccinate patients who:

- ☐ Are less than 18 years old
- ☐ Are 18 to 64 years old and are not in a "high risk" category above
- ☐ Were previously vaccinated since they turned 65
- ☐ Have had a allergic and/or neurological reaction to pneumococcal polysaccharide vaccine
- ☐ Have a fever (38^0C/100.4^0F or above)
- ☐ Do not want to be immunized during their hospitalization

Patient Refusal Signature:_____

Reason:_____ Date:_____

INFLUENZA VACCINE (October 1 – March 1)

High Risk Patients – Criteria to Receive Vaccine

- ☐ Adults 50 years old or older
- ☐ Adults with chronic disorders of the pulmonary or cardiovascular system including asthma.
- ☐ Adults who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, blood dyscrasias, or immunosuppression (including immunosuppression caused by medications).

Exclusion Criteria INFLUENZA VACCINE

Do not vaccinate patients who:

- ☐ Are less than 18 years old
- ☐ Are 18 to 49 years old and are not in a "high risk" category above
- ☐ Have been immunized this season
- ☐ Are allergic to eggs or egg products
- ☐ Have a fever (38^0C/100.4^0F or above)
- ☐ Have a previous history of Guillain-Barre syndrome
- ☐ Are admitted between March and September
- ☐ Do not want to be immunized during their hospitalization

Patient Refusal Signature:_____

Reason:_____ **Date:**_____

- ☐ Exclusion criteria were not identified during admission and assessment of this patient. The vaccination(s) checked are to be given to the patient.
- ☐ **Influenza vaccine 0.5ml IM in deltoid prior to discharge if no exclusion criteria checked**
- ☐ **Pneumococcal Polysaccharide vaccine 0.5ml IM or SC prior to discharge if no exclusion criteria checked**

Evaluating RN Signature_____ Date:_____

This standing order authorizes Robert Wood Johnson University Hospital at Rahway nurses to administer the influenza vaccine to adults over 50 years of age and pneumococcal vaccine to adults 65 years of age or older and adults over 18 with chronic illness. The vaccine(s) will be given in accordance with current guidelines established by the Centers for Disease Control and Prevention. Influenza and pneumococcal vaccines may be administered at the same time, but in different sites.

pp/pneu/fluorder.doc

Appendix H: Standing Order for Seasonal Influenza Vaccine

STANDING ORDER FOR SEASONAL INFLUENZA VACCINE

Policy:
Patients with no contraindications will be allowed to have the annual Influenza vaccine.

Warnings/Contraindications:

1. History of allergies to egg products or previous Influenza immunizations.
2. Pregnant patients in their first trimester should consult their doctor first.
3. History of Guillian Barre Syndrome.

Procedure:

1. Patients will be asked about contraindications and those with confirmed contraindications will be referred to their family provider for advice on receiving the Influenza vaccine.
2. Those without contraindications will be given a CDC Vaccine Information Sheet dated for 2002-2003 and asked to sign the consent form.
3. The immunization will be given 0.5ml IM in one of the deltoid regions.
4. Patients will be observed for 15 minutes before leaving.
5. EpiPen 0.3mg auto-injector IM, prn anaphylaxis with immediate provider evaluation.
6. Acetaminophen is recommended for soreness at the sight of administration or for a low-grade fever after receiving the vaccine.

As Medical Director (or designee) of Franklin Memorial Hospital, I hereby authorize the FMH Employee Health Nurse/ designee, to administer the above vaccine according to the above policy and procedure.

Created: 11/02 Reviewed: 11/03,02/05

_____
Medical Director/Designee Signature

APPENDIX E I

SKILL ASSESSMENT TOOLS

8. Optimizing Deployment of the Health Workforce

> Doctors and nurses were what was needed. And especially nurses ... The Red Cross had divided the country into 13 divisions, and the nursing committee chief of each one has already been told to find all people with any nursing training, not only professionals or those who had dropped out of nursing schools but down to and including anyone who had ever taken a Red Cross course in caring for the sick at home.
>
> The Great Influenza, J.M. Barr

During an influenza pandemic, health care workers will be called upon to provide care for people who have influenza. They will also be asked to continue to maintain other health care services during a pandemic. But health care workers will also be affected by influenza. Based on the assumptions in this plan, at the peak of a pandemic wave as many as 20 to 25% of health care workers may be absent from work – either because of illness or because of caregiving responsibilities at home. When the demand for care will be greatest, the health system will be hard pressed to maintain its workforce.

To optimize the availability of health human resources (HHR) and to ensure patient-centred care during a pandemic, Ontario will take a competency-based approach to HHR planning. The objective of this section of the OHPIP is to explain competency-based HHR planning and its relevance to key stakeholders including local planners, health care providers, health regulatory colleges and volunteer agencies. Employers and unions may also find the section useful for planning. All sectors of the health care system must work together to plan a coordinated and comprehensive approach to optimizing the deployment of the health workforce during a pandemic.

There is some concern on the part of health care providers that they may be deployed without being part of the decision-making process. This is not the intent. OHPIP recognizes the role that self-regulating professions and their regulatory colleges play in determining competencies and establishing standards for safe care, as well as the role of unions in discussions about deploying health care workers and the need to respect collective agreements.

The framework for competency-based planning is a guide to a collaborative approach to deploying staff during a pandemic. In the proposed approach, health care planners and employers play a key role in identifying the competencies required during an influenza pandemic, while the professions and health care providers play a key role in assessing their competencies and determining how their knowledge and skills can best be used.

The framework described in this chapter and the tools included in Chapter 8A provide an opportunity for planners, providers and volunteers to participate in preparing for an influenza pandemic and to understand what is required to make competency-based HHR planning effective. They also provide a starting point for discussions which will lead to an integrated and coordinated HHR strategy.

The more detailed background papers and guides used to develop this chapter are available on request from the Emergency Management Unit, Ministry of Health and Long-Term Care.

8.1 Objectives

- To describe a competency-based approach to health human resources (HHR) planning.
- To identify the skills and competencies required to provide influenza care.
- To provide tools that planners can use to develop pandemic HHR plans.
- To provide tools that health care providers can use to assess skills.

8.2 Responsibility for HHR Planning

The competency-based approach to planning for pandemic influenza may be helpful for stakeholders planning in individual health care organizations, in the local community, within the Local Health Integration Networks (LHINs), and at the provincial level. HHR planning and staffing is usually done organization by organization. During a pandemic, each health care organization will continue to be responsible for managing its staff. However, as part of pandemic preparedness, the ministry recommends that key stakeholders work together at the local, regional and provincial levels to ensure that planning occurs across all care settings including: community and primary health care, emergency departments, acute care, long-term care, and critical care sites. Planning should occur in a bottom up fashion. This means that local planners would estimate the health human resources required to provide influenza care in all settings in their local planning area. They can then coordinate with regional and provincial planners to determine how to make the most effective use of available people and skills.

Engaging the workforce leadership (i.e., regulatory colleges, professional associations, unions) in discussions about the competencies required to deliver care in a pandemic can help establish inter-disciplinary teams that can react quickly during a crisis.

8.3 A Competency-based Approach for Planners

Competencies are defined as the skills, knowledge and judgment required to deliver a particular health service. A competency-based approach identifies the competencies required and the competencies available to deliver the services that people need during an influenza pandemic.

The planning activities involved in this approach include both quantitative and qualitative data collection. Quantitative data would include information on such items as population size, attack rates and the number of providers available. Qualitative information would come from key informant interviews or focus group discussions with workforce leadership on the following:

- Are there non-registered providers (e.g., retirees) in our planning area who could be registered expeditiously?
- How can we get those providers who are in administration and research back into patient care?
- How do we shift part-time workers to full-time workers?
- What are the competencies of these providers?
- What is their level of productivity?

This approach is intended to increase the care capacity available for a large number of influenza patients by making strategic use of the competencies of all available health care providers, students, and volunteers. With

this approach, planners consider the competencies rather than the professions required to meet the needs of the population. This may allow for more staffing options given the range of different professionals who may be able to provide the required competencies during a crisis.

For example, if the emergency department (ED) triage nurses are suddenly unavailable due to illness during a pandemic, how would a hospital administrator know what other nurses might have the competencies to provide ED triage? One way could be to have hospital staff complete a skills/ competencies self-assessment survey, which might reveal that several nurses working in other capacities in the hospital have taken nursing triage courses or are military reservists with experience working in combat situations in the triage capacity. Another alternative would be to offer training in triage to other emergency and step down staff before a pandemic begins.

One of the goals of a competency-based approach to workforce deployment is to free up those health professionals who are specially trained and competent in influenza care to focus on those patients who are in greatest need.

Competencies by Setting

Different care settings provide different types and levels of service and, therefore, require different competencies. Different health care providers also have different levels of competencies. Planners use this information to find effective ways to address the "gap" in competencies (i.e., the difference between the competencies required and competencies supplied) by identifying people who have or could be quickly trained to provide those competencies such as: health care providers, students, volunteers and others. During the interpandemic period, planners are encouraged to engage workforce leaders in conversations to develop the appropriate provider networks and "up-skilling" training programs.

In the competency-based approach, planners attempt to answer two key questions:

- What is the spectrum of competencies required to meet the needs of patients in each care setting?
- What competencies can be supplied by providers in that planning area?

To answer these questions in terms of influenza care, planners will: estimate the number of influenza patients by care setting (i.e., using sample numbers provided by "FluSurge" or "FluAid"); identify the services provided in those settings and the competencies required to provide those services; and identify the professions who can deliver those competencies. With this information, planners can then think beyond traditional credential-based silos and consider a broader range of staffing options to meet the population's health needs.

***Note**: this section focuses on HHR planning for influenza care only. Health care settings and regions will also have to plan for the HHR required to maintain other essential health services during an influenza pandemic.*

8.4 Influenza Care Competencies

To provide care for people with influenza, different health care settings will require different competencies depending on the type of services they provide. See Chapter 8A: Health Human Resources Tools for a comprehensive list of influenza care competencies – that is, the competencies the health care system requires to provide care for people with influenza – organized into the following categories:

- administrative support
- transportation
- education
- infection control
- care services.

8.5 Influenza Competencies Required

As Figure 8.1 illustrates, the mix and quantity of influenza care competencies (ICCs) an individual health care setting or a geographic area will require during an influenza pandemic will depend on:

- the size and mix of population served in the setting or area (demographics)
- health status, attack rate, mortality, and morbidity (epidemiology of the virus)
- the type and level of service provided in the care setting or area
- the competencies required to provide that type and level of service.

For more detailed information on how to assess these factors, see *Key Questions for Planners* in a competency-based HHR approach in Chapter 8A: Health Human Resources Planning Tools.

Planners would use the information on available competencies to deploy staff to meet needs. If – after redeployment of existing staff – there is still a gap between the competencies required and the competencies available, planners would then look beyond the current workforce (e.g., students, retired health care providers, people with some first aid or other training, volunteers).

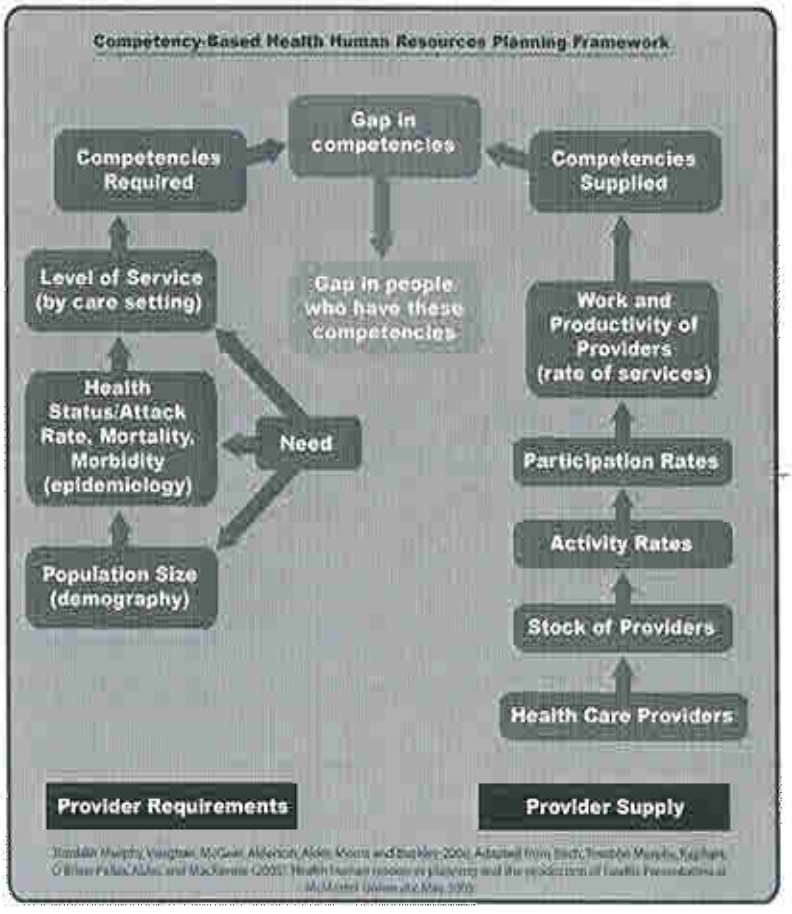
It is also important to note that the most useful means of extending the human resources available is not by identifying staff with competence for individual acts.

In order to be useful in teams providing care, staff will need to be able to perform several of the competencies.

Assessment Competencies

Many competencies are needed to provide care to influenza patients; however, the most important competencies, and those which will be most difficult to supply, are the competencies to assess patient status, to develop a care plan for the patient, to identify whether additional care is needed, and to determine whether the patient can be discharged from the care site. These competencies are also the most difficult to assess.

Figure 8.1: Competency-Based Health Human Resources Planning Framework



8.6 Identifying Competencies Available

As Figure 8.1 also illustrates, the influenza care competencies available to the setting (i.e., from existing providers) will depend on:

- the number and mix of health care providers in the setting or area
- their productivity – which is a function of the stock of providers and their activity and participation rates (i.e., how many hours they work and how much care they can deliver).

To prepare for an influenza pandemic, health care settings and/or local planners need information on the number of health care providers available and their competencies. See Chapter 8A: Health Human Resources Planning Tools for Key Questions for Planner on Provider Supply.

The tools chapter also includes a self-assessment tool developed to help health care providers reflect on their own abilities and competencies to provide care during an influenza pandemic. Planners may be able to collaborate with their workforce to use this tool to help quantify the competencies available.

To understand the actual amount of influenza care the existing workforce can provide; planners would then have to take into account the number of providers and the hours they work – as well as the potential 20% or higher absenteeism rates that are likely to occur at the peak of the first pandemic wave.

When considering the competencies available, health care settings may also contact and include recently retired employees, part-time employees who might be willing to work more hours during a pandemic and students. As part of HHR planning, employers are encouraged to talk to staff and other health care providers about the province's pandemic plan and to discuss how health care workers can contribute to both the planning process and pandemic response.

8.7 Health Care Providers' Role in Identifying Competencies

Health care providers and their professional colleges and associations will play a crucial role in optimizing the deployment of the health workforce during a pandemic. Health care providers and their regulatory colleges can assist in identifying competencies, determining the types of care that individuals can safely provide, and ensuring that health care providers do not end up in situations that are beyond their knowledge and skills.

To give individual health care providers an opportunity to reflect on their own ability to assist during a pandemic, Ontario has developed a self-assessment tool made up of two major components:

- **Part I** is an assessment of personal abilities as they relate to influenza care and to the health care provider's own professional and personal circumstances.
- **Part II** is an *RHPA* Controlled Act/ICCs Decision Tree that places ICCs within the regulatory context and provides an accessible overview of certain key questions and consequences in assessing abilities to assist in an influenza pandemic.

The self-assessment tool attempts to be as inclusive as possible recognizing that individual circumstances will vary depending upon the profession, the practice setting and the nature of the professional practice of the heath care provider. A resources handbook is available to guide

health care providers wishing to assist in the pandemic response.

8.8 Matching Competencies

Once employers/planners have an understanding of the influenza care competencies required as well as the competencies of existing staff, they will go through a matching process to determine whether they will have the right mix and amount of competencies to meet needs in each setting during a pandemic.

Many influenza care competencies (e.g., administrative support) can be provided by a variety of people from volunteers to regulated health professionals; some can only be provided by people with specific training or skills.

When matching competencies, planners and health care providers must work within the legislative framework for health care in Ontario: the RHPA specifies a number of controlled acts (or health care procedures) which are authorized ONLY to specific professions (see Chapter 8A: Health Human Resources Planning Tools) – although being in a certain profession doesn't necessarily mean that an individual has the necessary skill, education or experience to perform the controlled act safely and competently. For example, a physician who has practiced only psychiatry for the last 20 years may not be competent to intubate even though intubation is within the scope of practice of a physician. This reinforces the value of a competency-based rather than credential or profession-based approach to deploying the health workforce during a pandemic.

While any controlled act may be delegated by someone authorized to perform that act to another regulated health professional or non-regulated person, the ability to use delegation as a way to provide more care is often limited by profession specific standards of practice (e.g., a health care worker who feels he or she cannot perform the act safely can refuse to do so) and institutional rules that may prohibit delegation.

In addition to the restrictions placed on health care professions by the *RHPA*, regulatory college regulations, institutional rules, or their own self assessment of their skills, there are other legislative limitations. For example, under Regulation 965 of the *Public Hospitals Act*, only a physician can order tests and treatment for hospital in-patients and outpatients while Registered Nurses in the Extended Class can only order tests and treatment for outpatients of the hospital.

Even when influenza care competencies are not controlled acts, they may require a certain level of education, training and judgement to be done effectively. For example, "assessment" and a number activities associated with assessment -- such as taking a pulse, blood pressure measurement, assessing breathing or skin colour -- are not controlled acts, but people doing these activities must have the skill to interpret the results. Some activities can only be performed by a person who holds an appropriate registration/license to do so (e.g., registration with the College of Physicians and Surgeons of Ontario).

Given these restrictions and limitations, Chapter 8a: Health Human Resources Planning Tools sets out the influenza care competencies that are in the public domain as well as those that require more skills or are controlled acts.

8.9 Structuring Care to Make Effective Use of Provider Competencies

Health care settings can structure care in a number of ways that allow them to make

the most effective use of provider skills. For example, they can:

- use detailed care plans and algorithms – which rely more on set patterns of care rather than the judgement of the health care worker
- have experienced staff supervise less experienced staff (i.e., designing care to be delivered in "teams" or "pods") – which also provides the greatest support to providers working in extended or new roles
- use a "cascade" system for deploying resources – that is, as resources need to be extended, moving staff whose competencies require the least supplementation to take on new/different roles. For example, the triage role in the emergency department requires the highest level of competence in initial assessment and is usually provided by a subset of emergency nurses. As triage resources become stretched, the setting would first move other emergency nurses into this role, followed by nurses from in-patient units who have assessment/ED technical skill capacity being moved from in-patient units into the ED – who would be replaced in the inpatient units by student/retired nurses.
- differentiate between the competencies required to assess patients and the competence to discharge patients from the particular care site: referring to a "more competent" practitioner provides a safety net.

Chapter 8A includes an example of one approach to using competency assessments to create teams of care providers for different care settings. In this framework, providers are generally categorized as support providers, assessment providers, and decision-makers.

- Support providers are those who can provide some, but not all, of the technical skills. They are not sufficiently competent to assess the overall status of the patient.
- Assessment providers may or may not be able to provide all of the technical skills, but they have the competency to assess the status of the patient, and provide a care plan for some, but perhaps not all, patients. They can recognize when patients need additional care, but do not have the competence to discharge patients from the care setting.
- Decision-maker providers are those with the competence to assess all patients in the care setting, make final decisions regarding care plans, and discharge patients.

This framework also has some relatively specialized functions: telephone triage of patients, emergency department triage of patients, provision of psychosocial support and rehabilitation, and discharge planning

8.10 The Role of Volunteers

When planners identify a gap between the influenza care competencies required and those available from existing health care providers, they will have to look beyond their traditional workforce for assistance.

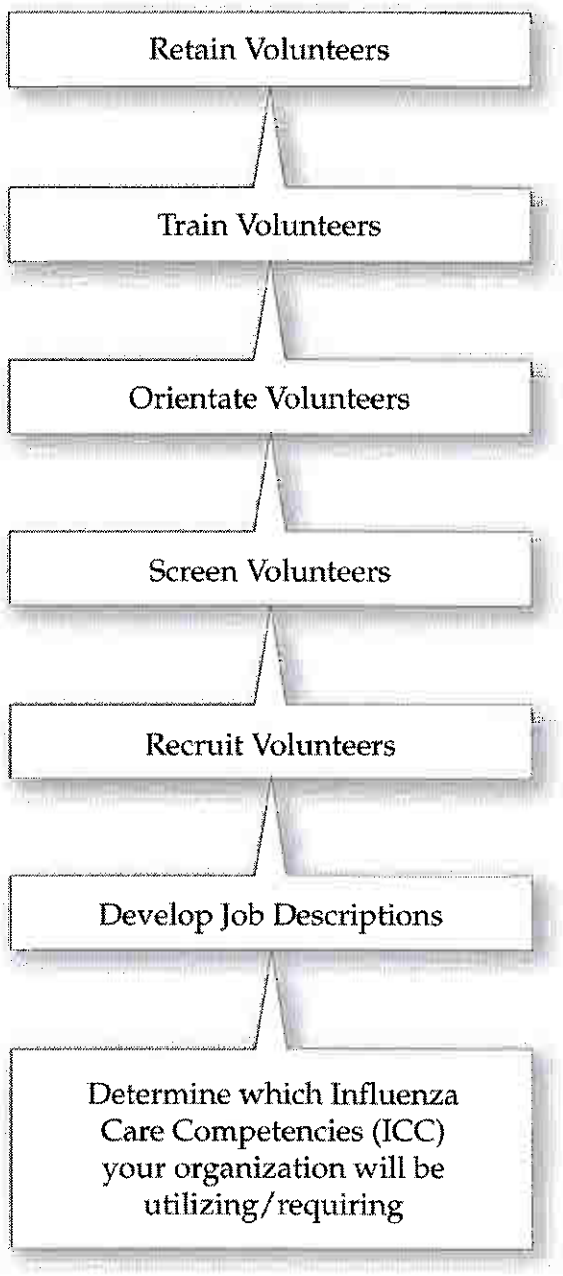
Volunteers provided valuable assistance in past pandemics and in other emergency situations. For example, in the 1918 pandemic, a doctor in Ottawa, Ontario, provided a two-day course and trained hundreds of women to help care for people at home. Organizations like the Red Cross and St. John's Ambulance also provided much needed medical personnel and administrative support. In just the last few years, volunteers played key roles in

responding to Hurricane Katrina and the tsunami. Past experience offers valuable lessons on how to plan for and use volunteers, including:

- Integrate local volunteer organizations early into the planning process – before a pandemic occurs.
- Develop effective working relationships/partnerships with local chapters rather than national organizations.
- Develop effective communication among volunteer groups, governments, local communities and other stakeholders.

Figure 8.2 illustrates the steps in planning for the use of volunteers during an influenza pandemic.

Figure 8.2: Steps in Planning for the use of Volunteers during an Influenza Pandemic



Identify Roles for Volunteers

To identify roles for volunteers, health care setting/planners will consider the following questions:

- Which influenza care competencies can be done by volunteers?
- Are there tasks currently performed by health care staff that could be done by volunteers during a pandemic?

Based on that assessment, the health care setting can develop job descriptions that will clearly lay out the roles and responsibilities, as well as the knowledge and skills required (see sample in the Chapter 8A.)

Recruit and Screen Volunteers

Planners may consider recruiting volunteers from a number of sources including:

- the organization's existing volunteers
- organizations who employ people with some health care training or skills (e.g., Red Cross, St. John Ambulance)

- volunteer centres in the community
- family members of residents (i.e., in long-term care homes)
- high schools, colleges and universities
- faith-based organizations.

The local pandemic planning committee may consider establishing a central clearinghouse for volunteers that would help recruit, orient and train volunteers as required for all care settings in the community. They may allow for more efficient use of volunteer resources during a pandemic.

A central mechanism for recruiting volunteers could also be responsible for screening volunteers. While it is possible to do a detailed screening of volunteers before a pandemic, once an emergency exists, this will be more difficult. Screening will likely consist of an application form (see Tools section) that collects some of the information required to meet legal (e.g., Child and Family Services Act, Safe Schools Act, Long-Term Care Act) and liability requirements, as well as other procedures, such as:

- interviews
- medical checks
- reference checks
- police record checks
- specialized testing
- orientation/training/probation
- buddy system
- regular supervision/evaluation
- unannounced spot checks.

Health care settings would give some thought to how they will manage screening and other volunteer activities during a pandemic. Here are some questions to consider:

- If a volunteer does not have the necessary competencies can training be provided to bring them up to the appropriate level?
- Are there any conditions that will automatically disqualify a volunteer from the position?
- If a volunteer is disqualified for one position, can they be used in another?
- Can your organization's screening protocols be modified to fit the context of a pandemic?
- Could a third party assist in screening volunteers?
- Who will develop and apply the screening process?
- Will you apply the process to current volunteers and those starting with the organization, or will you apply the process to only episodic volunteers present during the pandemic?
- Can the cost of some screening processes (e.g., a criminal record check be waived during an influenza pandemic)?

Orient and Train Volunteers

Volunteers will require effective orientation to the health care setting and training for their duties. During a pandemic, orientation programs will be less detailed. They should include:

- an overview of influenza
- a description of the volunteer position/s – with a written job description
- information volunteers need about the facility, patients and setting
- a volunteer orientation manual (if available).

Training may also have to be more focused than in a non-pandemic situation; however, it should include:

- infection control practices and procedures
- the duties/tasks of the job
- any other information the volunteer requires to perform the task
- supervision
- how to cope with any fear, stress or grief associated with their work.

Depending on the demands on the health care setting, more experienced volunteers may be responsible for providing the orientation and training for new volunteers.

When planning volunteer orientation and training programs, health are settings will consider the following:

- Can existing training programs be modified for use in a pandemic?
- Can volunteers be trained in advance?
- Are there third party organizations that could provide some of the necessary training for your volunteers?
- Are there online resources that could be used for training?
- Will training be done before the volunteer starts the position or on the job?
- Can more experienced volunteers provide training/mentoring to incoming volunteers?

Retain Volunteers

Because of the likely shortage of workers during a pandemic, it will be crucial for health care setting to retain their volunteers. One of the best ways to keep volunteers is to ensure they are kept informed and supported in their roles. If volunteers feel that they are receiving all necessary information, they are less likely to succumb to fear and more likely to stay involved. When developing strategies to retain volunteers, consider the following:

- How do you currently communicate with your volunteers? How will you communicate during a pandemic?
- How will volunteers provide feedback express concerns during an influenza pandemic?
- What spiritual/emotional supports are available for volunteers during and post pandemic? Who will provide these supports?
- What volunteer recognition initiatives could be carried out during an influenza pandemic?
- How do you expect to counteract the fear the pandemic will cause?

See Chapter 8A: Health Human Resources Planning Tools for a list of Ontario Volunteer Centres.

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APPENDIX E2

HUMAN RESOURCE TOOLS

8A. Health Human Resources Planning Tools

Contents

Influenza Care Competencies

Domain	Competencies
A. Administrative/ Support	**a. Management/leadership/innovation:** i Ability to respond to crises, develop strategies for response ii Care site management (care clinic, immunization clinic, ED, home care): iii Organization, staffing, response to changing situations for particular setting, iv Assessment of staff competencies, and matching to needs, and v Scheduling and deployment: staff (physician, employees, and volunteers), beds, and sites. vi Succession and contingency planning, and vii Coordination of triage and rationing decisions, ethics. **b. Coordination of patient flow:** i Answering patient questions, and ii Receiving and directing patients. **c. Communication** i Coordination with other levels of care, public health ii Internal communication: status of pandemic, changes. **d. For hospitals and alternate care sites:** i Pharmacy Ii Laboratory service Iii Radiology iv Supplies (clean/sterile, as well as office) v Health records vi Information infrastructure management: telephones, email, hospital information system, surveillance infrastructure vii Food services viii Laundry ix Parking x Security xi Housekeeping xii Disposal of waste (including handling and disposal of biohazardous waste) xiii Facility management (ventilation, creation of isolation space, etc.) xiv Ability to prepare bodies for burial/cremation, and store pending transport.
B. Transportation	**a. Patients including assessment and provision of care to patients during transport** **b. Laboratory specimens** **c. Waste** **d. Dangerous goods (e.g., oxygen)** **e. Staff.**
C. Education	**a. Ability to educate health care professionals about** i Provincial emergency and pandemic preparedness ii Individual preparedness (e.g. wills, stockpiling OTC meds, etc.) iii Influenza and pandemic influenza iv Self screening for influenza illness and for stress/ability to continue working v Assessment, triage, management protocols (patient with and without co-morbidities): within healthcare settings, within community/PHC settings (e.g., pharmacy, teletriage, schools) vi Infection control and occupational health and safety. **b. Ability to educate the general public about** i About influenza including self care ii Pandemic preparedness. **c. Ability to respond to questions about influenza and self care (phone, web, in person)**

D. Infection control/occupational health and safety	**a. Ability to screen staff for illness.** **b. Ability to identify staff who through other illness or burn out, need assistance/rest.** **c Ability to develop surveillance programs** i For disease ii For adverse events of immunization and therapy. **d. Ability to implement surveillance programs** i For disease ii For adverse events of immunization and therapy. **e. Ability to monitor workplace and patient safety** i Identify hazards/problems ii Provide on-going education and training iii Rectify hazards. **f. Provision of support for staff** i Psychosocial ii Logistic (food, gas, care for pets, care for family).
E. Care for well persons	**a. Immunization** i Ability to screen for eligibility for immunization ii Ability to obtain consent for immunization iii Ability to prepare vaccine for injection iv Ability to inject vaccine. **b. Prophylaxis** i Ability to screen persons for eligibility for antiviral prophylaxis ii Ability to obtain consent for antiviral prophylaxis iii Ability to prescribe antivirals for prevention of influenza iv Ability to dispense antivirals for prevention of influenza (public health or hospital supply).
F. Care for Ill patients	**a. Competencies Across Care Settings** i Taking a medical history ii Examining the chest iii Performing a complete physical exam iv Interpreting the results of history, physical exam, chest x-ray, laboratory and point of care testing v Prescribing medication vi Triaging patients to appropriate location: in community, to care location; in ED to level of care vii Deciding to refer patient for assessment by staff with greater competency viii Discharging patient home or to another care setting ix Deciding on palliative care/withdrawal of care x Certification of death xi Designing and implementing rehabilitation programs xii Psychosocial support. **b. Supports Across Care Settings** i Activities of daily living ii Delivery of food etc (community only) iii Care for dependents (community only). **c. Technical skills by Care Setting:** i Community/PHC: measuring temperature, pulse, blood pressure, taking blood, obtaining NP swabs, other cultures (e.g. skin swabs, urine), 02 sats ii ED/Acute Care/LTC: Community/PHC skills PLUS ECG, Chest x-ray, performing IM injections, starting intravenous lines, maintaining intravenous lines (site and tubing), setting up oxygen for administration; checking oxygen administration sets, administering oral, inhaled, iv and IM medication, suctioning non-intubated and trachea patients, insertion, maintenance of Foley catheters iii Critical Care: ED/Acute Care/LTC skills PLUS intubation, ventilation, central and arterial line insertion and maintenance, administration of medication by continuous infusion, suctioning, ACLS, management of inotropes and vasopressors, management of insulin infusions, management of dialysis.

Key Questions for Planners in a Competency-based Approach to Health Human Resources

Part I

Provider Requirements (i.e., how many providers are required to ensure sufficient 'flow' of health care services to meet the needs of the population?)	Key Questions
Population Size (demography) Refers to the population size by age and sex. Reflects the multiple characteristics of individuals in the population that create the demand for curative as well as preventive health services.	What is the population size of your geographic planning area? What is the population breakdown by age and sex cohorts? What proportion of your population routinely requires care that cannot be provided in your local area (e.g. in tertiary care centers outside of your area)? How geographically dispersed is your population, in particular is your population at high risk of complicated illness, and who may have trouble accessing care? What impact does your geography have on your ability to provide support at home for ill people? Who is responsible for gathering this information? Where would the information be available?
Health Status, Attack Rate, Morbidity and Mortality Rates (epidemiology) Refers to the health status including attack rate by age and sex (i.e., burden of disease). Collect the reportable disease information from the public health unit.	What are the available sources of information in your area concerning up to date information about the likely number of cases of illness and hospitalizations during pandemics of different degrees of severity? How can you use this information for planning purposes? How can you collect actual data during a pandemic to assist in on-going planning? What are the available sources of information in your area concerning up to date information about numbers of cases of reportable diseases? (e.g., pandemic flu)? How would you use this information for planning purposes (i.e., for calculating the attack by age groups or planning areas in your jurisdiction)? Are there geo-mapping resources available to assist in deployment planning? Who would you ask?
Level of Service: Required to cope with the burden of disease and the other health service needs not associated with the influenza pandemic. It is important to consider the distribution of patients by care settings and the associated intensity of care.	What is the expected distribution of patients across care settings (e.g., community clinics/PHC, ED/acute care hospital, ICUs)? What is the most valid way of determining this distribution? How many people will require supportive care at home (e.g. meals, medication delivery)? Who is the designated person responsible for coordinating the organization of health care delivery in each care setting? Who is their back-up should they become ill during the pandemic? Do you know the usual patient volumes by each of these same care settings? What information systems will be required? Who will update them? And how often?
Competencies Required Understanding the variety of competencies (knowledge, skills and judgement) that are required to offer the required level of service in each care setting.	Do you have the list of competencies necessary for the care of both the well and the ill in each of the care settings (i.e., community clinics/PHC, ED/acute care hospital/ ICUs)? With the distribution of influenza patients by care setting, and the list of influenza care competencies by the same care settings, does this help you to understand your planning targets?

Key Questions for Planners in a Competency-based Approach to Health Human Resources

Part II

Provider Supply (i.e., how many providers are or will be available to deliver health care services to the population?)	Key Questions
Health Care Providers Refers to the total number of health care providers in the jurisdiction. This includes all health care professions and providers who are currently registered with a regulatory college as well as those who are not.	Do you know how many of each health care profession are available in your jurisdiction? Can you get the number of those professionals in your jurisdiction from the respective regulatory colleges? What alternative sources of information could be utilized? How reliable will that information be? How will you update provider workforce information during a pandemic influenza crisis? Do you have the list of health care professions that have been matched with the influenza care competencies? Can the regulatory college(s) expedite registration of retired or inactive staff or IMGs who would be qualified to provide influenza care?
Stock of Providers Refers to the number of registered health care providers available to provide health care services (also includes those who left practice for retirement or other reasons but remain registered)	How will you engage local provider leadership to assist you in planning for provider stock information? What mechanism will you employ to update information during a crisis? Who will coordinate this? How many providers are training in your area, and in what professions? How many licensed health care providers live or work in your area? Or adjacent areas? How many are retired or working outside their field but are willing and available? What are the influenza care competencies of your local providers? How will you determine this? Have you considered using a provider self-assessment tool? Whose job will it be to engage providers? Who will be responsible for gathering the self-assessment information? Can you use that information to plan influenza competency training sessions? Who would run these training sessions?
Activity Rates Refers to the number of hours spent in the delivery of patient care service (i.e., worked hours).	How will you maintain activity rate information during a pandemic influenza crisis? Who will be responsible for gathering the information? How many of your providers are working full time, part time or casual? Where will you find the information? Have you engaged provider leaders in pandemic planning? Can you assume most providers will work full-time during a pandemic crisis?
Participation Rates Refers to the proportion of the stock involved in the delivery of patient care.	What percentage of your primary health care workforce is involved in direct patient care? What percentage of your ED/acute care hospital workforce is involved in direct patient care? How will you access this information before a pandemic influenza crisis? What alternative sources of information can you employ during a pandemic influenza crisis? Can you use a provider self assessment tool to determine the level of influenza care competencies among those not involved in direct patient care (i.e., those in administration or research)?
Work and Productivity of Providers Refers to the average rate of	How many vaccines can a public health nurse administer, on average per day? How many possible influenza patients can be assessed each hour in a flu

Provider Supply (i.e., how many providers are or will be available to deliver health care services to the population?)	Key Questions
services per hour of work delivered to people requiring care.	assessment clinic with a particular range of providers? How many people can a family physician assess per day (e.g., 40 per day which is 5 per hour)? How many prescriptions can pharmacist fill per day, in addition to providing communication, education, and advocacy? Who will coordinate human resource scheduling in your area? ICUs? ER/Acute Care Hospitals? Community Clinics? ALC? Homecare? How will you identify and prevent staff burnout? How will you plan for critical skills shortages? How will you identify staff for "up-skilling?" Are there programs, policies or procedures that could be considered and put in place before a pandemic crisis?
Competencies Supplied The variety of competencies that can be supplied by the available stock of providers across care settings. Different health care providers, even within the same profession, will have different levels of competencies.	With the potential stock of providers in your area with the influenza care competencies, and with estimates of productivity of these providers, can you estimate the competencies that could be supplied in your area by care setting? How does this compare with the competencies required in your area by care setting? Give the range of professions that can provide the influenza care competencies (see matching document described below); can you come up with a plan to address the gap in competencies?

List of Controlled Acts

Under the ***Regulated Health Professions Act,*** the following controlled acts can only be performed by members of specific professions.

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger: beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or (1) of the compounding of a drug as defined in subsection 117 Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

Influenza Care Competencies Self-Assessment: How Can I Assist In An Influenza Pandemic?

The purpose of this self-assessment tool is to give health care providers an opportunity to reflect on their own abilities and competencies in the context of the required influenza care competencies. This will help health care providers judge how they may be of assistance in an influenza pandemic.

The tool is comprised of two major components:

- Part I - a three-part assessment of personal abilities as they relate to the influenza care competencies and professional/personal circumstances.
- Part II - an *RHPA* Controlled Act/ICCs Decision Tree which place influenza care competencies within the regulatory context and provides an overview of key questions and consequences in assessing abilities to assist in an influenza pandemic.

Individual circumstances will vary depending upon a health care provider's profession, practice setting and the nature of his/her professional practice. The assessment tool attempts to be as inclusive as possible. There are no "right" or "wrong" answers; instead, it provides an opportunity for health care providers to understand the skills and competencies needed during an influenza pandemic and judge how best to be of assistance.

Part I: Professional/Personal Circumstances – Part I

I Practice Setting

I have clinical experience in the following practice settings:

A. Patient Care I have clinical experience			I am competent to practice in	
Hospital				
Neonatal ICU	☐ Yes	☐ No	☐ Yes	☐ No
Paeds ICU	☐ Yes	☐ No	☐ Yes	☐ No
Adult ICU	☐ Yes	☐ No	☐ Yes	☐ No
Stepdown unit	☐ Yes	☐ No	☐ Yes	☐ No
Ward	☐ Yes	☐ No	☐ Yes	☐ No
Emergency	☐ Yes	☐ No	☐ Yes	☐ No
Rehab	☐ Yes	☐ No	☐ Yes	☐ No
Palliative Care	☐ Yes	☐ No	☐ Yes	☐ No
Out-Patient Clinics	☐ Yes	☐ No	☐ Yes	☐ No
Other	☐ Yes	☐ No	☐ Yes	☐ No
Administration	☐ Yes	☐ No	☐ Yes	☐ No
Long-Term/Chronic Care				
Chronic care hospital	☐ Yes	☐ No	☐ Yes	☐ No
Residential	☐ Yes	☐ No	☐ Yes	☐ No
Day care	☐ Yes	☐ No	☐ Yes	☐ No
Hospice	☐ Yes	☐ No	☐ Yes	☐ No
Community Clinic/				
Private Office	☐ Yes	☐ No	☐ Yes	☐ No
In Home	☐ Yes	☐ No	☐ Yes	☐ No

B. Other health care settings		
Public Health	☐ Yes	☐ No
Pharmacy	☐ Yes	☐ No
Laboratory	☐ Yes	☐ No
Rural/Isolated Areas	☐ Yes	☐ No

II *Influenza Care Competencies Assessment*

Once you've identified your practice setting experience, consider the competencies you currently use or previously have used. For example:

- If those competencies are Administrative/Supportive in nature, consider the competencies in Domains 1, 2 and 4;
- If those competencies are Education, Infection Prevention or Occupational Health and Safety in nature, consider the competencies in Domains 2, 3 and 4.
- If those competencies are direct patient care, consider the competencies in Domains 2, 4 and 5.

Alternatively, you might want to consider all the competencies regardless of your practice experience. When you are thinking about the competencies, remember that the RHPA permits delegation of controlled acts. Therefore, think about both what you are able to do, what could be delegated to you during the crisis.

Influenza Care Competencies Domain #1: Administrative/Support

Competency Domain	**Have I ever done it?**	**If Yes to Q1, how long ago?**		**If 'Yes' to previous questions, I feel competent to perform those activities:**	**If 'No' to Q1, is the necessary education and/or training available?**
Major Competency	**Q1**	**Q2**		**Q3**	**Q4**
A. Administrative/Support					
a. ability to manage care site (care clinic, immunization clinic, ER, home care…..)	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
b. Co-ordination of Patient Care (all settings)					
i. answering patient questions	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. receiving and directing patients	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
c. Assessing of Staff competencies needs matching	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?		If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	**Q1**	**Q2**		**Q3**	**Q4**
d. Scheduling and deployment of staff, beds and sites	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
e. for hospital alternate care sites (that is, for newly opened sites to care for patients who cannot care for themselves at home, but for whom there is not enough space in hospitals) the following key departments will need to be functional. Think about your ability to contribute to these departments.					
i. Pharmacy (e.g., compounding and/or dispensing)	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Laboratory services (e.g., processing specimens, maintaining lab equipment, etc.)	☐ Yes ☐ No	☐ last 6 months ☐ 6m- 2yrs ago ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii. Radiology (e.g., ordering and/or applying prescribed forms of energy)	☐ Yes ☐ No	☐ last 6 months ☐ 6m- 2yrs ago ☐ 2-5 years ago ☐ >5 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iv. Supplies (e.g., clean/sterile, as well as office)	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
v. Health records	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vi. Security	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?		If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2		Q3	Q4
				With supervision ☐ Yes ☐ No	
vii. Food services (consider experience in providing food for large numbers, and knowledge of public health aspects of food preparation)	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
viii. Hospital/commercial laundry	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ix. Healthcare housekeeping	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
x. Ability to prepare bodies for burial/cremation	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
B. Transportation					
i. Patients	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	Do you have appropriate commercial license? ☐ Yes ☐ No	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Laboratory specimens	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	Do you have appropriate commercial license? ☐ Yes ☐ No	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii. Biohazardous waste	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago	Do you have appropriate commercial license?	By myself ☐ Yes ☐ No With a Team	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?		If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	**Q1**	**Q2**		**Q3**	**Q4**
		☐ >10 years ago	☐ Yes ☐ No	☐ Yes ☐ No With supervision ☐ Yes ☐ No	
iv. Dangerous goods (e.g. oxygen)	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	Do you have appropriate commercial license? ☐ Yes ☐ No	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Influenza Care Competencies Domain #2: Education

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
a. Ability to educate health care professionals about				
i. Provincial emergency outbreak preparedness	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Influenza and pandemic influenza	☐ Yes ☐ No	☐ last 6 months ☐ 6m- 2yrs ago ☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii. Assessment, triage, management protocols (patient with and without con-morbidities)	☐ Yes ☐ No	☐ current ☐ last 6 months ☐ 6m- 2yrs ago ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iv. Infection control and occupational health & safety	☐ Yes ☐ No	☐ current ☐ last 6 months ☐ 6m- 2yrs ago ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
b. Ability to educate the general public about				
i. Ability to educate about influenza, including self-care	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Ability to respond to questions about influenza and self-care (phone, web, in person)	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Influenza Care Competencies Domain #3: Infection Control/ occupational health/ surveillance

Competency Domain	**Have I ever done it?**	**If Yes to Q1, how long ago?**	**If 'Yes' to previous questions, I feel competent to perform those activities:**	**If 'No' to Q1, is the necessary education and/or training available?**
Major Competency	**Q1**	**Q2**	**Q3**	**Q4**
A. Ability to screen staff for illness.				
a. Ability to screen staff for illness	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
B. Ability to develop and implement surveillance programme (design data forms/databases, coordinate data collection and submission to MOHLTC)				
i. For disease	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. For adverse events of immunization and therapy	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
			☐ Yes ☐ No	
C. Ability to monitor work place and patient safety related to risks from influenza.				
1. Identify hazards/problems *(e.g., inappropriate use PPE, inadequately ventilated areas, staff burn out, inadequate screening practice)*	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
2. Provide on-going education and training	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
3. Rectify hazards	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Influenza Care Competencies Domain #4: Care for Well Persons

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
a. Immunization				
i. Ability to screen for eligibility for immunization	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Ability to obtain consent for immunization	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii. Ability to dispense vaccine for	☐ Yes	☐ last 2 yrs	By myself	☐ Yes

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
injection	☐ No	☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ No ☐ Uncertain
iv. Ability to inject vaccine	☐ Yes ☐ No	☐ last 5 yrs ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
b. Prophylaxis				
i. Ability to screen persons for eligibility for antiviral prophylaxis	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Ability to prescribe antivirals for prevention of influenza	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii. Ability to dispense antivirals for prevention of influenza (public health or hospital supply)	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
c. Psychosocial support				
Psychosocial support for staff	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Influenza Care Competencies Domain #5: Care for Ill Patients

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
A. Competencies to care for patients ill with influenza **Consider your competence to care for patients with influenza specifically, remembering that care plans will be available, but also that patients may have co-morbidities and complications.**				
i. Taking a medical history	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Examining the chest	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii. Performing a complete medical exam, including ordering of tests	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No In some, but not all care settings ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iv. Interpret results of history, physical exam, chest X-ray, and laboratory tests leading to a diagnosis	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No In some, but not all care settings ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
v. Prescribing medication	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vi. Triaging patients in the community to care sites	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vii. Triaging patients in the emergency department to levels of care	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vi. Deciding to refer patient for assessment by staff with greater competency	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
		☐ 5-10 years ago ☐ >10 years ago	With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No In some, but not all care settings ☐ Yes ☐ No	☐ Uncertain
vii. Discharging patient home or to another care setting	☐ Yes ☐ No	☐ current ☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No In some, but not all care settings ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
viii. Deciding on palliative care/withdrawal of care	☐ Yes ☐ No	☐ current ☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ix. Designing and implementing rehabilitation programs	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
x. Assistance with activities of daily living, (e.g., feeding, personal hygiene, skin care [prevention of pressure ulcers])	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
B. Support				
i. Assistance with activities of daily living, (e.g., feeding, personal hygiene, skin care [prevention of pressure ulcers])	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Community support – shopping delivery of food, medication etc.	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
iii. Care for dependents (community only)	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
C. Technical Skills				
I. COMMUNITY/PRIMARY HEALTH CARE				
i. Measure temperature	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Take pulse	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii. Take blood pressure	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iv. Take venous blood samples	☐ Yes ☐ No	☐ current ☐ 2-5 years ago ☐ 6m- 2yrs ago ☐ >5 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
v. Obtain nasal/NP swabs	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vi. Obtain throat swabs	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vii. Obtain other cultures (e.g.,. skin swabs, urine)	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
viii. Order appropriate lab tests	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ix. Measure O2 saturation	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
II. EMERGENCY DEPARTMENT/ACUTE CARE/LONG TERM CARE: Community/Primary Health Care Skills as above, plus:				
i. Obtain ECG	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Order Chest X-rays and CT scans	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii. IM Injections	☐ Yes ☐ No	☐ last 10 yrs ☐ >10 years ago	By myself ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iv. Starting intravenous lines	☐ Yes ☐ No	☐ current ☐ 6m- 2yrs ago ☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
v. Maintain intravenous line	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vi. Setting up oxygen	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vii. Checking oxygen administration setups	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
viii. Administer medications by inhalation	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ix. Administer medications by injection	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?	If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2	Q3	Q4
x. Administer medications orally	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
xi. Administer medications by IV	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
xii. Suctioning non-intubated patients	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
xiii. Insertion, maintenance of Foley catheters	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
III. CRITICAL CARE: Emergency Department/Acute Care/Long Term Care and Community/Primary Health Care Skills as above, plus:				
i. Intubation	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago ☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ii. Ventilation	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago ☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
iii.(a) Central line insertion	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago ☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
(b) Central line maintenance	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

Competency Domain	Have I ever done it?	If Yes to Q1, how long ago?		If 'Yes' to previous questions, I feel competent to perform those activities:	If 'No' to Q1, is the necessary education and/or training available?
Major Competency	Q1	Q2		Q3	Q4
		☐ 6m-2 years ago			
iv.(a) Arterial line insertion	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago	☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
(b) Arterial line maintenance	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago	☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
v. Administration of medication by continuous infusion	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago	☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vi. Suctioning	☐ Yes ☐ No	☐ last 2 yrs ☐ 2-5 years ago ☐ 5-10 years ago ☐ >10 years ago		By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
vii. Advanced Cardiac Life Support *ACLS*	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago	☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
viii. Management of inotropes and vasopressors	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago	☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
ix. Management of insulin infusions	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago	☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain
x. Management of dialysis	☐ Yes ☐ No	☐ current ☐ within 3 months ☐ 3-6 months ago ☐ 6m-2 years ago	☐ 2-5 years ago ☐ >5 years ago	By myself ☐ Yes ☐ No With a Team ☐ Yes ☐ No With supervision ☐ Yes ☐ No	☐ Yes ☐ No ☐ Uncertain

III Personal Circumstances

Have you given consideration to the following questions:

1. Do I work in a sector or for an employer that will allow me to be available to assist in a pandemic situation?

2. Do I require family support because of dependent child or children, spouse or parent(s)?

3. Do I have plans to care for family members who may become ill during a pandemic?

4. Does my family have a personal home pandemic plan?

5. Does my employer offer any family support?

6. Have I discussed my participation with family members?

7. Do I have Critical Illness Insurance?

8. Are my Will and Estate planning arrangements current?

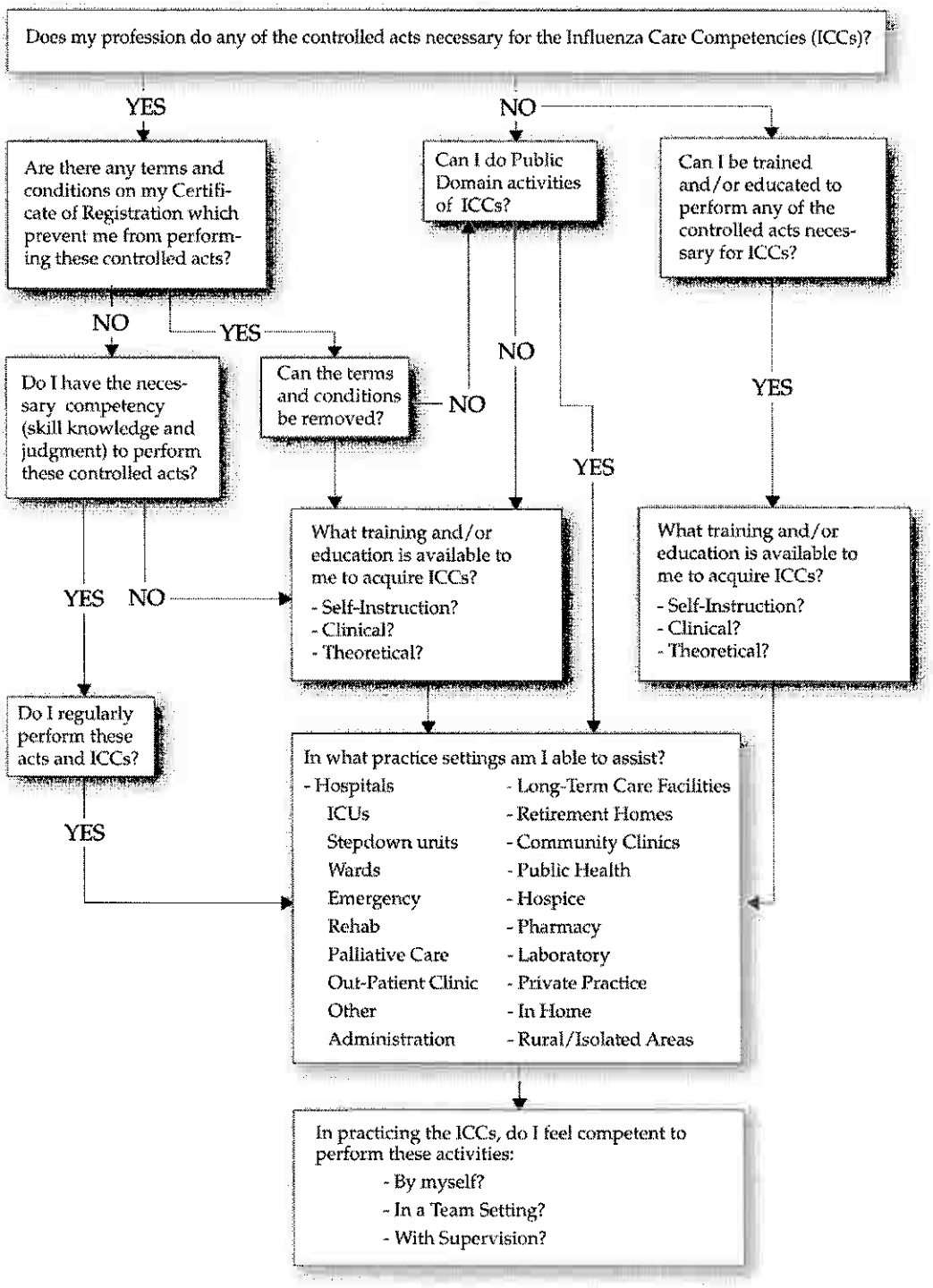
9. Am I available to travel within the province?

10 How would I be able to travel to and from work? (Car? Public Transit? Air? Train? Bus?)

11. Do I have language skills, other than English, that would be helpful to health care delivery during an influenza pandemic?

Part II: **RHPA Controlled Act/ICC Assessment**

RHPA Controlled Act/ICC Assessment



The Next Steps

As a general rule of thumb, the more "Yes" responses, the greater the ability to lend assistance. For "No" responses, the self-assessment tool prompts you to consider education/training possibilities to update your competency sets.

Once you have assessed your abilities and determined how best you can assist during an influenza pandemic, consider what steps you can take to ensure that your assistance will be utilized to the fullest:

- education upgrading?
- college/professional association notification?
- notify local health human resource planners?

For more information regarding Ontario's Health Pandemic Influenza Plan visit http://www.health.gov.on.ca/english/providers/program/emu/pan_flu/pan_flu_mn.html

For profession-specific planning information, check with your regulatory body and/or professional association.

Summary

Health care providers are encouraged to talk with their colleagues, employers, regulatory colleges and the volunteer sector about the province's pandemic planning process and to discuss how they might contribute to both planning and the pandemic response. Providers with influenza care competencies will be in great demand during a pandemic. Providers are therefore encouraged to give thought to their own personal preparation and how they might contribute their skills and competencies to the health care system during a pandemic.

RHPA Profession / Influenza Care Competencies Matching

Domain	Competencies	Profession
A. Administrative/ Support	**a. Management/leadership/innovation:** i. Ability to respond to crises, develop strategies for response. **b. Care site management (care clinic, immunization clinic, ED, home care):** iii Organization, staffing, response to changing situations for particular setting, iv Assessment of staff competencies, and matching to needs, and v Scheduling and deployment: staff (physician, employees, volunteers), beds, and sites vi Succession and contingency planning, and vii Coordination of triage and rationing decisions, ethics. **c. Coordination of patient flow:** i Answering patient questions, and ii Receiving and directing patients. **d. Communication** i Coordination with other levels of care, public health ii Internal communication: status of pandemic, changes.	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
	e. For hospitals and alternate care sites: i Pharmacy	**Public domain activities; not regulated under the *RHPA*; may require specific education, training and authorization.** **NOTE: Under the *Drug and Pharmacies Regulation Act* non-hospital pharmacies must be supervised by a Pharmacist; under that *RHPA* s.27 (2)8 "supervising the part of a pharmacy were drugs are kept" is a controlled act.** **NOTE Dispensing and/or compounding must be done by either a Physician or Pharmacist**
	ii Laboratory service iii Radiology	**Public domain activities; not regulated under the *RHPA*; may require specific education, training and authorization.** **Will require Medical Laboratory Technologists.**
	iv Supplies (clean/sterile, as well as office) v Health records vi Information infrastructure management: telephones, email, hospital information system, surveillance infrastructure vii Food services viii Laundry ix Parking x Security xi Housekeeping xii Disposal of waste (including handling and disposal of biohazardous waste) xiii Facility management (ventilation, creation of isolation space, etc.) xiv Ability to prepare bodies for burial/cremation, and store pending transport.	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**

Domain	Competencies	Profession
B. Transportation	**a. Patients including assessment and provision of care to patients during transport** **b. Laboratory specimens** **c. Waste** **d. Dangerous goods (e.g., oxygen)** **e. Staff.**	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
C. Education	**a. Ability to educate health care professionals about** i Provincial emergency and pandemic preparedness ii Individual preparedness (e.g., wills, stockpiling OTC meds, etc.) iii Influenza and pandemic influenza iv Self screening for influenza illness and for stress/ability to continue working v Assessment, triage, management protocols (patient with and without co-morbidities): within healthcare settings, within community/PHC settings (e.g., pharmacy, teletriage, schools) vi Infection control and occupational health and safety. **b. Ability to educate the general public about** i About influenza including self care ii Pandemic preparedness. **c. Ability to respond to questions about influenza and self care (phone, web, in person)**	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
D. Infection control/occupational health and safety	**a. Ability to screen staff for illness** **b. Ability to identify staff who through other illness or burn out, need assistance/rest** **c Ability to develop surveillance programs:** i For disease ii For adverse events of immunization and therapy. **d. Ability to implement surveillance programs:** i For disease ii For adverse events of immunization and therapy. **e. Ability to monitor workplace and patient safety:** i Identify hazards/problems ii Provide on-going education and training iii Rectify hazards. **f. Provision of support for staff:** i Psychosocial ii Logistic (food, gas, care for pets, care for family).	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
E. Care for well persons	**a. Immunization:** i Ability to screen for eligibility for immunization ii Ability to obtain consent for immunization	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
	iii Ability to prepare vaccine for injection	**Physicians, pharmacists**
	iv Ability to inject vaccine.	**Physicians, registered nurses (extended class), dentists.** **Authorized under order or regulation: registered nurses (general class), registered practical nurses, chiropody and podiatry (injection only into feet), medical radiation**

Domain	Competencies	Profession
		technologists, midwives (within scope), respiratory therapists, advanced care paramedics, critical care paramedics.
	b. Prophylaxis: i Ability to screen persons for eligibility for antiviral prophylaxis ii Ability to obtain consent for antiviral prophylaxis	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
	iii Ability to prescribe antivirals for prevention of influenza	**Physicians, registered nurses.**
	iv Ability to dispense antivirals for prevention of influenza (public health or hospital supply).	**Physicians, pharmacists.**
F. Care for Ill patients	**a. Competencies Across Care Settings:** i Taking a medical history ii Examining the chest	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
	iii Performing a complete physical exam	**Physicians, registered nurses (extended class).**
	iv Interpreting the results of history, physical exam, chest x-ray, laboratory and point of care testing	**Physicians, registered nurses (extended class), critical care paramedics.**
	v Prescribing medication	**Physicians, registered nurses (extended class), dentists (within scope).**
	vi Triaging patients to appropriate location: in community, to care location; in ED to level of care vii Deciding to refer patient for assessment by staff with greater competency	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
	viii Discharging patient home or to another care setting	**Physicians, registered nurses (extended class) – but not from hospital.**
	ix Deciding on palliative care/withdrawal of care.	**Physicians, registered nurses (extended class).**
	xi Designing and implementing rehabilitation programs xii Psychosocial support.	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
	b. Supports Across Care Settings: i Activities of daily living ii Delivery of food etc (community only) iii Care for dependents (community only)	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
	c. Technical skills by Care Setting: i Community/PHC: **measure temperature** **take pulse** **take blood pressure**	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.**
	take venous blood samples	**Physicians, registered nurses (extended class)** **Authorized under order or regulation: registered nurses (general class), registered practical nurses, medical laboratory technologists, medical radiation technologists, midwives (within scope), respiratory therapists.**
	obtain nasal, NP swabs	**Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.** **May be regarded by some as a "controlled act", especially if the taking of the swab involves going "beyond the point in the nasal passages where they normally narrow": *RHPA*, s. 27(2)6.ii.**
	obtain throat swabs **obtain other cultures (e.g., skins swabs, urine)**	**Public domain activities; Not regulated under the RHPA; may require specific education,**

Domain	Competencies	Profession
		training and authorization.
	order appropriate lab tests	Physicians, registered nurses (extended class), dentists (within scope), midwives.
	measure O2 saturation.	Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.
	ii ED/Acute Care/LTC: Community/PHC skills PLUS	
	obtain ECG	Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.
	order chest X-rays and CT scans	Physicians, registered nurses (extended class).
	IM injections	Physicians, dentists, registered nurses (extended class), dentist Authorized under order or regulation: medical radiation technologists, midwifery (within scope), registered nurses (general class), registered practical nurses, respiratory therapists, advanced care paramedics, critical care paramedics.
	starting intravenous line	Physicians, registered nurses (extended class), registered nurses (general class) dentists, midwifery. Authorized under order or regulation: registered practical nurses, respiratory therapists, advanced care paramedics, critical care paramedics.
	maintain intravenous line (site and tubing)	Physicians, registered nurses (extended class), registered nurses (general class) dentists, registered midwifes, respiratory therapists. Authorized under order or regulation: registered practical nurses, advanced care paramedics, critical care paramedics.
	setting up oxygen	Physicians, dentists, midwifes. Authorized under order or regulation: registered nurses (extended class), registered nurse (general class), registered practical nurses, respiratory therapists, advanced care paramedics, critical care paramedics.
	checking oxygen administration set-ups	Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization.
	administer medications by inhalation	Physicians, Dentists, Registered Nurses (Extended Class), dentists. Authorized under order or regulation: Medical Radiation Technologists, Midwifery (within scope), Registered Nurses (General Class), Registered Practical Nurses, Respiratory Therapists, Advanced Care Paramedics, Critical Care Paramedics.
	administer medications by injection	Physicians, dentists, registered nurses (extended class). Authorized under order or regulation: medical radiation technologists, midwifery (within scope), registered nurses (general class), registered practical nurses, respiratory therapists, advanced care paramedics, critical care paramedics.

Domain	Competencies	Profession
	administer medications orally	Public domain activities; Not regulated under the RHPA; may require specific education, training and authorization. Presupposes medication has been properly prescribed, compounded and /or dispensed (i.e., controlled acts).
	administer medications by IV	Physicians, dentists, registered nurses (extended class). Authorized under order or regulation: medical radiation technologists, midwifery (within scope), registered nurse (general class), registered practical nurses, respiratory therapists, advanced care paramedics, critical care paramedics.
	suctioning non-intubated patients	Physicians, registered nurses (extended class), respiratory therapists, physiotherapists, dentists. Authorized under order or regulation: registered nurses (general class), registered practical nurses, advanced care paramedics, critical care paramedics.
	insertion, maintenance of Foley catheters	Physicians, Registered Nurses (Extended Class), Dentists, Midwives, (female patients only). Registered Nurses (General Class), Registered Practical Nurses, Critical Care Paramedics.
	iii Critical Care: ED/Acute Care/LTC skills PLUS:	
	intubation	Physicians, Registered Nurses (Extended Class), dentists. Authorized under order or regulation: Registered Nurses (General Class), Registered Practical Nurse, Respiratory Therapists, Advanced Care Paramedics, Critical Care Paramedics.
	ventilation	Authorized under order or regulation: Respiratory Therapists, Critical Care Paramedic.
	central line insertion	Physicians.
	central line maintenance	Physicians registered nurses (extended class) nurses. Authorized under order or regulation: registered nurse (general class), registered practical nurse, respiratory therapists, critical care paramedics.
	arterial line insertion	Physicians. Authorized under order or regulation: Respiratory Therapists.
	arterial line maintenance	Physicians registered nurses (extended class) nurses. Authorized under order or regulation: registered nurse (general class), registered practical nurse, respiratory therapists, critical care paramedics.
	administration of medication by continuous infusion	Physicians, midwives. Authorized under order or regulation: Registered Nurses (Extended Class) Nurses Registered Nurse (General Class), Registered Practical Nurse, Respiratory Therapists,

Domain	Competencies	Profession
		Advanced Care Paramedics, Critical Care Paramedics.
	suctioning	Physician, Registered Nurses (Extended Class), respiratory therapists, dentists, midwives, Physiotherapists (tracheal suctioning). Authorized under order or regulation: Registered Nurses (General Class), Registered Practical Nurses, Advanced Care Paramedics, Critical Care Paramedics.
	advanced cardiac life support	Physicians, registered nurses (extended class). Authorized under order or regulation: registered nurses (general class) respiratory therapists, critical care paramedics.
	management of inotropes and vasopressors	Physicians, advanced care paramedic, critical care paramedic.
	management of insulin infusions	Physicians. Authorized under order or regulation: Registered Nurse (General Class) with ICU/Critical Care experience, Advanced Care Paramedic, Critical Care Paramedic.
	management of dialysis	Physicians, registered nurses (extended class). Authorized under order or regulation: registered nurses (general class), registered practical nurses.

Sample Framework for Using Competency Assessments to Plan Team-based Care for Patients with Influenza

Role	Competency Domain	Potential for controlled acts	Activities	Competencies required
Screener	Support	None	-Direct patients to "flu" or "non-flu" triage -Exclude visitors -Ensure hand hygiene and PPE use	Ability to maintain order Ability to use PPE as appropriate Language competencies an asset
Triage (ED only)	Triage	None, except in crisis, when decision making care withdrawal of care for patients arriving at ED might be made by this role	Triage patients to levels of care, assess CTAS category	ED triage competencies (advanced diagnosis capabilities)
Tele-triage (Telehealth only)	Tele-triage	None	Triage patients, provide education	Tele-triage competencies
ADL support (domiciliary only)	Support	None	Assists patients in domiciliary care with basic hygiene, activities of daily living Prepare bodies for morgue / funeral home	Physical ability to assist patients Ability to use PPE Ability to read English Language competencies an asset Ability to assess vital signs an asset
Assistant	Assessment	IM injection, drawing blood, obtain other lab specimens, administer meds, oxygen therapy, iv / Foley catheter insertion and maintenance	Support for assessment – has some or all of technical skills for care, and may be able to take some / all elements of history	As ADL, plus: Some / all of technical skills for non-ICU / resuscitate
Assessor	Assessment	As assistant, plus: • dispense meds, • order lab tests • Interpret tests (to some degree).	Takes history for flu patients, examines chest, assesses patient status within care plan, all technical skills for non-ICU setting Refers on appropriately within care setting	As assistant, but with ability to make diagnosis, order lab tests, recognize impact of modifying factors and co-morbidities, determine if patient "fits" in standard treatment algorithms
Critical care assessor (ED only)	Assessment	As assessor plus: some / all ICU technical skills	Monitors, assesses patients with compromised hemodynamic / respiratory status in ED	Ability to monitor patients requiring ICU level care in the ED
Primary decision-maker	Decision-maker	As assessor, plus For uncomplicated patients with influenza: decide on disposition, prescribe medications, order non-care plan lab tests, change therapy	For uncomplicated flu patients and those in clinic settings, decide on disposition, prescribe medications, order non-care plan lab tests, change therapy	All of assessment competencies (except critical care), plus ability to diagnose, recommend treatment plan, prescribe meds, discharge patient to another location as long as patient has uncomplicated influenza and / or while working with supervision
Secondary decision maker	Decision-maker	As primary decision-maker, plus: For complicated patients, decide on disposition, prescribe medications, order non-care plan lab tests, change therapy	As decision-maker, but for acute care in-patients, and those in ED with significant co-morbidities / complications	All of assessment competencies (except critical care), plus ability to diagnose, recommend treatment plan, prescribe meds for and discharge patient, for patients with complicated influenza
Critical care decision maker (ED only)	Decision-maker	All technical skills for critical care	Manages / directs management of patients in the ED with compromised hemodynamic and respiratory status	All of other assessment and decision making competencies, plus the ability to diagnose and treat patients requiring ICU level care
Rehab / discharge planning	Support	None	To direct rehab programs and assess domiciliary patients for suitability for discharge to other care locations / home	Ability to assess ADL capacity and home support Ability to plan and deliver physical rehab
Psychosocial support	Support	None	To provide psychosocial support for patients and families	Ability to provide psych / social support

Volunteer Position Description Template

Volunteer Position Description Template[1]
Position Title:
Location:
Purpose:
Risk Level:
Time Commitment: # Hours: Term:
Major Responsibilities:
Reports to:
Competencies required:
Orientation/Training Required:
Screening Required:
Supervision and Evaluation:
Benefits:
Supporting Policies:

[1] This template is based on a compilation of the templates found in:
Volunteer Canada (2001) *A Matter of Design: Job Design theory and application to the voluntary sector.* Available at http://www.volunteer.ca/volunteer/pdf/MatterofDesignEng.pdf p.65.
Cooper,Reva (2002) *Risk Management by Position Design: A guide for community support organizations in Ontario* Volunteer Canada: Ottawa, Ontario. Available at: http://www.volunteer.ca/volunteer/pdf/RiskEng.pdf p.9.
Nonprofit Risk Management Center (2001) *Staff Screening Tool Kit: Building a Strong Foundation Through Careful Staffing Corporation for National Service*: Washington, D.C. Available at:
http://www.nationalserviceresources.org/resources/online_pubs/program_management/staff_screening_toolkit.php?search&search_term=toolkit&m=all p.35.
Mason Ward, Tarra (2001) *Resource Guide: Answers to the most frequently asked questions about volunteerism and the services of Volunteer Victoria* Volunteer Victoria: Victoria, British Columbia. Available at:
http://www.islandnet.com/~volvic/_pdfs/programs_resguide.pdf p.94.

Sample Volunteer Job Description

Position Title: Primary Screener

Location: Entrance to Hospital/Emergency Room

Purpose: To direct patients to the appropriate waiting rooms to be triaged

Risk Level: Low

Time Commitment:
Hours: 8 hour shifts, 7-3, 3-11, 11-7
Term: Duration of the pandemic

Major Responsibilities:
Greet patients that enter the hospital site
Direct patients to the appropriate waiting area
Answer general patient questions
Instruct patients on the use of basic infection control procedures

Reports to: Security Manager

Competencies required:
Ability to deal with patients in a kind and compassionate manner
Ability to deal with patients who will be scared and/or frustrated
Ability to communicate basic infection control procedures
Ability to respond to basic patient questions
Ability to direct patients to waiting rooms based on established medical protocols

Orientation/Training Required:
Basic orientation to the layout of the hospital so as to be able to instruct patients to required facilities
Orientation on the medical directives established
Training on the basic infection control procedures

Screening Required:
Minimal
Application through central volunteer staffing organization
Reference check if time permits

Supervision and Evaluation:
This individual will be supervised by the security staff on duty at the hospital site
Triage nurses will provide feedback as to the appropriateness of the individuals use of the medical directives and advice concerning which waiting rooms incoming patients should be directed to

Benefits:
Personal Protective Equipment
Access to prophylaxis/antivirals if available
Accident/Illness Coverage

Supporting Policies:
See policies on first assessments of influenza patients
See hospital health and safety policy

Sample Request for Volunteers[2]

Agency:		How Many Volunteers Needed:
Address:		Work Location:
Contact Person:	Phone #:	Ext:
Contact Hours:		Email:

Title Of Volunteer Position(s) (If Possible Attach Job Descriptions):

Description Of Position (Tasks To Be Done):

Other Information:

Indicate Who Can Do This Job:

Volunteer Ages	Gender	Vehicle Required	Does Your Facility Have:
Child (Up to 12 years) ☐	Male ☐	License Class____	Wheelchair Access ☐
Youth (13-18 years) ☐	Female ☐	Background Check Required☐	
Adult (19-64 years) ☐	Either ☐		Public Transit Access ☐
Senior (65+ years) ☐			

ICCs The Volunteer Needs To Do This Job:

Training:	Orientation:
Reimbursement For:	Other Benefits:

Indicate Who The Volunteer Will Work With (Complete where applicable):

Ages To Work With	People May Have	Relationship
Child (Up to 12 years) ☐	Mental Disability ☐	Group ☐
Youth (13-18 years) ☐	Emotional Disability ☐	Individual ☐
Adult (19-64 years) ☐	Physical Disability ☐	Both ☐
Senior (65+ years) ☐	Influenza ☐	

Volunteer Commitment Required (Actual Days/Hours/Duration Of Position):

[2] Adapted from Mason Ward, *Resource Guide: Answers to the most frequently asked questions about volunteerism and the services of Volunteer Victoria*, p.104

Sample Volunteer Application Form

First Name: Last Name: Please circle Mr. Ms. etc
Languages please check fluency : Speak Write Both English French Specify other
Address:
Phone:
Emergency Contact Information: Name: Phone number: Relationship:
E-Mail:
What is the best method/time to contact you:
Availability: □ Day □Evening □Weekends
Length of time available:
Do you have any physical or mental conditions or other restrictions that could affect the kind of volunteering service you can provide?
Current Job Responsibilities and Hours:
How will your volunteer work affect your family and work responsibilities:
* In the context of the pandemic you may want to include a question about whether volunteers will require child or elder care in order to lend assistance
Previous Work Experience:
Special Competencies, Training, and Hobbies:
Previous Volunteer Experience:
Do you have your own transportation? □Yes □No Liability insurance? □Yes □No A valid driver's license? □Yes □No
How did your hear about the volunteer opportunities at our organization?
Signature: Date:_____
* If you were using a central organization for screening your volunteers, you could ask the volunteers to select which job description they were interested in and which ones they had the competencies for, you could also have the central organization include a competency list based on the job descriptions which potential volunteers could check off. They could then be matched to the appropriate job.
* If you were doing the screening yourself, it might be helpful to include a competency checklist based on the necessary competencies of the positions you are hoping to fill. You can then use this to determine which applicant would be appropriate for which position.

Directory of Ontario Volunteer Centres

ON - Central

Community Link North Simcoe Volunteer and Information Connection
67 Fourth Street
Midland, L4R 3S9
tel: 705-528-6999
fax: 705-528-6990
www.communitylink.ca
volunteer@communitylink.ca

Volunteer Resource Centre for Durham Region
50 Richmond Street, Suite 116
Oshawa, L1G 7C7
tel: 905-436-2035
fax: 905-571-1460
www.volunteerdurham.org
nburke@volunteerdurham.org

Helpmate Community Information & Volunteer Bureau
1 Atkinson Street, 4th Floor
Richmond Hill, L4C 0H5
tel: 905-884-3000 3839
fax: 905-884-4798
www.helpmate.volnetmmp.net
helpmate@volnetmmp.net

ON - Eastern

Volunteer Bureau of Leeds and Grenville
42 George Street P.O. Box 1813
Brockville, K6V 6K8
tel: 613-342-7040
fax: 613-342-7831
www.volunteerleedsgrenville.com
execdir@volunteerleedsgrenville.com

Volunteer and Information Kingston
260 Brock Street, Suite 5, 2nd Floor
Kingston, K7L 1S4
tel: 613-542-8512
fax: 613-542-8216
www.volunteerkingston.ca
blandry@volunteerkingston.ca

Bureau central des Bénévoles de la région de Hawkesbury
331 McGill Street
Hawksbury, K6A 1P9
tel: 613-632-6901
fax: 613-632-7581
bcbrh@cnwl.igs.net

Volunteer Ottawa / Bénévoles Ottawa
402-2197 Riverside Drive
Ottawa, K1H 7X3
tel: 613-736-5266 226
fax: 613-736-5262
www.volunteerottawa.ca
lsilver@volunteerottawa.ca

ON - Metro-Toronto

Information Markham and Volunteer Centre
101 Town Centre Boulevard
Markham, L3R 9W3
tel: 905-477-7000 6840
www.city.markham.on.ca/infomark/InfoMark-main.htm
inf@markham.ca

Volunteer Centre of Peel
207-160 Traders Boulevard
Mississauga, L4Z 3K7
tel: 905-306-0668
fax: 905-306-8221
www.volunteerpeel.com
progserv@volunteerpeel.com

Volunteer Toronto
344 Bloor Street West, Suite 404
Toronto, M5S 3A7
tel: 416-961-6888
fax: 416-961-6859
www.volunteertoronto.on.ca
dgardner@volunteertoronto.on.ca

ON - North

Elliot Lake Volunteer Resource Centre
1 Washington Crescent, Suite 108
Elliot Lake, P5A 2W9
tel: 705-848-1337
basjess@vianet.ca

Fort Frances Volunteer Bureau
140 Fourth Street West, Suite 1
Fort Frances, P9A 3B8
tel: 807-274-9555
fax: 807-274-5456
haneyk13@yahoo.ca

Volunteer Centre of the Blue Sky Region
183 First Avenue West
North Bay, P1B 3B8
tel: 705-472-0200 22
fax: 705-472-1448
www.volunteernorthbay.on.ca
youthvolunteer@bellnet.ca

Volunteer Sault Ste. Marie
8 Albert Street East
Sault Ste. Marie, P6A 2H6
tel: 705-949-6565
fax: 705-759-5899
www.ssmunitedway.ca
linklaterc@ssmunitedway.ca

Volunteer Sudbury/Bénévolat Sudbury
960 Notre Dame Avenue
Sudbury, P3A 2T4
tel: 705-561-8873
fax: 705-560-2767
www.volunteersudbury.com
office@volunteersudbury.com

Volunteer Thunder Bay
125 South Syndicate Avenue, Unit 13, Victoriaville Mall
Thunder Bay, P7E 6H8
tel: 807-623-8272 225
fax: 807-622-6435
www.volunteerthunderbay.ca
info@volunteerthunderbay.ca

Volunteer Timmins
85 Pine Street South, Suite 07, Lower Concourse
Timmins, P4N 2K1
tel: 705-264-9765
fax: 705-264-9767
www.volunteertimmins.com
timvol@vianet.on.ca

ON - South-Western

Volunteer Halton
860 Harrington Court, Suite 209
Burlington, L7N 3N4
tel: 905-632-1975
fax: 905-632-0778
www.volunteerhalton.ca
acoburn@cdhalton.ca

Volunteer Cambridge
150 Main Street, 2nd Floor
Cambridge, N1R 6P9
tel: 519-623-0423
fax: 519-623-9298
www.cvbinfocam.on.ca
jacki@cvbinfocam.on.ca

Volunteer Hamilton
627 Main Street East, Suite 206
Hamilton, L8M 1J5
tel: 905-523-4444
fax: 905-523-7465
www.volunteerhamilton.on.ca
christopher@volunteerhamilton.on.ca

Volunteer Centre of Guelph/Wellington
46 Cork Street East, Unit 1
Guelph, N1H 2W8
tel: 866-693-3318
fax: 519-822-1389
www.volunteerguelphwellington.on.ca
info@volunteerguelphwellington.on.ca

Volunteer Connections
5017 Victoria Avenue
Niagara Falls, L2E 4C9
tel: 905-356-6580
fax: 905-356-3522
www.informationniagara.com
claire@informationniagara.com

Volunteer Action Centre of Kitchener-Waterloo and Area
151 Frederick Street, Suite 300
Kitchener, N2H 2M2
tel: 519-742-8610
fax: 519-742-0559
www.volunteerkw.ca
jane@volunteerkw.ca

United Way of Windsor-Essex County Volunteer Centre
300 Giles Boulevard East, Unit A1
Windsor, N9A 4C4
tel: 519-258-0000 1188
fax: 519-258-2346
www.weareunited.com
nadams@weareunited.com

APPENDIX E3

MUTUAL AID AGREEMENT

MUTUAL ASSISTANCE AGREEMENT

This Mutual Assistance Agreement is entered into by and among those hospitals executing it, effective as to each hospital on the date of its execution. The North Dakota Healthcare Association (NDHA) will advise each hospital executing this Agreement of the identity of other hospitals which have executed the Agreement, and the names, addresses and telephone numbers of each executing hospital's Designated Representative. Each executing hospital and the North Dakota Department of Health shall be a "party" to this Agreement.

RECITALS

WHEREAS, hospital acknowledges that each party may from time to time find it necessary to evacuate and transfer patients due to the occurrence of an external or internal disaster; and

WHEREAS, the parties further acknowledge that each party may from time to time lack the staff, equipment, supplies and other essential services to optimally meet the needs of patients due to the occurrence of an external or internal disaster; and

WHEREAS, the parties recognize that certain of the equipment and supplies which may be used in meeting the needs of patients during an internal or external disaster were purchased through grant money provided by the Department; and

WHEREAS, the parties have determined that a Mutual Assistance Agreement, developed prior to a sudden and immediate disaster is needed to facilitate communication between and among the parties to coordinate the transfer of patients and the sharing of staff, equipment, supplies and other essential services in the event of an external or internal disaster;

NOW, THEREFORE, in consideration of the above recitals and for other good and valuable considerations, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Definitions.

a. "Affected Hospital" is a party which is impacted by an External or Internal Disaster and requests to transfer patients to another party, or requests the assistance of another party.

b. "Assisting Hospital" is a party which is available upon request to receive the transfer of patients from an Affected Hospital.

c. "Designated Representative" is the individual or position designated by each party to communicate with another party and to determine the distribution of information within their own healthcare organization in the event of an External or Internal Disaster.

d. "External Disaster" means a disaster occurring or imminent in the community surrounding a party. An External Disaster may affect the entire facility or only a portion of the facility.

e. "Internal Disaster" means a disaster occurring within a party's facility that materially affects the party's ability to provide patient care. An Internal Disaster may affect the entire facility or only a portion of the facility.

f. "Lending Hospital" is a party which is available to provide staff, equipment, supplies and/or other essential services to another party in the event of an External or Internal Disaster. Each executing hospital recognizes and agrees that, depending on circumstances, it may be an Affected Hospital, an Assisting Hospital, or a Lending Hospital.

2. Identification of Designated Representative. Each party agrees to provide to the NDHA and the Department the name and contact information of its Designated Representative who will be available to perform the functions stated in the definition above, and at least one back-up individual to serve as the Designated Representative in the primary Designated Representative's absence. The names and contact information for the executing hospital's Designated Representative and back-up individual will be provided to each executing hospital by the NDHA.

3. Transfer of Patients. Each party is willing to accept patients transferred by another party under the terms and conditions set forth in this Agreement.

4. Transfer Responsibilities of Affected Hospital. The parties agree that in the event it becomes necessary to transfer patients from an Affected Hospital to an Assisting Hospital, the Affected Hospital shall

a. Contact the Designated Representative at the Assisting Hospital as soon as the Affected Hospital becomes aware of the need to transfer patients;

b. Comply with any limitations communicated to the Affected Hospital regarding the numbers and types/acuity of patients that the Assisting Hospital is able to accept;

c. Triage all patients prior to transfer to verify that the types and acuity of services required are within any limitations communicated to the Affected Hospital regarding the numbers and types/acuity of patients that the Assisting Hospital is able to accept;

d. Arrange for the transport of each patient to the Assisting Hospital, with support of such medical personnel and equipment as is required by the patient's condition;

e. Deliver to the Assisting Hospital, with each patient transferred, to the extent available, the patient's medical records, or copies thereof, sufficient to indicate the patient's diagnoses, condition, and treatment provided and planned;

f. Make available one or more physicians of the Affected Hospital to address questions from the medical staff at the Assisting Hospital; and

g. If feasible, inventory the patient's personal effects and valuables transported to the Assisting Hospital with the patient. The Affected Hospital shall deliver the inventory and the patient's valuables to the personnel transporting the patient, and receive a receipt for such items. The Assisting Hospital shall, in turn, acknowledge and sign a receipt for the valuables delivered to it.

5. Transfer Responsibilities of Assisting Hospital. The parties agree that in accepting the transfer of patients from an Affected Hospital, an Assisting Hospital shall:

a. Ensure that the Designated Representative is available twenty-four (24) hours a day, seven (7) days a week to implement this Agreement and to communicate with the Affected Hospital regarding the numbers and types/acuity of patients who may be transferred.

b. Accept all transfers from the Affected Hospital that are within the limitations communicated by the Designated Representative of the Assisting Hospital. An Assisting Hospital shall not be obligated to accept any patients which exceed its capacity or staffing, which shall be determined in the Assisting Hospital's sole discretion.

c. Record in the clinical records of each transferred patient notations of the condition of the patient upon arrival at the Assisting Hospital.

d. If personal effects and valuables of the patient are transported with the patient, check those items against the inventory prepared by the Affected Hospital, and issue a receipt for such items as are received by the Assisting Hospital to the personnel transporting the patient.

6. Return of Patients to Affected Hospital. Once the internal or external disaster conditions that required the transfer have sufficiently resolved, and if medically appropriate for each individual patient, an Assisting Hospital shall make arrangements to transfer the patients back to the Affected Hospital as soon as practicable. Upon re-transfer to the Affected Hospital, the Assisting Hospital will return any original medical records, including x-ray films, transferred with the patient. The Assisting Hospital shall also provide copies of medical records regarding all care provided to the patient by the Assisting Hospital.

7. Discharge by Assisting Hospital. If a transferred patient is discharged by an Assisting Hospital, the Assisting Hospital will return to the Affected Hospital any original medical records, including x-ray films, transferred with the patient. If the Affected Hospital is not then able to receive the returned medical records, the Assisting Hospital will retain the records in its records department until requested by the Affected Hospital.

8. Charges for Services. All charges for services provided at an Affected Hospital or at an Assisting Hospital for patients transferred pursuant to this Agreement shall be collected by the party providing such services directly from the patient, third party payor or other source normally billed by the party. The parties agree to cooperate with each other in billing and collecting for services furnished to patients pursuant to this Agreement. The billing and collection of charges for transportation of the patient from an Affected Hospital to an Assisting Hospital (and to return the patient to the Affected Hospital) shall be the responsibility of the Affected Hospital.

9. Loans of Personnel. The parties agree that an Affected Hospital may, due to an external or internal disaster, require the need for additional personnel from a Lending Hospital. The Lending Hospital, in its sole discretion and consistent with paragraph 24 below, will identify personnel that it can make available to the Affected Hospital, the time periods during which the personnel are available, and the duration of time the Lending Hospital anticipates it can continue to make such personnel available to the Affected Hospital. If at any time the Lending Hospital determines the return of all or some of its loaned personnel is necessary for the proper staffing of the Lending Hospital, then upon notice to the Affected Hospital, the Lending Hospital may direct its personnel

to return to work at the Lending Hospital and such action shall not be a breach of this Agreement.

10. Communication of Request for Personnel. A request for the loan of personnel can be made verbally. The request, however, must be followed up in writing. The Affected Hospital will identify to the Lending Hospital the following:

a. The type (including required competencies) and number of requested personnel;

b. An estimate of how quickly the response is needed;

c. The location where such loaned personnel are to report; and

d. A brief description of how the loaned personnel will be used.

11. Identification of Loaned Personnel. Arriving loaned personnel will present their identification at the site designated by the Affected Hospital. The Affected Hospital will be responsible for the following:

a. Meeting the arriving loaned personnel; and

b. Confirming the loaned personnel's identification with the list of personnel provided by the Lending Hospital.

12. Supervision of Loaned Personnel. The Affected Hospital's Designated Representative will identify where and to whom the loaned personnel are to report. Professional staff of the Affected Hospital will supervise the loaned personnel.

13. Credentials of Loaned Personnel. The Affected Hospital agrees to accept the professional credentialing determination made by the Lending Hospital for those services for which such personnel are credentialed or certified by the Lending Hospital.

14. Return of Loaned Personnel. The Affected Hospital is responsible for providing the loaned personnel transportation necessary for their return to the Lending Hospital.

15. Charges. The Affected Hospital will reimburse to Lending Hospital all costs associated with the loaned personnel, including, without limitation, the wages and benefits of such personnel for the period loaned. The Lending Hospital will furnish to the Affected Hospital an invoice reflecting the costs, and upon request by the Affected Party

will provide information as necessary to reasonably verify the claimed costs. All charges for patient care provided by loaned personnel will be billed by and shall be the property of the Affected Hospital.

16. Loaning Supplies and/or Equipment. The parties agree that an Affected Hospital may, due to an external or internal disaster, need the use of additional supplies and equipment.

17. Communication of Request for Supplies and Equipment. A request for supplies or the loan of equipment can be made verbally. The request, however, must be followed up in writing. The Affected Hospital will identify the following:

a. The quantity and exact type of requested items;

b. An estimate of how quickly a response is needed;

c. Time period for which the supplies or equipment will be needed; and

d. Location to which the supplies or equipment should be delivered.

The Lending Hospital, in its sole discretion and consistent with paragraph 24 and subject to paragraph 25 below, will identify which requests it can meet, how long it will take to fulfill the request, and, in the case of loaned equipment, how long the equipment can be made available to the Affected Hospital. If at any time the Lending Hospital determines the return of all or some of the loan equipment is necessary for the proper operation of the Lending Hospital, then upon request by notice to the Affected Hospital, the Affected Hospital will return such equipment, and such request shall not be a breach of this Agreement.

18. Documentation of Supplies and Equipment. The Affected Hospital will use the Lending Hospital's standard order requisition form as documentation of the request and receipt of the materials. The Affected Hospital's Designated Representative will confirm the receipt of the material resources. The documentation will detail at least the following:

a. The supplies and/or equipment involved; and

b. The condition of the equipment prior to the loan (if applicable).

19. Transportation of Supplies and Equipment. When feasible, the Affected Hospital will be responsible for transporting the requested supplies and equipment. If the

Affected Hospital is unable to transport such supplies or equipment, the Lending Hospital will arrange for shipping/transportation to and from the Affected Hospital. All expenses of shipping/transport shall be the responsibility of the Affected Hospital.

20. Responsibility for Supplies and Equipment. The Affected Hospital is responsible for appropriate use and maintenance of all loaned supplies and equipment.

21. Charges for Loaned Supplies and Equipment. The Affected Hospital shall be responsible for all costs arising from the use, damage, or loss of requested supplies and loaned equipment. Charges for equipment shall be at actual lease rate prorated by the number of days of use, or by the fair market rental value of comparable equipment, as chosen by the Lending Hospital. Charges for supplies will be at the Lending Hospital's costs.

22. Responsibility; Insurance. Each party shall be responsible for any and all property damage or personal injury caused by the acts or omissions of its employees acting within the scope of employment. Each party shall throughout the term of this Agreement maintain comprehensive general liability insurance, workers compensation insurance, property insurance and professional liability (malpractice) insurance to cover their activities hereunder and upon request of another party shall provide to the other party certificates evidencing the existence of such insurance coverage. Each party may at its option satisfy its obligations under this section through self-insurance programs and protections deemed by it to be comparable to the insurance coverage described herein, and upon request, provide to the other party information showing that the self-insurance programs offer such comparable protection.

23. Independent Relationship. None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create a partnership, joint venture or any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement.

24. Affiliation With Other Facilities. Nothing in this Agreement shall be construed as limiting the right of the parties to affiliate or contract with any other entity operating a hospital or any other health care facility on either a limited or general basis while this Agreement is in effect. Each party acknowledges that, in the event of a large scale External Disaster, the ability of an Assisting Hospital to accept patients from the Affected Hospital may be affected by its receipt of patients from other sources, including direct admissions from the community and transfers of patients from other facilities, or other factors. This Mutual Assistance Agreement is not intended to establish a preferred status for patients of Affected Hospitals. All decisions regarding allocation of available personnel, equipment and supplies will be made by the Assisting Hospital and/or the

Lending Hospital using its best judgment about its capabilities at the time and the needs of its community.

25. **Authority of Department.** All parties to this agreement recognize that certain of the supplies and equipment available for use in any internal and external disaster have been purchased through a grant administered by the Department. In the event of an internal or external disaster requiring coordination at statewide level, as determined by an appropriate representative designated by the Governor, the Department may direct the distribution, utilization and location of use of any and all supplies and equipment owned by any party to this Agreement, which supplies and equipment were initially purchased with grant funds from the Department.

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

27. **Copy of Agreement.** A conformed copy of this Agreement, with all amendments, if any, together with a copy of any policies and procedures, referral forms or other documents adopted by the parties to implement this Agreement shall be kept in an administrative file of each of the parties for ready reference.

28. **Modification of Agreement.** This Agreement contains the entire understanding of the parties and shall not be modified except by an instrument in writing signed by the parties.

29. **No Waiver.** No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision of this Agreement or of any succeeding breach of the same provision.

30. **Governing Law.** This Agreement, and the rights, obligations and remedies of the parties hereto, shall be governed by and construed in accordance with the laws of the State of North Dakota.

31. **Access to Records.** If this Agreement is subject to Section 952 of the Omnibus Reconciliation Act of 1980, 42 U.S.C. § 1395-x (v)(1)(I) (the "Statute") and the regulations promulgated thereunder, 42 C.F.R. Part 420, Subpart D (the "Regulations"), the parties shall, until the expiration of four (4) years after furnishing of services pursuant to this Agreement, make available, upon proper request, to the Secretary of Health and Human Services and to the Comptroller General of the United States, or any of their duly authorized representatives, the Agreement and the books, documents and records of the

parties that are necessary to certify the nature and extent of the cost of services furnished pursuant to the Agreement for which payment may be made under the Medicare program. If the Agreement is subject to the Statute and Regulations and any party carries out any of the duties of the Agreement through a subcontract, with a value or cost of $10,000 or more over a twelve (12) month period, with a related organization, that subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of services pursuant to such subcontract, the related organization shall make available, upon proper request, to the Secretary and the Comptroller General, or any of their duly authorized representatives, the subcontract and the books, documents and records of such related organization that are necessary to verify the nature and extent of such costs.

32. Termination of Agreement by Party. Any party may terminate its participation in this Agreement by providing sixty (60) days written notice to the President of NDHA. The NDHA will notify all other parties of said termination.

Date:_____ _____

BY:_____
Its:_____

Identification of Designated Representatives:_____

APPENDIX E4

EMERGENCY HEALTH POWERS ACT

TITLE 26. HEALTH AND VITAL STATISTICS
CHAPTER 13. EMERGENCY HEALTH POWERS

N.J. Stat. § 26:13-1 (2008)

§ 26:13-1. Short title

This act shall be known and may be cited as the "Emergency Health Powers Act."

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
*** FIRST ANNUAL SESSION (P.L. 2008 CH. 12) ***
*** ANNOTATIONS CURRENT THROUGH APRIL 14, 2008 ***

TITLE 26. HEALTH AND VITAL STATISTICS
CHAPTER 13. EMERGENCY HEALTH POWERS

N.J. Stat. § 26:13-2 (2008)

§ 26:13-2. Definitions relative to emergency health powers

As used in this act:

"Biological agent" means any microorganism, virus, bacterium, rickettsiae, fungus, toxin, infectious substance or biological product that may be naturally occurring or engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, bacterium, rickettsiae, fungus, infectious substance or biological product, capable of causing death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism.

"Bioterrorism" means the intentional use or threat of use of any biological agent, to cause death, disease or other biological malfunction in a human, animal, plant or other living organism, or degrade the quality and safety of the food, air or water supply.

"Chemical weapon" means a toxic chemical and its precursors, except where intended for a lawful purpose as long as the type and quantity is consistent with such a purpose. Chemical weapon includes, but is not limited to: nerve agents, choking agents, blood agents and incapacitating agents.

"Commissioner" means the Commissioner of Health and Senior Services, or the commissioner's designee.

"Contagious disease" means an infectious disease that can be transmitted from person to person.

"Department" means the Department of Health and Senior Services.

"Health care facility" means any non-federal institution, building or agency, or portion thereof whether public or private for profit or nonprofit that is used, operated or designed to provide health services, medical or dental treatment or nursing, rehabilitative or preventive care to any person. Health care facility includes, but is not limited to: an ambulatory surgical facility, home health agency, hospice, hospital, infirmary, intermediate care facility, dialysis center, long-term care facility, medical assistance facility, mental health center, paid and volunteer emergency medical services, outpatient facility, public health center, rehabilitation facility, residential treatment facility, skilled nursing facility and adult day care center. Health care facility also includes, but is not limited to, the following related property when used for or in connection with the foregoing: a laboratory, research facility, pharmacy, laundry facility, health personnel training and lodging facility, patient, guest and health personnel food service facility, and the portion of an office or office building used by persons engaged in health care professions or services.

"Health care provider" means any person or entity who provides health care services including, but not limited to: a health care facility, bioanalytical laboratory director, perfusionist, physician, physician assistant, pharmacist, dentist, nurse, paramedic, respiratory care practitioner, medical or laboratory technician, and ambulance and emergency medical workers.

"Infectious disease" means a disease caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, virus or prion. An

infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person.

"Isolation" means the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected, on the basis of signs, symptoms or laboratory analysis, with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.

"Local health agency" means a county, regional, municipal or other governmental agency organized for the purpose of providing health services, administered by a full-time health officer and conducting a public health program pursuant to law.

"Local Information Network and Communications System Agency" or " LINCS agency" means the lead local public health agency in each county or identified city, as designated and determined by the commissioner pursuant to section 21 of this act, responsible for providing central planning, coordination and delivery of specialized services within the designated county or city, in partnership with the other local health agencies within that jurisdiction, in order to prepare for and respond to acts of bioterrorism and other forms of terrorism or other public health emergencies or threats, and to discharge the activities as specified under this act.

"Microorganism" includes, but is not limited to, bacteria, viruses, fungi, rickettsiae, or protozoa.

"Nuclear or radiological device" means: any nuclear device which is an explosive device designed to cause a nuclear yield; an explosive radiological dispersal device used directly or indirectly to spread radioactive material; or a simple radiological dispersal device which is any act, container or any other device used to release radiological material for use as a weapon.

"Overlap agent or toxin" means: any microorganism or toxin that poses a risk to both human and animal health and includes:

Anthrax -- Bacillus anthracis

Botulism -- Clostridium botulinum toxin, Botulinum neurotoxins, Botulinum neurotoxin producing species of Clostridium

Plague -- Yersinia pestis

Tularemia -- Francisella tularensis

Viral Hemorrhagic Fevers -- Ebola, Marburg, Lassa, Machupo

Brucellosis- Brucellosis species

Glanders -- Burkholderia mallei

Melioidosis -- Burkholderia pseudomallei

Psittacosis -- Chlamydophila psittaci

Coccidiodomycosis -- Coccidiodes immitis

Q Fever -- Coxiella burnetii

Typhus Fever -- Rickettsia prowazekii

Viral Encephalitis -- VEE (Venezuelan equine encephalitis virus), EEE (Eastern equine encephalitis), WEE (Western equine encephalitis)

Toxins -- Ricinus communis, Clostridium perfringens, Staph. Aureus, Staphylococcal enterotoxins, T-2 toxin, Shigatoxin

Nipah -- Nipah virus

Hantavirus -- Hantavirus

West Nile Fever -- West Nile virus

Hendra -- Hendra virus

Rift Valley Fever -- Rift Valley Fever virus

Highly Pathogenic Avian Influenza

"Public health emergency" means an occurrence or imminent threat of an occurrence that:

a. is caused or is reasonably believed to be caused by any of the following: (1) bioterrorism or an accidental release of one or more biological agents; (2) the appearance of a novel or previously controlled or eradicated biological agent; (3) a natural disaster; (4) a chemical attack or accidental release of toxic chemicals; or (5) a nuclear attack or nuclear accident; and

b. poses a high probability of any of the following harms: (1) a large number of deaths, illness or injury in the affected population; (2) a large number of serious or long-term impairments in the affected population; or (3) exposure to a biological agent or chemical that poses a significant risk of substantial future harm to a large number of people in the affected population.

"Quarantine" means the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possibly contagious disease and who do not show signs or symptoms of a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals. "Toxin" means the toxic material of plants, animals, microorganisms, viruses, fungi or infectious substances, or a recombinant molecule, whatever its origin or method of production, including:

a. any poisonous substance or biological product that may be engineered as a result of biotechnology or produced by a living organism; or

b. any poisonous isomer or biological product, homolog, or derivative of such a substance.

TITLE 26. HEALTH AND VITAL STATISTICS
CHAPTER 13. EMERGENCY HEALTH POWERS

N.J. Stat. § 26:13-3 (2008)

§ 26:13-3. Declaration of public health emergency

a. The Governor, in consultation with the commissioner and the Director of the State Office of Emergency Management, may declare a public health emergency. In declaring a public health emergency, the Governor shall issue an order that specifies:

(1) the nature of the public health emergency;

(2) the geographic area subject to the declaration;

(3) the conditions that have brought about the public health emergency to the extent known; and

(4) the expected duration of the state of public health emergency, if less than 30 days. Such order may also prescribe necessary actions or countermeasures to protect the public's health.

b. Any public health emergency declared pursuant to this act shall be terminated automatically after 30 days unless renewed by the Governor under the same standards and procedures set forth in subsection a. of this section.

c. The commissioner shall coordinate all matters pertaining to the public health response to a public health emergency, and shall have primary jurisdiction, responsibility and authority for:

(1) planning and executing public health emergency assessment, prevention, preparedness, response and recovery for the State;

(2) coordinating public health emergency response between State and local authorities;

(3) collaborating with relevant federal government authorities, elected officials and relevant agencies of other states, private organizations or companies;

(4) coordinating recovery operations and prevention initiatives subsequent to public health emergencies; and

(5) organizing public information activities regarding public health emergency response operations.

All such activities shall be taken in coordination with the State Office of Emergency Management and shall be executed in accordance with the State Emergency Operations Plan. The State Office of Emergency Management shall provide the commissioner with all required assistance.

d. In instances involving an overlap agent or toxin that causes or has the potential to cause a public health emergency, if the Commissioner of Health and Senior Services suspects or detects conditions that could potentially affect animals, plants or crops under the jurisdiction of the Department of Agriculture pursuant to the provisions of Title 4 of the Revised Statutes, he shall immediately notify the Secretary of Agriculture. If the Secretary of Agriculture suspects or detects conditions that could potentially affect humans, he shall immediately notify the commissioner. Information shared by each department shall be held confidential by the departments and their employees and their designees,

and shall not be released without the approval of the department that was the source of the information.

e. To the fullest extent practicable, the commissioner shall also promptly notify the elected municipal officials and applicable health care facilities of the jurisdiction affected by the public health emergency of the nature and extent of the emergency.

f. All orders of the commissioner shall remain in effect during the period of the public health emergency until superseded by order of the Governor pursuant to P.L. 1942, c. 251 (C. App.A:9-33 et seq.). Upon the issuance of an order by the Governor pursuant to P.L. 1942, c. 251, the commissioner shall coordinate the public health emergency in accordance with the State Emergency Operations Plan. Upon declaration of a disaster pursuant to P.L. 1942, c. 251, the Governor may exercise the powers granted to the commissioner pursuant to this act.

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N.J. Stat. § 26:13-4 (2008)

§ 26:13-4. Investigation of incident, imminent threat; reporting requirements

a. In order to detect the occurrence or imminent threat of an occurrence of a public health emergency as defined in this act, the commissioner may take reasonable steps to investigate any incident or imminent threat of any human disease or health condition. Such investigation may include, and the commissioner may issue and enforce orders requiring, information from any health care provider or other person affected by, or having information related to, the incident or threat, inspections of buildings and conveyances and their contents, laboratory analysis of samples collected during the course of such inspection, and where the commissioner has reasonable grounds to believe a public health emergency exists, requiring a physical examination or the provision of specimens of body secretions, excretions, fluids and discharge for laboratory examination of any person suspected of having a disease or health condition that necessitates an investigation under this subsection, except where such action would be reasonably likely to lead to serious harm to the affected person.

In instances involving an overlap agent or toxin, the Department of Agriculture shall be the lead agency with respect to surveillance, testing, sampling, detection and investigation related to animals, plants or crops under the jurisdiction of the Department of Agriculture pursuant to the provisions of Title 4 of the Revised Statutes, and shall coordinate its activities with all appropriate local, State and federal agencies.

b. A health care provider or medical examiner shall report to the department and to the local health official all cases of persons who harbor or are suspected of harboring any illness or health condition that may be reasonably believed to be potential causes of a public health emergency. Reportable illnesses and health conditions include, but are not limited to, any illnesses or health conditions identified by the commissioner.

c. In addition to the foregoing requirements for health care providers, a pharmacist shall, at the direction of the commissioner, report:

(1) an unusual increase in the number or type of prescriptions to treat conditions that the commissioner identifies by regulation;

(2) an unusual increase in the number of prescriptions for antibiotics; and

(3) any prescription identified by the commissioner that treats a disease that is relatively uncommon or may be associated with terrorism.

d. The reports shall be made to such State and local officials in accordance with the method and time frame as specified by the commissioner. The reports shall include the specific illness or health condition that is the subject of the report and a case number assigned to the report that is linked to the patient file in possession of the health care provider or medical examiner, along with the name and address of the health care provider or medical examiner. Based on any such report, where the commissioner has reasonable grounds to believe that a public health emergency exists, the health care provider or medical examiner shall provide a supplemental report including the following information: the patient's name, date of birth, sex, race, occupation, current home and work

addresses, including city and county, and relevant telephone contact numbers; the name and address of the health care provider or medical examiner and of the reporting individual, if different; designated emergency contact; and any other information needed to locate the patient for follow-up.

e. The provisions of this section shall not be deemed or construed to limit, alter or impair in any way the authority of the Department of Environmental Protection pursuant to "The Radiation Accident Response Act," P.L. 1981, c. 302 (C. 26:2D-37 et seq.), or of the State Office of Emergency Management in the Division of State Police, Department of Law and Public Safety. Any powers of inspection of buildings and conveyances for sources of radiation that are granted to the commissioner shall only be exercised upon the concurrence of the Commissioner of Environmental Protection.

f. The provisions of this section shall not be deemed or construed to limit, alter or impair in any way the authority of the Department of Agriculture pursuant to its jurisdiction under the laws and policies governing that department.

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N.J. Stat. § 26:13-5 (2008)

§ 26:13-5. Duties of commissioner relative to public health emergency

Where the commissioner has reasonable grounds to believe a public health emergency exists, the commissioner shall: ascertain the existence of cases of an illness or health condition that may be potential causes of a public health emergency; investigate all such cases for sources of infection and ensure that they are subject to proper control measures; and define the distribution of the illness or health condition. To fulfill these duties, the commissioner shall identify exposed individuals as follows:

a. The commissioner shall identify individuals thought to have been exposed to an illness or health condition that may be a potential cause of a public health emergency.

b. The commissioner shall counsel and interview such individuals where needed to assist in the positive identification of exposed individuals and develop information relating to the source and spread of the illness or health condition. The information shall include the name and address, including city and county, of any person from whom the illness or health condition may have been contracted and to whom the illness or health condition may have spread.

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N.J. Stat. § 26:13-6 (2008)

§ 26:13-6. Emergency Health Care Provider Registry

The commissioner may establish a registry of health care workers, public health workers and support services personnel who voluntarily consent to provide health care, public health services and support logistics during a public health emergency. This registry shall be known as the Emergency Health Care Provider Registry.

The commissioner may require training related to the provision of health care, public health services and support services in an emergency or crisis as a condition of registration.

a. The commissioner may issue identification cards to health care workers, public health workers and support services personnel included in the registry established under this section that:

(1) Identify the health care worker, public health worker or support services personnel;

(2) Indicate that the individual is registered as a New Jersey emergency health care worker, public health worker or support services personnel;

(3) Identify the professional license or certification held by the individual; and

(4) Identify the individual's usual area of practice if that information is available and the commissioner determines that it is appropriate to provide that information.

b. The commissioner shall establish a form for identification cards issued under this section.

c. The commissioner may identify all or part of a health care facility or other location as an emergency health care center. Upon the declaration of a public health emergency, an emergency health care center may be used for:

(1) Evaluation and referral of individuals affected by the emergency or crisis;

(2) Provision of health care services, including vaccination, mass prophylaxis, isolation and quarantine; and

(3) Preparation of patients for transportation.

The commissioner may direct designated LINCS agencies, or their successors, and local public health authorities to identify emergency health care centers under this subsection.

d. In the event the Governor declares a public health emergency, the commissioner may direct health care workers, public health workers and support services personnel registered under this section who are willing to provide health care services on a voluntary basis to proceed to any place in this State where health care services or public health services are required by reason of the public health emergency.

e. An emergency health care worker, public health worker and support services personnel registered under this section may volunteer to perform health care or public health services at any emergency health care center.

f. In the event the Governor declares a public health emergency, the commissioner may waive health care facility medical staff privileging requirements for individuals registered as emergency health care workers, and hospitals shall permit registered emergency health care workers to exercise privileges at the hospital for the duration of the public health emergency.

g. An emergency health care worker, public health worker and support services personnel registered under this section who provides health care services on a voluntary basis shall not be liable for any civil damages as a result of the person's acts or omissions in providing medical care or treatment related to the public health emergency in good faith and in accordance with the provisions of this act.

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
*** FIRST ANNUAL SESSION (P.L. 2008 CH. 12) ***
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N.J. Stat. § 26:13-7 (2008)

§ 26:13-7. Actions during state of public health emergency, coordination

During a state of public health emergency or in response to a public health emergency:

a. The commissioner, State Medical Examiner and Commissioner of Environmental Protection shall coordinate and consult with each other on the performance of their respective functions regarding the safe disposition of human remains, to devise and implement measures which may include, but are not limited to, the following:

(1) To take actions or issue and enforce orders to provide for the safe disposition of human remains as may be reasonable and necessary to respond to the public health emergency. Such measures may include, but are not limited to, the temporary mass burial or other interment, cremation, disinterment, transportation and disposition of human remains. To the extent possible, religious, cultural, family, and individual beliefs of the deceased person or his family shall be considered when determining disposition of any human remains;

(2) To determine whether there is a need to investigate any human deaths related to the public health emergency, and take such steps as may be appropriate to enable the State Medical Examiner, or his designee, to take possession or control of any human remains and perform an autopsy of the body under protocols of the State Medical Examiner consistent with safety as the public health emergency may dictate;

(3) To direct or issue and enforce orders requiring any business or facility, including but not limited to, a mortuary or funeral director, authorized to hold, embalm, bury, cremate, inter, disinter, transport and dispose of human remains under the laws of this State to accept any human remains or provide the use of its business or facility if such actions are reasonable and necessary to respond to the public health emergency and are within the safety precaution capabilities of the business or facility; and

(4) To direct or issue and enforce orders requiring that every human remains prior to disposition be clearly labeled with all available information to identify the decedent, which shall include the requirement that any human remains of a deceased person with a contagious disease shall have an external, clearly visible tag indicating that the human remains are infected and, if known, the contagious disease.

b. The person in charge of disposition of any human remains shall maintain a written or electronic record of each human remains and all available information to identify the decedent and the circumstances of death and disposition. If human remains cannot be identified prior to disposition, a person authorized by the State Medical Examiner shall, to the extent possible, take fingerprints and photographs of the human remains, obtain identifying dental information, and collect a DNA specimen, under protocols of the State Medical Examiner consistent with safety as the public health emergency may dictate. All information gathered under this subsection shall be promptly forwarded to the State Medical Examiner who shall forward relevant information to the commissioner.

c. The commissioner and State Medical Examiner shall coordinate with the appropriate law enforcement agencies in any case where human remains may constitute evidence in a criminal investigation.

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
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N.J. Stat. § 26:13-8 (2008)

§ 26:13-8. Powers of commissioner relative to facilities, property; hearing

During a state of public health emergency, the commissioner may exercise the following powers over facilities or property:

a. Facilities. To close, direct and compel the evacuation of, or to decontaminate or cause to be decontaminated, any facility of which there is reasonable cause to believe that it may endanger the public health.

(1) Concurrent with or within 24 hours of decontamination or closure of a facility, the commissioner shall provide the facility with a written order notifying the facility of:

(a) the premises designated for decontamination or closure;

(b) the date and time at which the decontamination or closure will commence;

(c) a statement of the terms and conditions of the decontamination or closure;

(d) a statement of the basis upon which the decontamination or closure is justified; and

(e) the availability of a hearing to contest a closure order of a health care facility, as provided in paragraph (2) of this subsection.

(2) A health care facility subject to a closure order pursuant to this section may request a hearing in the Superior Court to contest the order.

Upon receiving a request for a hearing, the court shall fix a date for a hearing. The hearing shall be held within 72 hours of receipt of the request by the court, excluding Saturdays, Sundays and legal holidays. The court may proceed in a summary manner. At the hearing, the burden of proof shall be on the commissioner to prove by a preponderance of the evidence that the health care facility poses a threat to the public health and the closure order issued by the commissioner is warranted to address the threat.

(3) If, upon a hearing, the court finds that the closure of the health care facility is not warranted, the facility shall be released immediately from the closure order and reopened.

(4) The manner in which the request for a hearing pursuant to this subsection is filed and acted upon shall be in accordance with the Rules of Court.

b. Property. To decontaminate or cause to be decontaminated, or destroy, subject to the payment of reasonable costs as provided for in sections 24 and 25 of this act, any material of which there is reasonable cause to believe that it may endanger the public health.

c. In instances involving an overlap agent or toxin that causes a public health emergency, the department and the Department of Agriculture shall be responsible for their roles under their respective jurisdictions.

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
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N.J. Stat. § 26:13-9 (2008)

§ 26:13-9. Powers of commissioner relative to health care, other facilities, property, roads, public areas

During a state of public health emergency, the commissioner may exercise, for such period as the state of public health emergency exists, the following powers concerning health care and other facilities, property, roads, or public areas:

a. Use of property and facilities. To procure, by condemnation or otherwise, subject to the payment of reasonable costs as provided for in sections 24 and 25 of this act, construct, lease, transport, store, maintain, renovate or distribute property and facilities as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof. Such property and facilities include, but are not limited to, communication devices, carriers, real estate, food and clothing. This authority shall also include the ability to accept and manage those goods and services donated for the purpose of responding to a public health emergency. The authority provided to the commissioner pursuant to this section shall not affect the existing authority or emergency response of other State agencies.

b. Use of health care facilities.

(1) To require, subject to the payment of reasonable costs as provided for in sections 24 and 25 of this act, a health care facility to provide services or the use of its facility if such services or use are reasonable and necessary 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 health care facility. After consultation with the management of the health care facility, the commissioner may determine that the use of the facility may include transferring the management and supervision of the facility to the commissioner for a limited or unlimited period of time, but shall not exceed the duration of the public health emergency. In the event of such a transfer, the commissioner shall use the existing management of the health care facility.

(2) Concurrent with or within 24 hours of the transfer of the management and supervision of a health care facility, the commissioner shall provide the facility with a written order notifying the facility of:

(a) the premises designated for transfer;

(b) the date and time at which the transfer will commence;

(c) a statement of the terms and condition of the transfer;

(d) a statement of the basis upon which the transfer is justified; and

(e) the availability of a hearing to contest the order, as provided in paragraph (3) of this subsection.

(3) A health care facility subject to an order to transfer management and supervision to the commissioner pursuant to this section may request a hearing in the Superior Court to contest the order.

(a) Upon receiving a request for a hearing, the court shall fix a date for a hearing. The hearing shall be held within 72 hours of receipt of the request by the court, excluding Saturdays, Sundays and legal holidays. The court may proceed in a summary manner. At the hearing, the burden of proof shall be on the

commissioner to prove by a preponderance of the evidence that transfer of the management and supervision of the health care facility is reasonable and necessary to respond to the public health emergency and the order issued by the commissioner is warranted to address the need.

(b) If, upon a hearing, the court finds that the transfer of the management and supervision of the health care facility is not warranted, the facility shall be released immediately from the transfer order.

(c) The manner in which the request for a hearing pursuant to this subsection is filed and acted upon shall be in accordance with the Rules of Court.

(4) A health care facility which provides services or the use of its facility or whose management or supervision is transferred to the commissioner pursuant to this subsection shall not be liable for any civil damages as a result of the commissioner's acts or omissions in providing medical care or treatment or any other services related to the public health emergency.

(5) For the duration of a state of public health emergency, the commissioner shall confer with the Commissioner of Banking and Insurance to request that the Department of Banking and Insurance waive regulations requiring compliance by a health care provider or health care facility with a managed care plan's administrative protocols, including but not limited to, prior authorization and precertification.

c. Control of property. To inspect, control, restrict, and regulate by rationing and using quotas, prohibitions on shipments, allocation or other means, the use, sale, dispensing, distribution or transportation of food, clothing and other commodities, as may be reasonable and necessary to respond to the public health emergency.

d. To identify areas that are or may be dangerous to the public health and to recommend to the Governor and the Attorney General that movement of persons within that area be restricted, if such action is reasonable and necessary to respond to the public health emergency.

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
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N.J. Stat. § 26:13-10 (2008)

§ 26:13-10. Powers of commissioner relative to safe disposal of infectious waste

Notwithstanding the provisions of P.L. 1989, c. 34 (C. 13:1E-48.1 et seq.) to the contrary, during a state of public health emergency the commissioner may exercise in consultation with, and upon the concurrence of, the Commissioner of Environmental Protection, for such period as the state of public health emergency exists, the following powers regarding the safe disposal of infectious waste including, but not limited to, regulated medical waste as defined under P.L.1989, c.34.

a. To issue and enforce orders to provide for the safe disposal of infectious waste as may be reasonable and necessary to respond to the public health emergency. Such orders may include, but are not limited to, the collection, storage, handling, destruction, treatment, transportation, and disposal of infectious waste, including specific wastes generated in a home setting or in isolation or quarantine facilities.

b. To require any business or facility authorized to collect, store, handle, destroy, treat, transport and dispose of infectious waste under the laws of this State, and any landfill business or other such property, to accept infectious waste, or provide services or the use of the business, facility or property if such action is reasonable and necessary to respond to the public health emergency, as a condition of licensure, authorization or the ability to continue doing business in the State as such a business or facility. The use of the business, facility or property may include transferring the management and supervision of such business, facility or property to the department for a limited or unlimited period of time, but shall not exceed the duration of the public health emergency.

c. To procure, by condemnation or otherwise, subject to the payment of reasonable costs as provided for in sections 24 and 25 of this act, any business or facility authorized to collect, store, handle, destroy, treat, transport and dispose of infectious waste under the laws of this State and any landfill business or other such property as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof.

d. To require that all bags, boxes or other containers for infectious waste shall be clearly identified as containing infectious waste, and if known, the type of infectious waste.

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N.J. Stat. § 26:13-11 (2008)

§ 26:13-11. Powers of commissioner relative to medications, medical supplies; rationing

a. During a state of public health emergency, the commissioner may purchase, obtain, store, distribute or take for priority redistribution any anti-toxins, serums, vaccines, immunizing agents, antibiotics and other pharmaceutical agents or medical supplies as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof.

b. If a state of public health emergency results in a Statewide or regional shortage or threatened shortage of any product under subsection a. of this section, the commissioner may issue and enforce orders to control, restrict and regulate by rationing and using quotas, prohibitions on shipments, allocation or other means, the use, sale, dispensing, distribution or transportation of the relevant product necessary to protect the public health, safety and welfare of the people of the State.

c. In making rationing or other supply and distribution decisions, the commissioner may give preference to health care providers, disaster response personnel, mortuary staff and such other persons as the commissioner deems appropriate in order to respond to the public health emergency.

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N.J. Stat. § 26:13-12 (2008)

§ 26:13-12. Measures to prevent transmission, exposure

With respect to a declared state of public health emergency, the commissioner may take all reasonable and necessary measures to prevent the transmission of infectious disease or exposure to toxins or chemicals and apply proper controls and treatment for infectious disease or exposure to toxins or chemicals.

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N.J. Stat. § 26:13-13 (2008)

§ 26:13-13. Orders to submit specimen for diagnostic purposes

a. During a state of public health emergency, the commissioner may issue and enforce orders to any person to submit a specimen for physical examinations or tests as may be necessary for the diagnosis or treatment of individuals to prevent the spread of a contagious or possibly contagious disease, except where such actions are reasonably likely to lead to serious harm to the affected person, and to conduct an investigation as authorized under section 5 of this act.

b. Any person subject to an order to submit a specimen or for physical examination may request a hearing in the Superior Court to contest such order. The commissioner shall provide notice of the right to contest the order. The court may proceed in a summary manner. At the hearing, the burden of proof shall be on the commissioner to prove by a preponderance of the evidence that the person poses a threat to the public health and that the order issued by the commissioner is warranted to address such threat.

c. The commissioner may issue and enforce orders for the isolation or quarantine, pursuant to section 15 of this act, of any person whose refusal of medical examination or testing, or the inability to conduct such medical examination or testing due to the reasonable likelihood of serious harm caused to the person thereby, results in uncertainty regarding whether the person has been exposed to or is infected with a contagious or possibly contagious disease or otherwise poses a danger to public health.

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N.J. Stat. § 26:13-14 (2008)

§ 26:13-14. Powers of commissioner during public health emergency

During a state of public health emergency, the commissioner may exercise the following powers as necessary to address the public health:

a. Require the vaccination of persons as protection against infectious disease and to prevent the spread of a contagious or possibly contagious disease, except as provided in paragraph (3) of this subsection.

(1) Vaccination may be performed by any person authorized to do so under State law.

(2) No vaccine shall be administered without obtaining the informed consent of the person to be vaccinated.

(3) To prevent the spread of a contagious or possibly contagious disease, the commissioner may issue and enforce orders for the isolation or quarantine, pursuant to section 15 of this act, of persons who are unable or unwilling to undergo vaccination pursuant to this section.

b. Require and specify in consultation with and upon the concurrence of the Department of Environmental Protection and the State Office of Emergency Management, the procedures for the decontamination of persons, personal property, property and facilities exposed to or contaminated with biological agents, chemical weapons or release of nuclear or radiological devices.

c. Require, direct, provide, specify or arrange for the treatment of persons exposed to or infected with disease.

(1) Treatment may be administered by any person authorized to do so under State law.

(2) To prevent the spread of a contagious or possibly contagious disease, the commissioner may issue and enforce orders for the isolation or quarantine, pursuant to section 15 of this act, of persons who are unable or unwilling for reasons of health, religion or conscience to undergo treatment pursuant to this section.

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N.J. Stat. § 26:13-15 (2008)

§ 26:13-15. Isolation, quarantine procedures

The following isolation and quarantine procedures shall be in effect during a state of public health emergency:

a. The commissioner may exercise, for such period as the state of public health emergency exists, the following emergency powers over persons:

(1) to designate, including an individual's home when appropriate, and establish and maintain suitable places of isolation and quarantine;

(2) to issue and enforce orders for the isolation or quarantine of individuals subject to the procedures specified in this section; and

(3) to require isolation or quarantine of any person by the least restrictive means necessary to protect the public health, subject to the other provisions of this section. All reasonable means shall be taken to prevent the transmission of infection among the isolated or quarantined individuals, as well as among the personnel maintaining and caring for individuals in isolation or quarantine.

b. The following standards shall apply for quarantine or isolation.

(1) Persons shall be isolated or quarantined if it is determined by a preponderance of the evidence that the person to be isolated or quarantined poses a risk of transmitting an infectious disease to others. A person's refusal to accept medical examination, vaccination, or treatment pursuant to section 13 or 14 of this act shall constitute prima facie evidence that the person should be quarantined or isolated.

(2) Isolation or quarantine of any person shall be terminated by the commissioner when the person no longer poses a risk of transmitting an infectious disease to others.

c. (1) To the extent possible, the premises in which persons are isolated or quarantined shall be maintained in a safe and hygienic manner, designed to minimize the likelihood of further transmission of infection or other harm to persons subject to isolation or quarantine. Adequate food, clothing, medication, means of communication, other necessities and competent medical care shall be provided.

(2) An isolated person shall be confined separately from a quarantined person, unless otherwise determined by the commissioner.

(3) The health status of isolated and quarantined persons shall be monitored regularly to determine if their status should change. If a quarantined person subsequently becomes infected or is reasonably believed to have become infected with a contagious or possibly contagious disease, the person shall promptly be moved to isolation.

d. (1) A person subject to isolation or quarantine shall obey the commissioner's orders, shall not go beyond the isolation or quarantine premises, and shall not put himself in contact with any person not subject to isolation or quarantine other than a physician or other health care provider, or person authorized to enter the isolation or quarantine premises by the commissioner.

(2) No person, other than a person authorized by the commissioner, may enter the isolation or quarantine premises. Any person entering an isolation or quarantine premises may be isolated or quarantined.

e. (1) Except as provided in paragraph (4) of this subsection, the commissioner shall petition the Superior Court for an order authorizing the isolation or quarantine of a person or groups of persons.

(2) A petition pursuant to paragraph (1) of this subsection shall specify the following:

(a) the identity of the person or group of persons, by name or shared characteristics, subject to isolation or quarantine;

(b) the premises designated for isolation or quarantine;

(c) the date and time at which the commissioner requests isolation or quarantine to commence;

(d) the suspected contagious disease, if known;

(e) a statement of the terms and conditions of isolation and quarantine;

(f) a statement of the basis upon which isolation or quarantine is justified; and

(g) a statement of what effort, if any, has been made to give notice of the hearing to the person or group of persons to be isolated or quarantined, or the reason supporting the claim that notice should not be required.

(3) Except as provided in paragraph (4) of this subsection, before isolating or quarantining a person, the commissioner shall obtain a written order, which may be an ex parte order, from the Superior Court authorizing such action. The order shall be requested as part of a petition filed in compliance with paragraphs (1) and (2) of this subsection. The court shall grant an order upon finding by a preponderance of the evidence that isolation or quarantine is warranted pursuant to the provisions of this section. 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.

(4) Notwithstanding the provisions of paragraphs (1) through (3) of this subsection to the contrary, the commissioner may issue a verbal order, to be followed by a written order requiring the immediate, temporary isolation or quarantine of a person or group of persons, including those persons who have entered an isolation or quarantine premises, without first obtaining an order from the court if the commissioner determines that any delay in the isolation or quarantine of the person would significantly jeopardize the ability to prevent or limit the transmission of infectious or possibly infectious disease to others. The commissioner's written order shall specify:

(a) the identity of the person or group of persons, by name or shared characteristics, subject to isolation or quarantine;

(b) the premises designated for isolation or quarantine;

(c) the date and time at which the isolation or quarantine commences;

(d) the suspected contagious disease, if known;

(e) a statement of the terms and conditions of isolation and quarantine;

(f) a statement of the basis upon which isolation or quarantine is justified; and

(g) the availability of a hearing to contest the order.

The commissioner shall provide notice of the order for isolation or quarantine upon the person or group of persons specified in the order. If the commissioner determines that service of the notice required is impractical because of the number of persons or geographical areas affected, or other good cause, the

commissioner shall ensure that the affected persons are fully informed of the order using the best possible means available. A copy of the order shall also be posted in a conspicuous place in the isolation or quarantine premises.

Following the issuance of the commissioner's order directing isolation or quarantine, the commissioner shall file a petition pursuant to paragraphs (1) through (3) of this subsection as soon as possible, but not later than 72 hours thereafter.

(5) 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. In any proceedings brought for relief under this subsection, the court may extend the time for a hearing upon a showing by the commissioner that extraordinary circumstances exist that justify the extension.

(6) The court may order consolidation of individual claims into a group of claims where:

(a) the number of persons involved or to be affected is so large as to render individual participation impractical;

(b) there are questions of law or fact common to the individual claims or rights to be determined;

(c) the group claims or rights to be determined are typical of the affected individuals' claims or rights; and

(d) the entire group will be adequately represented in the consolidation, giving due regard to the rights of affected individuals.

f. (1) Following a hearing as provided for in paragraph (5) of subsection e. of this section, on or after a period of time of no less than 10 days but not more than 21 days, as determined by the commissioner based on the generally recognized incubation period of the infectious disease warranting the isolation or quarantine, a person isolated or quarantined pursuant to the provisions of this section may request a court hearing to contest his continued isolation or quarantine. The court may proceed in a summary manner.

The hearing shall be held within 72 hours of receipt of the request, excluding Saturdays, Sundays and legal holidays. A request for a hearing shall not act to stay the order of isolation or quarantine. At the hearing, the commissioner must show by a preponderance of the evidence that continuation of the isolation or quarantine is warranted because the person poses a significant risk of transmitting a disease to others with serious consequences.

(2) A person isolated or quarantined pursuant to the provisions of this section may request at any time a hearing in the Superior Court for injunctive relief regarding his treatment and the terms and conditions of the quarantine or isolation. Upon receiving a request for either type of hearing described in this paragraph, the court shall fix a date for a hearing. The court may proceed in a summary manner. The hearing shall be held no later than 10 days after the receipt of the request by the court. A request for a hearing shall not act to stay the order of isolation or quarantine.

(3) If, upon a hearing, the court finds that the isolation or quarantine of the individual is not warranted under the provisions of this section, then the person shall be immediately released from isolation or quarantine. If the court finds that the isolation or quarantine of the person is not in compliance with the provisions of subsection c. of this section, the court may fashion remedies appropriate to the circumstances of the state of public health emergency and in keeping with the provisions of this section.

g. (1) The petitioner shall have the right to be represented by counsel.

(2) The manner in which the request for a hearing under this section is filed and acted upon shall be in accordance with the Rules of Court.

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
*** FIRST ANNUAL SESSION (P.L. 2008 CH. 12) ***
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TITLE 26. HEALTH AND VITAL STATISTICS
CHAPTER 13. EMERGENCY HEALTH POWERS

N.J. Stat. § 26:13-16 (2008)

§ 26:13-16. Reinstatement of employment after isolation, quarantine

a. Any person who has been placed in isolation or quarantine pursuant to an order of the commissioner and who at the time of quarantine or isolation was in the employ of any public or private employer, other than a temporary position, shall be reinstated to such employment or to a position of like seniority, status and pay, unless the employer's circumstances have so changed as to make it impossible or unreasonable to do so, if the person:

(1) receives a certificate of completion of isolation or quarantine issued by the department or the authorized local health department;

(2) is still qualified to perform the duties of such position; and

(3) makes application for reemployment within 90 days after being released from isolation or quarantine.

b. If a public or private employer fails or refuses to comply with the provisions of this section, the Superior Court may, upon the filing of a complaint by the person entitled to the benefits of this section, specifically require the employer to comply with the provisions of this section, and may, as an incident thereto, order the employer to compensate the person for any loss of wages or benefits suffered by reason of the employer's unlawful action. A person claiming to be entitled to the benefits of this section may appear and be represented by counsel, or, upon application to the Attorney General, request that the Attorney General appear and act on his behalf. If the Attorney General is reasonably satisfied that the person so applying is entitled to the benefits, he shall appear and act as attorney for the person in the amicable adjustment of the claim, or in the filing of any complaint and the prosecution thereof. No fees or court costs shall be assessed against a person so applying for the benefits under this section. Attorney fees shall be awarded to the Attorney General or to the counsel for a person entitled to benefits under this section, who prevails in the proceeding.

c. The Attorney General may apply to the Superior Court and the court may grant additional relief to persons placed in isolation or quarantine under section 15 of this act, which relief may include, but is not limited to, relief similar to that accorded to military personnel under P.L. 1979, c. 317 (C. 38:23C-1 et seq.).

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
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N.J. Stat. § 26:13-17 (2008)

§ 26:13-17. Access to medical information

With respect to a state of public health emergency:

a. Access to medical information of individuals who have participated in medical testing, treatment, vaccination, isolation or quarantine programs or efforts by the commissioner pursuant to this act shall be limited to those persons having a legitimate need to acquire or use the information to:

(1) provide treatment to the individual who is the subject of the health information;

(2) conduct epidemiologic research;

(3) investigate the causes of the transmission;

(4) assist law enforcement agencies in the identification and location of victims of the public health emergency; or

(5) provide payment by a responsible party for treatment or services rendered.

b. Medical information held by the commissioner shall not be disclosed to others without individual written, specific informed consent, except for disclosures made:

(1) directly to the individual;

(2) to the individual's immediate family members or personal representative;

(3) to appropriate federal agencies or authorities pursuant to federal law;

(4) to local health departments assisting in the epidemiological investigation or disease containment countermeasures;

(5) to law enforcement agencies, including the State Medical Examiner, investigating the circumstances giving rise to the public health emergency, or in the identification and location of victims of the public health emergency;

(6) pursuant to a court order to avert a clear danger to an individual or the public health; or

(7) to identify a deceased individual or determine the manner or cause of death.

c. Strictly for the purposes of controlling and containing the public health emergency, the commissioner may provide medical information to a health care facility about an employee who has participated in medical treatment or testing which may impact upon the public health emergency. This information may include, but is not limited to, medical testing, treatment, vaccination, isolation or quarantine programs or efforts by the commission pursuant to this act when the commissioner deems that the health care facility should be advised of such medical information in order to take actions necessary to protect the health and well being of its patients, residents or other health care employees.

Nothing in this subsection shall be construed to allow for the release of medical information that is not related to the public health emergency or is protected under federal or State law.

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
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N.J. Stat. § 26:13-18 (2008)

§ 26:13-18. Emergency powers regarding health care personnel

During a state of public health emergency, the commissioner may exercise, for such period as the state of public health emergency exists, the following emergency powers regarding health care personnel:

a. To require in-State health care providers to assist in the performance of vaccination, treatment, examination or testing of any individual;

b. To appoint and prescribe the duties of such out-of-State emergency health care providers as may be reasonable and necessary to respond to the public health emergency, as provided in this subsection.

(1) The appointment of out-of-State emergency health care providers may be for such period of time as the commissioner deems appropriate, but shall not exceed the duration of the public health emergency. The commissioner may terminate the out-of-State appointments at any time or for any reason if the termination will not jeopardize the health, safety and welfare of the people of this State.

(2) The commissioner may waive any State licensing requirements, permits, fees, applicable orders, rules and regulations concerning professional practice in this State by health care providers from other jurisdictions; and

c. To authorize the State Medical Examiner, during the public health emergency, to appoint and prescribe the duties of county medical examiners, regional medical examiners, designated forensic pathologists, their assistants, out-of-State medical examiners and others as may be required for the proper performance of the duties of the office.

(1) The appointment of persons pursuant to this subsection may be for a limited or unlimited time, but shall not exceed the duration of the public health emergency. The State Medical Examiner may terminate the out-of-State appointments at any time or for any reason.

(2) The State Medical Examiner may waive any licensing requirements, permits or fees otherwise required for the performance of these duties, so long as the appointed emergency assistant medical examiner is competent to properly perform the duties of the office. In addition, if from another jurisdiction, the appointee shall possess the licensing, permit or fee requirement for medical examiners or assistant medical examiners in that jurisdiction.

d. (1) An in-State health care provider required to assist pursuant to subsection a. of this section and an out-of-State emergency health care provider appointed pursuant to subsection b. of this section shall not be liable for any civil damages as a result of the provider's acts or omissions in providing medical care or treatment related to the public health emergency in good faith and in accordance with the provisions of this act.

(2) An in-State health care provider required to assist pursuant to subsection a. of this section and an out-of-State emergency health care provider appointed pursuant to subsection b. of this section shall not be liable for any civil damages as a result of the provider's acts or omissions in undertaking public health preparedness activities, which activities shall include but not be limited to pre-event planning, drills and other public health preparedness efforts, in good faith and in accordance with the provisions of this act.

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N.J. Stat. § 26:13-19 (2008)

§ 26:13-19. Definitions relative to, and immunity from liability

a. As used in this section:

"Injury" means death, injury to a person or damage to or loss of property.

"Public entity" includes the State, and any county, municipality, district, public authority, public agency, and any other political subdivision or public body in the State. Public entity also includes any foreign governmental body, which is acting in this State under the authority of this act.

"State" means the State and any office, department, division, bureau, board, commission or agency of the State.

b. (1) A public entity and the agents, officers, employees, servants or representatives of a public entity, including volunteers, shall not be liable for an injury caused by any act or omission in connection with a public health emergency, or preparatory activities, that is within the scope of the authority granted under this act, including any order, rule or regulation adopted pursuant thereto. An agent, officer, employee, servant, representative or volunteer is not immune under this section, however, for an injury that results from an act that is outside the scope of the authority granted by this act or for conduct that constitutes a crime, actual fraud, actual malice, gross negligence or willful misconduct.

(2) A public entity or agent, officer, employee, servant or representative or volunteer, shall not be liable for an injury arising out of property of any kind that is donated or acquired according to the provisions of this or any other act for use in connection with a public health emergency. An agent, officer, employee, servant, representative or volunteer is not immune under this section, however, for an injury that results from an act that is outside the scope of the authority granted by this act or for conduct that constitutes a crime, actual fraud, actual malice, gross negligence or willful misconduct.

c. (1) A person or private entity who:

(a) owns, manages or controls property that is used in connection with a public health emergency shall not be liable for an injury with respect to the property, unless the injury is a result of gross negligence or willful misconduct. The immunity applies whether the person or entity owning, managing or controlling the property permits the use of the property voluntarily, with or without compensation, or the State or another public entity exercises the condemnation powers in this or any other act with respect to the use of the property;

(b) is acting in the performance of a contract with a public entity in connection with a public health emergency shall not be liable for an injury caused by the person or entity's negligence in the course of performing the contract, unless the injury is a result of gross negligence or willful misconduct; and

(c) in connection with a public health emergency, renders assistance or advice to a public entity or public employee or donates goods and services shall not be liable for an injury arising out of the person or entity's assistance, advice or services, or associated with the donated goods, unless the injury is a result of gross negligence or willful misconduct.

(2) A person or private entity and the employees of the entity shall not be liable for an injury caused by any act or omission in connection with a public health emergency, or preparatory activities, provided that the action of the person or entity is undertaken pursuant to the exercise of the authority provided pursuant to this act, including any order, rule or regulation adopted pursuant thereto. A person, entity or employee of the entity is not immune under this section, however, for an injury that results from an act that is outside the scope of the authority granted by this act or for conduct that constitutes a crime, actual fraud, actual malice, gross negligence or willful misconduct.

(3) The immunities established under this subsection shall not apply to a person or private entity whose act or omission caused or contributed to the public health emergency.

(4) As used in this subsection, "private entity" includes, but is not limited to, a health care provider.

d. The immunities established under this section shall be liberally construed to carry out the purposes of this act and shall apply to all public health preparedness activities, including pre-event planning, drills or other public health preparedness efforts. The immunities are in addition to, and shall not limit or abrogate in any way, other statutory immunities, common law immunities, statutory conditions on maintaining a lawsuit such as the notice provisions of the "New Jersey Tort Claims Act," N.J.S.59:1-1 et seq., or other defenses available to those who participate in responding to, or preparing for, a public health emergency.

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
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N.J. Stat. § 26:13-20 (2008)

§ 26:13-20. Protective action relative to radiological emergency, conditions

The commissioner may authorize any school, health care facility, child care center or youth camp to provide potassium iodide as a supplemental protective action during a radiological emergency to residents, staff members, minors or other persons present in such facility, if:

a. prior written permission has been obtained from each resident or representative of a resident, staff member, or parent or guardian of a minor for providing the potassium iodide; and

b. each person providing permission has been advised, in writing: (1) that the ingestion of potassium iodide is voluntary only, (2) about the contraindications of taking potassium iodide and (3) about the potential side effects of taking potassium iodide.

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N.J. Stat. § 26:13-21 (2008)

§ 26:13-21. LINCS agencies to serve as planning, coordinating agency for local government entity

a. In order to assist the department with comprehensive Statewide planning and coordination of all activities related to public health preparedness, LINCS agencies shall, at the direction of the commissioner, serve as the planning and coordinating agency for all municipalities and local health agencies within the county or city, as applicable.

b. The commissioner, either directly or through the LINCS agencies, shall coordinate the activities of all local health agencies in the county with regard to public health protection related to preparing for and responding to public health emergencies. The LINCS agency shall notify each local health agency in its jurisdiction of the nature and extent of the emergency, except that nothing in this subsection shall be construed to prevent the commissioner from notifying a local health agency directly.

c. The LINCS agency and all other local health agencies within the county shall be subject to the direction and authority of the commissioner, and shall perform such activities as are directed by the commissioner, in accordance with the provisions of this act.

d. The LINCS agencies shall be responsible for performing human disease surveillance, terrorism response and public health emergency response-related activities in such a manner as the commissioner may direct, and for reporting to the commissioner on the conduct of these activities as performed in the county or city, as applicable.

e. The commissioner may utilize the LINCS agencies to disseminate such information to the other local health agencies in the county, and to collect such information from those agencies, as the commissioner deems necessary; and the LINCS agencies shall transmit the information to the commissioner or the other local health agencies as directed by the commissioner.

f. The commissioner is authorized to use available federal funds received by the State to offset the costs incurred by LINCS agencies in implementing the provisions of this act, and shall reimburse local health agencies, subject to the approval of the State Treasurer and in accordance with the provisions of this act.

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N.J. Stat. § 26:13-22 (2008)

§ 26:13-22. Definitions relative to biological agents, Biological Agent Registry

a. As used in this section:

"Biological Agent" means:

(1) any select agent that is a microorganism, virus, bacterium, fungus, rickettsia or toxin listed in Appendix A of Part 72 of Title 42 of the Code of Federal Regulations;

(2) any genetically modified microorganism or genetic element from an organism listed in Appendix A of Part 72 of Title 42 of the Code of Federal Regulations, shown to produce or encode for a factor associated with a disease;

(3) any genetically modified microorganism or genetic element that contains nucleic acid sequences coding for any of the toxins listed in Appendix A of Part 72 of Title 42 of the Code of Federal Regulations, or their toxic subunits;

(4) high consequence livestock pathogens and toxins as determined by the U.S. Department of Agriculture and the New Jersey Department of Agriculture;

(5) any agents defined pursuant to R.S. 4:5-107 et seq. and N.J.A.C. 2:6-1.1 et seq. and the Secretary of Agriculture;

(6) any other agent as determined by the commissioner to represent a significant risk to human and animal health.

"Possess or maintain" includes, but is not limited to, any of the following: development, production, acquisition, transfer, receipt, stockpiling, retention, ownership or use of a biological agent.

"Registry" means the Biological Agent Registry established pursuant to this section.

b. The commissioner, in coordination with the Secretary of Agriculture, shall establish a Biological Agent Registry and administer a program for the registration of biological agents. The registry shall identify the biological agents possessed or maintained by any person in this State and shall contain such other information as required by regulation of the commissioner pursuant to this section.

c. A person who possesses or maintains any biological agent required to be registered under this section shall report the information to the department by submitting a duplicate of the form required under Part 331 of Title 7, Part 121 of Title 9, and Parts 72 and 73 of Title 42 of the Code of Federal Regulations. Forms submitted pursuant to these provisions shall not be reproduced by photographic, electronic or other means, and shall be stored in a manner that is both confidential and secure.

d. Except as otherwise provided in this section, information prepared for or maintained in the registry shall be confidential.

(1) The commissioner may, in accordance with rules adopted by the commissioner, utilize information contained in the registry for the purpose of conducting or aiding in a communicable disease investigation.

(2) The commissioner shall cooperate, and may share information contained in the registry, with the United States Centers for Disease Control and Prevention, the Department of Homeland Security, the New Jersey Department of Agriculture, and State and federal law enforcement agencies pursuant to a communicable disease investigation commenced or conducted by the department, the New Jersey Domestic Security Preparedness Task Force established pursuant to P.L. 2001, c. 246 (C.App. A:9-64 et seq.), or other State or federal law enforcement agency having investigatory authority, or in connection with any investigation involving the release, theft or loss of a registered biological agent. Access to this information shall terminate upon the completion of the investigation.

(3) Release of information from the registry as authorized under this section shall not render the information released or information prepared for or maintained in the registry a public or government record under P.L. 1963, c. 73 (C. 47:1A-1 et seq.) and P.L. 2001, c. 404 (C. 47:1A-5 et al.).

e. Any person who willfully or knowingly violates any provision of this section is liable for a penalty not to exceed $ 10,000 per day of the violation, and each day the violation continues shall constitute a separate and distinct violation. A penalty imposed under this section may be recovered with costs in a summary proceeding before the Superior Court pursuant to the "Penalty Enforcement Law of 1999," P.L. 1999, c. 274 (C. 2A:58-10 et seq.).

f. The commissioner shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L. 1968, c. 410 (C. 52:14B-1 et seq.) that are consistent with Part 331 of Title 7, Part 121 of Title 9, and Parts 72 and 73 of Title 42 of the Code of Federal Regulations, to carry out the purposes of this section; except that, notwithstanding any provision of P.L. 1968, c. 410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as he deems necessary to implement the provisions of this section, which shall be effective for a period not to exceed six months and thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L. 1968, c. 410.

The regulations shall include, but not be limited to:

(1) a list of the biological agents required to be registered pursuant to this section;

(2) designation of the persons required to make reports, the specific information required to be reported, time limits for reporting, the form of the reports, and the person to whom the report shall be submitted;

(3) provisions for the release of information in the registry to State and federal law enforcement agencies, the Centers for Disease Control and Prevention, the Department of Homeland Security and the New Jersey Department of Agriculture pursuant to paragraph (2) of subsection d. of this section;

(4) establishment of a system of safeguards that requires a person who possesses or maintains a biological agent required to be registered under this section to comply with the federal standards that apply to a person registered to possess or maintain the agent under federal law;

(5) establishment of a process for a person that possesses or maintains a registered biological agent to alert appropriate authorities of unauthorized possession or attempted possession of a registered biological agent, and designation of appropriate authorities for receipt of the alerts; and

(6) establishment of criteria and procedures for the commissioner to grant exemptions to the requirements if it is determined that the public benefit of such exemption outweighs the need for regulation.

*** THIS SECTION IS CURRENT THROUGH NEW JERSEY 213TH LEGISLATURE ***
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TITLE 26. HEALTH AND VITAL STATISTICS
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N.J. Stat. § 26:13-23 (2008)

§ 26:13-23. New Jersey Vaccine Education and Prioritization Plan

a. The commissioner shall develop and implement a New Jersey Vaccine Education and Prioritization Plan, as provided in subsection b. of this section, when the commissioner determines that: (1) an emergent condition exists and there is clear evidence that adverse and avoidable health outcomes from a preventable and acute communicable disease are expected to affect identifiable categories of high-risk individuals throughout the State; and (2) in order to protect or treat such individuals, assistance with the administration of vaccine is warranted due to a vaccine shortage.

b. To protect the public health during a vaccine shortage, the commissioner shall issue an order to implement a New Jersey Vaccine Education and Prioritization Plan, which shall comprise:

(1) procedures for the assessment of available vaccine Statewide;

(2) procedures for the distribution and administration of vaccines that shall apply to physicians, nurses, health care facilities, pharmacies and others that dispense vaccines. The procedures shall include, but not be limited to, a definition of high-risk groups for priority protection or treatment in the event a vaccine shortage is imminent or existent; and

(3) procedures for: (a) mobilizing public and private health resources to assist in vaccine distribution and administration; and

(b) reallocating available supplies of vaccine to most effectively meet the needs of the State's high-risk groups, if necessary.

c. As used in this section, "vaccine" includes vaccines, immune products and chemoprophylactic and treatment medications.

d. A person who willfully or knowingly violates the New Jersey Vaccine Education and Prioritization Plan or any procedures contained therein shall be liable for a civil penalty of $ 500 for each violation. The penalty shall be sued for and collected by the commissioner in a summary proceeding before the Superior Court pursuant to the "Penalty Enforcement Law of 1999," P.L. 1999, c. 274 (C. 2A:58-10 et seq.).

e. The commissioner shall notify the appropriate professional or occupational licensing board or licensing authority, in the case of a facility, of repeated violations of the procedures by a health care professional or licensed facility.

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N.J. Stat. § 26:13-24 (2008)

§ 26:13-24. State Public Health Emergency Claim Reimbursement Board

a. There is hereby established in the Department of Health and Senior Services a State Public Health Emergency Claim Reimbursement Board. The board shall include the following members: the Commissioner of Health and Senior Services, who shall be the presiding officer, the Attorney General, the Adjutant General of the Department of Military and Veterans' Affairs, the State Director of Emergency Management, the Secretary of Agriculture, the Commissioner of Banking and Insurance, the Commissioner of Environmental Protection, the Commissioner of Community Affairs, the State Medical Examiner, and the State Treasurer, or their designees. The members of the board shall serve without pay in connection with all such duties as are prescribed in this act.

b. The board shall meet at such times as may be necessary to fulfill the requirements set forth herein. The Commissioner of Health and Senior Services shall convene the board within 45 days of the filing of a complete petition. The concurrence of six members of the board shall be necessary for the validity of all acts of the board.

c. Subject to available appropriations, the board shall have the authority to award reasonable reimbursement, as determined by the board, for any services required of any person under the provisions of this act, which shall be paid at the prevailing established rate for services of a like or similar nature as determined by the board. Subject to available appropriations, the board shall have the authority to award reasonable reimbursement, as determined by the board, for any property employed, taken or used under the provisions of this act.

d. All awards shall be paid from any funds appropriated by the State, any political subdivision of the State, or the federal government, for such purpose. In awarding reimbursement under this section, the board shall take into account any funds, or any other thing of value, received by a claimant from any other source, including but not limited to private donations, contributions and insurance proceeds. The board shall not award reimbursement unless the claimant has demonstrated, to the satisfaction of the board, that the claimant has first sought reimbursement for any loss incurred due to the declaration of a public health emergency from any and all appropriate third party payers.

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N.J. Stat. § 26:13-25 (2008)

§ 26:13-25. Claims for reimbursement

a. Any person making a claim for reimbursement for private property or services employed, taken or used for a public purpose under this act shall, subsequent to the termination of the public health emergency, file a petition for an award with the State Public Health Emergency Claim Reimbursement Board, established pursuant to section 24 of this act, through the Commissioner of Health and Senior Services. The petition shall be signed by the claimant and shall set forth the following:

(1) a description of the services or property employed, taken or used;

(2) the dates of the employment, taking or usage;

(3) the person or entity ordering the employment, taking or usage;

(4) such additional information as the petitioner deems relevant to a full consideration of the claim; and

(5) any additional information that the board may require.

b. The board may establish such forms, documents and procedures as may be necessary to expedite the processing of claims, and all claimants shall utilize and follow the forms, documents and procedures, if so established. Subsequent to the filing of an initial petition, the board may request such additional information as it deems necessary from any claimant and may require the claimant, and any other person with knowledge of facts and circumstances relevant to the claim, to appear before the board for a hearing. No petition shall be filed with the board more than 180 days from the last date the services or property were employed, taken or used, except that this deadline may be extended by the board as is necessary to further the purposes of this act.

c. The board's determination concerning a claimant's petition for reimbursement shall be transmitted to the claimant in writing. The claimant may appeal the decision to the Superior Court subject to the Rules of Court regarding the review of State agency actions.

d. Any person seeking reimbursement under this act shall proceed in accordance with the provisions of this section unless the declaration of public health emergency which gives rise to the claim or petition for reimbursement is superseded by order of the Governor pursuant to P.L. 1942, c. 251 (C. App.A:9-33 et seq.). Upon the declaration of an emergency by the Governor pursuant to P.L. 1942, c. 251 which supersedes the declaration of a public health emergency, the person shall proceed in accordance with the provisions of P.L. 1942, c. 251 and the person's rights, remedies and entitlement to reimbursement shall be limited to that which is afforded in that act.

e. Notwithstanding the provisions of this section to the contrary, in the event funds are otherwise made available for reimbursement, a person shall not be required to file a petition for an award with the board pursuant to this section.

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N.J. Stat. § 26:13-26 (2008)

§ 26:13-26. Material not considered public, government record

Any correspondence, records, reports and medical information made, maintained, received or filed pursuant to this act shall not be considered a public or government record under P.L. 1963, c. 73 (C. 47:1A-1 et seq.) and P.L. 2001, c. 404 (C. 47:1A-5 et al.).

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N.J. Stat. § 26:13-27 (2008)

§ 26:13-27. Power of enforcement

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.

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N.J. Stat. § 26:13-28 (2008)

§ 26:13-28. Laws, regulations not preempted by act

The provisions of this act do not explicitly preempt other laws or regulations that preserve to a greater degree the powers of the Governor or commissioner, provided such laws or regulations are consistent and do not otherwise restrict or interfere with the operation or enforcement of the provisions of this act.

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N.J. Stat. § 26:13-29 (2008)

§ 26:13-29. Additional powers of State Medical Examiner

The powers granted in the act are in addition to, and not in derogation of, powers otherwise granted by law to the State Medical Examiner.

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N.J. Stat. § 26:13-30 (2008)

§ 26:13-30. Construction of act relative to Highway Traffic Safety Act

The provisions of this act shall not be construed to abrogate the effect or status of the "New Jersey Highway Traffic Safety Act of 1987," P.L. 1987, c. 284 (C. 27:5F-18 et seq.).

APPENDIX E5

REASSIGNMENT CENTER GUIDELINES

INFLUENZA PANDEMIC HUMAN RESOURCES REDEPLOYMENT PRINCIPLES

Working With Other Hospitals/Sites

1. Staff will be restricted to providing services to only one site unless otherwise advised.

2. NYGH staff that provide services to other hospitals will be asked to restrict their services to NYGH. Part-time staff that commit their services to NYGH and are subject to loss of scheduled shifts with other hospitals will be given the opportunity to pick up extra shifts to supplement the lost wages. Verification of lost shifts will be required.

Principles

1. Staff will be treated as much as possible in a manner consistent with established Human Resources principles, which respect the core values of NYGH .

2. Staff in positions that are curtailed or stopped due to closures, will be redeployed to assist with other related staffing shortages.

3. Managers will make redeployment requests only through the Redeployment Centre.

4. The Redeployment Centre will be staffed with Human Resources staff and managers with clinical knowledge in order to assess staffing competencies required.

5. The Redeployment Centre will assess staffing requests for priority of need. Priority will be given to direct patient care requirements and then to specific administrative requirements.

6. The Redeployment Centre will endeavour to place staff equitably such that workload is shared to the extent it is possible.

7. The Redeployment Centre will require staff to be flexible and be redeployed based on need, at times this may require shift work or weekend work. Every attempt will be made to distribute shifts equitably.

8. The Hospital recognizes the need to provide orientation to new working units or positions resulting from an Infulenza pandemic and to provide the most suitably qualified staff to the extent this is possible, in an emergency situation.

9. Staff re-assigned to other units will identify any skill deficiencies they may have to an appropriate person in charge. If skill deficiency is verified, the staff member may still be required to provide services based on their skill level.

10. During the declared outbreak, staff that are reassigned will continue to be charged to their home cost centre.

APPENDIX F I

NIMS IMPLEMENTATION ACTIVITIES

NIMS IMPLEMENTATION ACTIVITIES FOR HOSPITAL AND HEALTHCARE SYSTEMS IMPLEMENTATION FAQS

ADOPTION AND IMPLEMENTION

Regarding National Incident Management System (NIMS) implementation, what constitutes a hospital and/or healthcare system? (Posted 4/24/07)

All hospitals and healthcare systems receiving Federal preparedness and response grants, contracts or cooperative agreements (e.g., Bioterrorism Hospital Preparedness Program, Department of Homeland Security grants) must work to implement the National Incident Management System (NIMS). Hospital and healthcare systems are defined as all facilities that receive medical and trauma emergency patients on a daily basis. These facilities do not include non-hospital receivers (i.e., nursing homes, assisted living communities, long-term care facilities and specialty hospitals (i.e. psychiatric, rehabilitation facilities)). However, non-hospital receivers are strongly encouraged to work with their local hospitals, public health departments and emergency management to integrate applicable elements of NIMS Implementation (i.e. planning, communications, resources) to allow for better communication and coordination.

Are there requirements that hospitals must meet in order to be NIMS compliant? (Posted 4/20/07)

Yes, the National Integration Center (NIC), in conjunction with the Department of Health and Humans Services (HHS) and the Hospital Incident Command System (HICS) working group, developed NIMS implementation activities that were released on September 12, 2006. http://www.fema.gov/emergency/nims/compliance/assist_non_govt.shtm. Some requirements need to be achieved by September 30, 2007. The additional remaining requirements need to be achieved by September 30, 2008. More details are provided below.

What specific requirements do hospitals and healthcare systems need to achieve by September 30, 2007 to be NIMS-compliant? (Posted 4/24/07)

The Department of Health and Human Services (HHS) requires the following four (4) NIMS activities be adopted and/or implemented by hospitals receiving FY 2006 Federal preparedness and response grants, contracts, or cooperative agreements by September 30, 2007.

- Revise and update plans [i.e. Emergency Operations Plan (EOPs)] and standard operating procedures (SOPs) to incorporate NIMS components, principles and policies, to include planning, training, response, exercises, equipment, evaluation, and corrective actions.
- Complete *IS-700: NIMS: An Introduction*
- Complete *IS-800.A: NRP: An Introduction*
- Complete *ICS 100* and *ICS 200* Training or equivalent courses

For further information, please contact your regional or state Bioterrorism Hospital Preparedness Program Project Officer.

Original posting date 4/13/07
Revised posting date 4/20/07

NIMS IMPLEMENTATION ACTIVITIES FOR HOSPITAL AND HEALTHCARE SYSTEMS IMPLEMENTATION FAQS

What specific requirements do hospitals and healthcare systems need to achieve by September 30, 2008 to be NIMS-compliant? (Posted 4/24/07)

Hospitals receiving Federal preparedness and response grants, contracts or cooperative agreement funds for FY 2007 have until September 30, 2008, to fully implement all 17 NIMS activities.

The 17 *NIMS Implementation Activities for Hospital and Healthcare Systems* are as follows:

- Organizational Adoption
  - Adoption of NIMS
- Command and Management
  - Incident Command System (ICS)
  - Multi-agency Coordination System (MACS)
  - Public Information System (PIS)
- Preparedness Planning
  - NIMS Implementation Tracking
  - Preparedness Funding
  - Revise and Update Plans
  - Mutual-Aid Agreements
- Preparedness Training
  - IS 700 NIMS
  - IS 800a NRP
  - ICS 100 or equivalent and 200 or equivalent
- Preparedness Exercises
  - Training and Exercises
  - All Hazard Exercise Program
  - Corrective Actions
- Resource Management
  - Response Inventory
  - Resource Acquisition
- Communication and Information Management
- Standard and Consistent Terminology

State, territory, tribal and local jurisdictions have additional NIMS activities for FY07. Does a hospital have to also complete those activities? (Posted 4/13/07)

No. NIMS activities focused initially on state, territory, local and tribal jurisdictions. NIMS activities for hospitals and healthcare systems were added later. Any Federal preparedness funding programs that assist State, territory, tribal, local, private sector or non-governmental agencies to prepare to, respond to and/or recover from an incident requires NIMS implementation. As a result, many of these NIMS activities have been incorporated into the 17 hospital-specific activities.

The National Integration Center, along with the Department of Health and Human Services, will continue to coordinate with hospitals and healthcare systems and State, territory, tribal and local

governments to ensure that NIMS activities for hospitals and healthcare systems are clearly articulated and implemented as appropriate.

Training

Which NIMS courses should hospital and healthcare system employees complete? (Posted 4/20/07)

The function of the responder during an incident, whether it is within the hospital or at an incident, will determine the appropriate courses required. The National Integration Center (NIC) and HICS working group outlined who should take the IS 700, 800 and ICS 100, 200 courses in the NIMS Implementation Activities for Hospitals and Healthcare Systems document http://www.fema.gov/emergency/nims/compliance/assist_non_govt.shtm . Hospitals have the discretion to determine which employees complete the courses.

Courses for ICS100 and 200 for healthcare workers have been released on the EMI website. Do hospital workers have to complete that course if they have already taken an ICS 100 and 200 course? (Posted 4/20/07)

ICS100 and 200 have been modified to reflect preparedness and response activities in hospitals and healthcare system settings. The overall concepts and principles in the course for healthcare workers follow those of the generic, law enforcement, and public works ICS courses that are also posted on the EMI website. A healthcare worker only needs to complete the ICS 100 and/or 200 courses once, unless additional requirements are imposed by the State, territory, tribal or local government or by the employing healthcare agency.

Can a hospital utilize a vendor created training course? If so, how do we verify that it is NIMS compliant? (Posted 4/20/07)

The NIC has posted the NIMS National Standard Curriculum Training Development Guidance (March 2007) on the NIC website http://www.fema.gov/pdf/emergency/nims/nims_tsctdg_0307v2.pdf . This document outlines the objectives that must be met for ICS 100, 200, 300, and 400 for any vendor created courses. As long as the course meets the objectives then it is considered NIMS compliant. The sponsoring organization is responsible to ensure any vendor created training meets the objectives for a course.

Will the NIC certify an ICS course as NIMS compliant for hospital and healthcare system responders? (Posted 4/20/07)

The NIC does not certify ICS courses as NIMS compliant. The NIMS National Standard Curriculum Training Development Guidance (March 2007) on the NIC website http://www.fema.gov/pdf/emergency/nims/nims_tsctdg_0307v2.pdf outlines the minimum objectives that must be met for each ICS course. Hospitals may create their own "equivalent courses" for 100, 200, 700, and 800 provided their course(s) meet the objectives found in the NIMS Training Guidance document. It is the responsibility of the organization sponsoring the NIMS ICS training to determine whether the course meets the objectives outlined in the NIMS National Standard Curriculum Training Development Guidance.

Original posting date 4/13/07
Revised posting date 4/20/07

The sponsoring agency also reserves the right to create their own test for ICS courses as long as the test questions meet the objectives as outlined in the NIMS National Standard Curriculum Training Development Guidance (March 2007).

To where should a hospital submit NIMS training records? (Posted 4/20/07)

Any documentation for NIMS training courses needs to be maintained by the hospital or healthcare system. If courses are completed through the Emergency Management Institute (EMI) website, EMI does maintain a database by State of who has completed courses. Currently, the database is not separated by individual agencies so a hospital would not be able to track solely by the database list.

The NIMS Integration Center has not set a timeline as to how long NIMS training records/certificates must be kept on file.

Where do I find classroom materials to teach 100, 200, 700 and or 800? (Posted 4/20/07)

The classroom materials for these courses can be found at the following websites:

IS 100 - http://www.training.fema.gov/EMIWeb/IS/is100.asp
IS 200 - http://www.training.fema.gov/EMIWeb/IS/is200.asp
IS 700 - http://www.training.fema.gov/EMIWeb/IS/is700.asp
IS 800 - http://www.training.fema.gov/EMIWeb/IS/is800a.asp

Specific classroom materials for ICS 100 and 200 for healthcare workers will be posted on the EMI website in April 2007.

What qualifications does an instructor need to teach ICS 100 and 200 in the classroom setting? (Posted 4/20/07)

All lead ICS instructors should have training and experience in adult education and have served as Incident Commander or in a command staff or general staff position. The lead instructor can be a member of a hospital, healthcare organization, or other response discipline.

Specific requirements for ICS-100 and ICS-200 are as follows:

ICS-100
ICS-100 Lead and Unit Instructors should have successfully completed ICS-100, ICS-200 and IS-700.

ICS-200
Two instructors recommended to teach ICS-200 level classes

- Lead instructor should have successfully completed ICS-300
- Unit instructors should have successfully completed ICS-200, and
- Lead instructor should have training and experience in adult education and have served as an Incident Commander or in a command staff or general staff position

The NIC also recognizes that first responders and disaster workers across the nation can complete ICS-200 level training on-line to meet NIMS requirements. When completing the training on-line no instructors are utilized.

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Revised posting date 4/20/07

The NIC also recognizes that the completion of ICS-200 training in a classroom with other staff members or with a multi-discipline audience is extremely beneficial. Some emergency management disciplines may not have enough qualified lead instructors or easy access to individuals in other disciplines that have completed ICS-300 training or have experience serving in the command structure. While the NIC, strongly recommends the above referenced guidelines for ICS-200 instructors it fully realizes that there may simply not be enough qualified lead instructors that meet the guidelines to teach ICS-200 training in the classroom. The overall benefit of ***teaching the training in a classroom***, even with a lead instructor who has not yet completed ICS-300 training or has extensive ICS experience ... far exceeds ***completing the training on-line***.

Hospital Incident Command System (HICS)

What is the relationship between HICS and NIMS? (Posted 4/13/07)

As released in September 2006, there are 17 elements that hospitals should address to become NIMS compliant. The implementation of HICS as the hospital incident command system will assist hospitals in meeting some but not all of these requirements. In particular, HICS covers topic areas for hospitals with regards to planning, responding, decision-making, and documentation will be found. Hospitals should carefully review all of these elements and undertake the steps necessary to ensure complete compliance within the outlined activities.

Do hospital personnel who have been previously trained in the Hospital Emergency Incident Command System (HEICS) need to be re-trained in HICS in order for a receiving hospital to be NIMS compliant? (Posted 4/13/07)

HEICS was built upon Incident Command System principles and therefore is compatible with NIMS. However, it is not compliant with all NIMS activities for hospitals. HICS functionally uses ICS, but has translated it to meet the specific needs of hospitals. Hospitals should update their plans, procedures, and/or policies and conduct training as necessary to reflect NIMS compliance.

The HICS updated Incident Management Team chart (formerly known as the organization chart) has been restructured to be consistent with ICS and NIMS principles and will provide greater flexibility/adaptability for the hospital setting.

Does completion of the HICS course materials, as they are listed on-line, make a hospital NIMS compliant? (Posted 4/13/07)

The HICS materials are posted on the California EMS Authority website, http://www.emsa.ca.gov/hics/hics.asp. These materials do not make a hospital NIMS compliant since the materials primarily support Element 2 – Incident Command System in the NIMS Activities for Hospitals and Healthcare Systems. The teaching of the HICS materials on this website alone do not provide materials to cover the objectives for 100, 200 and 700, which are required activities to be NIMS compliant.

Does a HICS course take the place of ICS 100 & 200 and IS700 courses? (Posted 4/13/07)

The on-line HICS materials, http://www.emsa.ca.gov/hics/hics.asp , do not meet the objectives as outlined in the NIMS National Standard Curriculum Training Development Guidance (March

2007) on the NIC website http://www.fema.gov/pdf/emergency/nims/nims_tsctdg_0307v2.pdf for ICS 100 and 200 and IS700. When HICS was developed it was not intended to meet the objectives for 100, 200 and 700 courses.

However, the Center for HICS Education and Training is currently conducting a classroom train-the-trainer (TTT) course that also covers the objectives for IS700 and ICS 100 and 200 in addition to the HICS material. This course provides trainers with the ability to teach HICS within the hospital environment. The TTT materials will support a trainer to teach the 100, 200 and 700 courses since the classroom materials meet the objectives as outlined in the NIMS Training Guidance. The materials for TTT are not publicly posted; therefore teaching from the materials that are online at http://www.emsa.ca.gov/hics/hics.asp will not meet NIMS compliance for 100, 200 and 700. Please refer to the Center for HICS Education and Training website for current information on the approved training http://www.hicscenter.org/ .

Joint Commission and Centers for Medicaid and Medicare Services (CMS)

To receive Joint Commission accreditation, must my hospital implement NIMS? (Posted 4/13/07)

No. Per Joint Commission, at this time a hospital is not required to implement NIMS in order to receive accreditation.

Must my hospital implement NIMS in order to meet CMS Medicare and Medicaid requirements? (Posted 4/13/07)

No. Per CMS, a hospital does not have to implement NIMS in order to meet CMS coverage and reimbursement requirements.

APPENDIX G I

EMERGENCY PLANNING TOOL FOR FAMILIES

Family Emergency Health Information Sheet

It is important to think about health issues that could arise if an influenza pandemic occurs, and how they could affect you and your loved ones. For example, if a mass vaccination clinic is set up in your community, you may need to provide as much information as you can about your medical history when you go, especially if you have a serious health condition or allergy.

Create a family emergency health plan using this information. Fill in information for each family member in the space provided. Like much of the planning for a pandemic, this can also help prepare for other emergencies.

1. Family Member Information:

Family Member	Blood Type	Allergies	Past/Current Medical Conditions	Current Medications/ Dosages

2. Emergency Contacts:

Contacts		Name/Phone Number
Local personal emergency contact		
Out-of-town personal emergency contact		
Hospitals near:	Work	
	School	
	Home	
Family physician(s)		
State public health department (See list on www.pandemicflu.gov/state/statecontacts.html)		
Pharmacy		
Employer contact and emergency information		
School contact and emergency information		
Religious/spiritual organization		
Veterinarian		

Ready

Prepare. Plan. Stay Informed.

Family Emergency Plan

Make sure your family has a plan in case of an emergency. Before an emergency happens, sit down together and decide how you will get in contact with each other, where you will go and what you will do in an emergency. Keep a copy of this plan in your emergency supply kit or another safe place where you can access it in the event of a disaster.

Out-of-Town Contact Name: **Telephone Number:**

Email:

Neighborhood Meeting Place: **Telephone Number:**

Regional Meeting Place: **Telephone Number:**

Evacuation Location: **Telephone Number:**

Fill out the following information for each family member and keep it up to date.

Name: **Social Security Number:**
Date of Birth: **Important Medical Information:**

Name: **Social Security Number:**
Date of Birth: **Important Medical Information:**

Name: **Social Security Number:**
Date of Birth: **Important Medical Information:**

Name: **Social Security Number:**
Date of Birth: **Important Medical Information:**

Name: **Social Security Number:**
Date of Birth: **Important Medical Information:**

Name: **Social Security Number:**
Date of Birth: **Important Medical Information:**

Write down where your family spends the most time: work, school and other places you frequent. Schools, daycare providers, workplaces and apartment buildings should all have site-specific emergency plans that you and your family need to know about.

Work Location One
Address:
Phone Number:
Evacuation Location:

School Location One
Address:
Phone Number:
Evacuation Location:

Work Location Two
Address:
Phone Number:
Evacuation Location:

School Location Two
Address:
Phone Number:
Evacuation Location:

Work Location Three
Address:
Phone Number:
Evacuation Location:

School Location Three
Address:
Phone Number:
Evacuation Location:

Other place you frequent
Address:
Phone Number:
Evacuation Location:

Other place you frequent
Address:
Phone Number:
Evacuation Location:

Important Information	Name	Telephone Number	Policy Number
Doctor(s):			
Other:			
Pharmacist:			
Medical Insurance:			
Homeowners/Rental Insurance:			
Veterinarian/Kennel (for pets):			

Dial 911 for Emergencies

Ready

Prepare. Plan. Stay Informed.

Family Emergency Plan

Make sure your family has a plan in case of an emergency. Fill out these cards and give one to each member of your family to make sure they know who to call and where to meet in case of an emergency.

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION:

Family Emergency Plan

EMERGENCY CONTACT NAME:
TELEPHONE:

OUT-OF-TOWN CONTACT NAME:
TELEPHONE:

NEIGHBORHOOD MEETING PLACE:
TELEPHONE:

OTHER IMPORTANT INFORMATION:

Ready

DIAL 911 FOR EMERGENCIES

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ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION:

Family Emergency Plan

EMERGENCY CONTACT NAME:
TELEPHONE:

OUT-OF-TOWN CONTACT NAME:
TELEPHONE:

NEIGHBORHOOD MEETING PLACE:
TELEPHONE:

OTHER IMPORTANT INFORMATION:

Ready

DIAL 911 FOR EMERGENCIES

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION:

Family Emergency Plan

EMERGENCY CONTACT NAME:
TELEPHONE:

OUT-OF-TOWN CONTACT NAME:
TELEPHONE:

NEIGHBORHOOD MEETING PLACE:
TELEPHONE:

OTHER IMPORTANT INFORMATION:

Ready

DIAL 911 FOR EMERGENCIES

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ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION:

Family Emergency Plan

EMERGENCY CONTACT NAME:
TELEPHONE:

OUT-OF-TOWN CONTACT NAME:
TELEPHONE:

NEIGHBORHOOD MEETING PLACE:
TELEPHONE:

OTHER IMPORTANT INFORMATION:

Ready

DIAL 911 FOR EMERGENCIES

APPENDIX G2

PANDEMIC FLU GUIDE FOR FAMILIES

PandemicFlu.gov AvianFlu.gov

A Guide for Individuals and Families

En Español

Get Informed. Be Prepared.

U.S. Department of Health and Human Services
May 2006

"While the Federal Government will use all resources at its disposal to prepare for and respond t an influenza pandemic, it cannot do the job alone. This effort requires the full participation of an coordination by all levels of government and all segments of society... perhaps most important, addressing the challenge will require active participation by individual citizens in each communit across our Nation."

George W. Bush, President
United States of America

"Pandemics are global in nature, but their impact is local. When the next pandemic strikes, as it surely will, it is likely to touch the lives of every individual, family, and community. Our task is t make sure that when this happens, we will be a Nation prepared."

Michael O. Leavitt, Secretary
U.S. Department of Health and Human Services

Pandemic Influenza - Get Informed. Be Prepared.

This guide is designed to help you understand the threat of a pandemic influenza outbreak in ou country and your community. It describes commonsense actions you can take now in preparing for a pandemic. We cannot predict how severe the next pandemic will be or when it will occur, b being prepared may help lower the impact of an influenza pandemic on you and your family. Additional information including a planning checklist for individuals and families can be found at www.pandemicflu.gov.

What You Need to Know

An influenza (flu) pandemic is a worldwide outbreak of flu disease that occurs when a new type influenza virus appears that people have not been exposed to before (or have not been exposed in a long time). The pandemic virus can cause serious illness because people do not have immunity to the new virus. Pandemics are different from seasonal outbreaks of influenza that w see every year. Seasonal influenza is caused by influenza virus types to which people have alre been exposed. Its impact on society is less severe than a pandemic, and influenza vaccines (flu shots and nasal-spray vaccine) are available to help prevent widespread illness from seasonal fl

Influenza pandemics are different from many of the other major public health and health care threats facing our country and the world. A pandemic will last much longer than most flu outbreaks and may include "waves" of influenza activity that last 6-8 weeks separated by month The number of health care workers and first responders able to work may be reduced. Public health officials will not know how severe a pandemic will be until it begins.

A Historical Perspective

In the last century there were three influenza pandemics. All of them were called pandemics because of their worldwide spread and because they were caused by a new influenza virus. The 1918 pandemic was especially severe.

- 1918-1919 Most severe, caused at least 675,000 U.S. deaths and up tp 50 million deaths worldwide.
- 1957-1958 Moderately severe, caused at least 70,000 U.S. deaths and 1-2 million deaths worldwide.
- 1968-1969 Least severe, caused at least 34,000 U.S. deaths and 700,000 deaths worldwide.

Some Differences Between Seasonal Flu and Pandemic Flu

Seasonal Flu	Pandemic Flu
Caused by influenza viruses that are similar to those already circulating among people.	Caused by a new influenza virus that people have not been exposed to before. Likely to be more severe, affect more people, and cause more deaths than seasonal influenza because people will not have immunity to the new virus.
Symptoms include fever, headache, tiredness, dry cough, sore throat, runny nose, and muscle pain. Deaths can be caused by complications such as pneumonia.	Symptoms similar to the common flu but may be more severe and complications more serious.
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 adults may be at increased risk for serious complications.
Every year in the United State, on average: • 5% to 20% of the population gets the flu; • More than 200,000 people are hospitalized from flu complications; and • About 36,000 people die from flu.	The effects of a severe pandemic could be much more damaging than those of a regular flu season. It could lead high levels of illness, death, social disruption, and economi loss. Everyday life could be disrupted because so many people in so many places become seriously ill at the same time. Impacts could range from school and business closin to the interruption of basic services such a public transportation and food delivery.

Importance and Benefits of Being Prepared

The effects of a pandemic can be lessened if you prepare ahead of time. Preparing for a disaster will help bring peace of mind and confidence to deal with a pandemic.

When a pandemic starts, everyone around the world could be at risk. The United States has bee

working closely with other countries and the World Health Organization (WHO) to strengthen systems to detect outbreaks of influenza that might cause a pandemic.

A pandemic would touch every aspect of society, so every part of society must begin to prepare. All have roles in the event of a pandemic. Federal, state, tribal, and local governments are developing, improving, and testing their plans for an influenza pandemic. Businesses, schools, universities, and other faith-based and community organizations are also preparing plans.

As you begin your individual or family planning, you may want to review your state's planning efforts and those of your local public health and emergency preparedness officials. State plans a other planning information can be found at www.pandemicflu.gov/plan/checklists.html.

The Department of Health and Human Services (HHS) and other federal agencies are providing funding, advice, and other support to your state. The federal government will provide up-to-date information and guidance to the public if an influenza pandemic unfolds. For reliable, accurate, and timely information, visit the federal government's official Web site at www.pandemicflu.gov.

Pandemic Influenza - Challenges and Preparation

As you and your family plan for an influenza pandemic, think about the challenges you might fac particularly if a pandemic is severe.

You can start to prepare now to be able to respond to these challenges. The following are some challenges you or your family may face and recommendations to help you cope. In addition, checklists and other tools have been prepared to guide your planning efforts. A series of plannin checklists can be found at www.pandemicflu.gov/plan/checklists.html.

Essential Services You Depend on May Be Disrupted

- Plan for the possibility that usual services may be disrupted. These could include services provided by hospitals and other healthcare facilities, banks, restaurants, government offices, telephone and cellular phone companies, and post offices.
- Stores may close or have limited supplies. The planning checklists can help you determine what items you should stockpile to help you manage without these services
- Transportation services may be disrupted and you may not be able to rely on public transportation. Plan to take fewer trips and store essential supplies.
- Public gatherings, such as volunteer meetings and worship services, may be canceled. Prepa contact lists including conference calls, telephone chains, and email distribution lists, to acce or distribute necessary information.
- Consider that the ability to travel, even by car if there are fuel shortages, may be limited.
- You should also talk to your family about where family members and loved ones will go in ar emergency and how they will receive care, in case you cannot communicate with them.
- In a pandemic, there may be widespread illness that could result in the shut down of local ATMs and banks. Keep a small amount of cash or traveler's checks in small denominations fc easy use.

Food and Water Supplies May Be Interrupted and Limited

Food and water supplies may be interrupted so temporary shortages could occur. You may also unable to get to a store. To prepare for this possibility you should store at least one to two week supply of non-perishable food and fresh water for emergencies.

Food

- Store two weeks of nonperishable food.
- Select foods that do not require refrigeration, preparation (including the use of water), or cooking.
- Insure that formulas for infants and any child's or older person's special nutritional needs are part of your planning.

Water

- Store two weeks of water, 1 gallon of water per person per day. (2 quarts for drinking, 2 quarts for food preparation/sanitation), in clean plastic containers. Avoid using containers th will decompose or break, such as milk cartons or glass bottles.

Being Able to Work May Be Difficult or Impossible

- Ask your employer how business will continue during a pandemic.
- Discuss staggered shifts or working at home with your employer. Discuss telecommuting possibilities and needs, accessing remote networks, and using portable computers.
- Discuss possible flexibility in leave policies. Discuss with your employer how much leave you can take to care for yourself or a family member
- Plan for possible loss of income if you are unable to work or the company you work for temporarily closes.

For the Business Checklist visit:
http://www.pandemicflu.gov/plan/business/businesschecklist.html

Schools and Daycare Centers May Be Closed for an Extended Period of Time

Schools, and potentially public and private preschool, childcare, trade schools, and colleges and universities may be closed to limit the spread of flu in the community and to help prevent childr from becoming sick. Other school-related activities and services could also be disrupted or cancelled including: clubs, sports/sporting events, music activities, and school meals. School closings would likely happen very early in a pandemic and could occur on short notice.

- Talk to your teachers, administrators, and parent-teacher organizations about your school's pandemic plan, and offer your help.
- Plan now for children staying at home for extended periods of time, as school closings may occur along with restrictions on public gatherings, such as at malls, movie theaters.
- Plan home learning activities and exercises that your children can do at home. Have learning materials, such as books, school supplies, and educational computer activities and movies o hand.
- Talk to teachers, administrators, and parent-teacher organizations about possible activities, lesson plans, and exercises that children can do at home if schools are closed. This could include continuing courses by TV or the internet.
- Plan entertainment and recreational activities that your children can do at home. Have

materials, such as reading books, coloring books, and games, on hand for your children to u

For the "Childcare, School, and University Checklist," visit:
http://www.pandemicflu.gov/plan/tab5.html

Medical Care for People with Chronic Illness Could be Disrupted

In a severe pandemic, hospitals and doctors' offices may be overwhelmed.

- If you have a chronic disease, such as heart disease, high blood pressure, diabetes, asthma, depression, you should continue taking medication as prescribed by your doctor.
- Make sure you have necessary medical supplies such as glucose and blood-pressure monitoring equipment.
- Talk to your healthcare provider to ensure adequate access to your medications.
- If you receive ongoing medical care such as dialysis, chemotherapy, or other therapies, talk with your health care provider about plans to continue care during a pandemic.
- A "Family Emergency Health Information Sheet" is provided in this guide and at:
  http://www.pandemicflu.gov/planguide/familyhealthinfo.html

Pandemic Influenza - Prevention and Treatment

Stay Healthy

These steps may help prevent the spread of respiratory illnesses such as the flu:

- Cover your nose and mouth with a tissue when you cough or sneeze-throw the tissue away immediately after you use it.
- Wash your hands often with soap and water, especially after you cough or sneeze. If you are not near water, use an alcohol-based (60-95%) hand cleaner.
- Avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them from getting sick too.
- If you get the flu, stay home from work, school, and social gatherings. In this way you will help prevent others from catching your illness.
- Try not to touch your eyes, nose, or mouth. Germs often spread this way.

Vaccination

Vaccines are used to protect people from contracting a virus once a particular threat is identifiec After an individual has been infected by a virus, a vaccine generally cannot help to combat it. Because viruses change over time, a specific pandemic influenza vaccine cannot be produced un a pandemic influenza virus emerges and is identified. Once a pandemic influenza virus has been identified, it will likely take 4-6 months to develop, test, and begin producing a vaccine.

While there is currently no human pandemic influenza in the world, the federal government is facilitating production of vaccines for several existing avian influenza viruses. These vaccines ma provide some protection should one of these viruses change and cause an influenza pandemic. T supply of pandemic vaccine will be limited, particularly in the early stages of a pandemic. Efforts are being made to increase vaccine-manufacturing capacity in the United States so that supplies of vaccines would be more readily available. In addition, research is underway to develop new ways to produce vaccines more quickly.

Antivirals

A number of antiviral drugs are approved by the U.S. Food and Drug Administration to treat and prevent seasonal influenza. Some of these antiviral medications may be effective in treating pandemic influenza. These drugs may help prevent infection in people at risk and shorten the duration of symptoms in those infected with pandemic influenza. However, it is unlikely that antiviral medications alone would effectively contain the spread of pandemic influenza. The fede government is stockpiling antiviral medications that would most likely be used in the early stage of an influenza pandemic and working to develop new antiviral medications. These drugs are available by prescription only.

Stay Informed

- Knowing the facts is the best preparation. Identify sources you can count on for reliable information. If a pandemic occurs, having accurate and reliable information will be critical.
- Reliable, accurate, and timely information is available at www.pandemicflu.gov.
- Another source for information on pandemic influenza is the Centers for Disease Control and Prevention (CDC) Hotline at: 1-800-CDC-INFO (1-800-232-4636). This line is available in English and Spanish, 24 hours a day, 7 days a week.
- Look for information on your local and state government Web sites. Links are available to ea state department of public health at www.pandemicflu.gov.
- Listen to local and national radio, watch news reports on television, and read your newspape and other sources of printed and web-based information.
- Talk to your local health care providers and public health officials.

Questions and Answers

Will bird flu cause the next influenza pandemic?

Avian influenza (bird flu) is a disease of wild and farm birds caused by avian influenza viruses. Bird flu viruses do not usually infect humans, but since 1997 there have been a number of confirmed cases of human infection from bird flu viruses. Most of these resulted from direct or close contact with infected birds (for example: domesticated chickens, ducks, and turkeys). It is important not to handle, play with, or pick up dead birds. Information on who to contact in your state is at: http://www.pandemicflu.gov/state/statecontacts.html

The spread of bird flu viruses from an infected person to another person has been reported very rarely and has not been reported to continue beyond one person. A worldwide pandemic could occur if a bird flu virus were to change so that it could easily be passed from person to person. Experts around the world are watching for changes in bird flu viruses that could lead to an influenza pandemic.

Is it safe to eat poultry?

Yes, it is safe to eat properly cooked poultry. Cooking destroys germs, including bird flu viruses. The United States maintains trade restrictions on the importation of poultry and poultry product from countries where the highly pathogenic H5N1 avian influenza strain has been detected in commercial or traditionally raised poultry, not in wild or migratory birds.

Guidelines for the safe preparation of poultry include the following:

- Wash hands before and after handling food.
- Keep raw poultry and its juices away from other foods.

- Keep hands, utensils, and surfaces, such as cutting boards, clean.
- Use a food thermometer to ensure food has reached the safe internal temperature - in all pa of the bird. Cook poultry to at least 165°F to kill food-borne germs that might be present, including the avian influenza virus.

For more information, see poultry preparation fact sheets at:
http://www.fsis.usda.gov/Fact_Sheets/Poultry_Preparation_Fact_Sheets/index.asp

What types of birds can carry bird flu viruses?

Avian influenza viruses can infect chickens, turkeys, pheasants, quail, ducks, geese, and guinea fowl, as well as a wide variety of other birds, including migratory waterfowl.

Each year, there is a flu season for birds just as there is for humans and, as with people, some forms of the flu are worse than others, depending on how strong the virus. A weak virus may cause only mild illness in infected poultry and birds but a strong virus could cause severe and extremely contagious illness, and even death, among infected poultry and birds.

Will the seasonal flu shot protect me against pandemic influenza?

- No, it won't protect you against pandemic influenza. But flu shots can help you to avoid seasonal flu.
- Get a flu shot to help protect you from seasonal flu.
- Get a pneumonia shot to prevent secondary infection if you are over the age of 65 or have a chronic illness such as diabetes or asthma. For specific guidelines, talk to your health care provider or call the Centers for Disease Control and Prevention (CDC) Hotline at 1-800-232-4636.
- Make sure that your family's immunizations are up-to-date.

What is the U.S. government doing to prepare for pandemic influenza?

The U.S. government has been preparing for pandemic influenza for several years. In November 2005, the President announced the National Strategy for Pandemic Influenza. Ongoing preparations include the following:

- Monitoring migratory and wild birds for avian flu.
- Working with the World Health Organization (WHO) and other nations to help detect human cases of bird flu and respond to an influenza pandemic, if one begins.
- Supporting the manufacturing and testing of influenza vaccines, including finding more reliat and quicker ways to make large quantities of vaccines through cell-based technologies.
- Developing a national stockpile of antiviral drugs to help treat and control the spread of disease.
- Supporting the efforts of federal, state, tribal, and local health agencies to prepare for and respond to pandemic influenza, including hosting planning summits with state and local leaders in each state.
- Working with federal agencies to prepare and to encourage communities, businesses, and organizations to plan for pandemic influenza. These efforts have included joint exercises in pandemic preparation.

- Pandemic Flu Planning Checklist for Individuals and Families

- Family Emergency Health Information Sheet
- Emergency Contacts Form

For More Information

- Visit: www.pandemicflu.gov
- The Centers for Disease Control and Prevention (CDC) hotline, 1-800-CDC-INFO (1-800-232 4636), is available in English and Spanish, 24 hours a day, 7 days a week. TTY: 1-888-232-6348. Questions can be emailed to inquiry@cdc.gov.
- Links to state departments of public health can be found at www.pandemicflu.gov/state/statecontacts.html.

Last revised: September 13, 2006

APPENDIX N1

ABSENCE MONITORING FORM

Absence Monitoring Form

Date/Time: _____

Employee Name: _____

Department/Division: _____

Reason for Absence:

❒ Illness (self)
Symptoms include:

- ❒ Fever of _____ F
- ❒ Cough
- ❒ Shortness of Breath
- ❒ Difficulty Breathing
- ❒ Headache
- ❒ Diarrhea
- ❒ Muscular Stiffness
- ❒ Loss of Appetite
- ❒ Malaise
- ❒ Confusion
- ❒ Rash

❒ Employee will seek medical attention: ❒ Yes ❒ No

❒ Illness (family member)
Is employee able to telecommute: ❒ Yes ❒ No
(provide form to appropriate staff for follow up)

❒ Childcare
Are resources available to assist employee: ❒ Yes ❒ No
Is employee able to telecommute: ❒ Yes ❒ No
(provide form to appropriate staff for follow up)

❒ Eldercare
Are resources available to assist employee: ❒ Yes ❒ No
Is employee able to telecommute: ❒ Yes ❒ No
(provide form to appropriate staff for follow up)

❒ Transportation
Are resources available to assist employee: ❒ Yes ❒ No
Is employee able to telecommute: ❒ Yes ❒ No
(provide form to appropriate staff for follow up)

❒ Other (please specify): _____