

**STATE OF FLORIDA
Department of Health**



Pandemic Influenza Appendix

Version 11.2

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Plan Approval

The Department of Health Emergency Operations Plan, Pandemic Influenza Appendix, outlines the department's approach to a Pandemic Influenza Event, in alignment with federal emergency management plans and guidance as well as the state's Comprehensive Emergency Management Plan (CEMP). According to the CEMP, the Department of Health is the coordinating agency for Emergency Support Function 8 (ESF 8), which coordinates all the State's public health and medical resources, capabilities and capacities in an emergency or disaster event.

Questions and comments regarding this document should be directed to the Florida Department of Health, Division of Emergency Medical Operations, Office of Emergency Operations.

Reviewed and adopted this date _____ by:

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This plan supersedes all previous versions of this plan.

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I. Introduction

B. Purpose

1. The purpose of this Florida Department of Health (FDOH) Pandemic Influenza Appendix is to serve as guidance for preparedness, response, recovery, and mitigation activities in the event of a pandemic in order to minimize morbidity and mortality in residents and visitors within the state of Florida. This effort will be achieved by:
 - a. Detecting outbreaks with pandemic influenza potential.
 - b. Responding to pandemic influenza outbreaks.
 - c. Delaying the introduction, and slowing the transmission of influenza.
 - d. Assisting local and tribal health authorities in the management and mitigation of an influenza pandemic event.
2. Critical tasks are arranged by the World Health Organization (WHO) phases of disease progression indicating what must be accomplished during each of the phases, before and during the pandemic.
3. U.S. Government stages are included in this Appendix for reference. The phases and stages are a useful tool for pandemic influenza planning. Response, recovery, and mitigation activities will be driven by the epidemiology and virology of the pandemic influenza virus.

C. Scope

1. This Appendix and its associated activities will apply to the FDOH Central Office and County Health Departments (CHDs). It references coordinated, complementary activities of the department's public health partners. Activities start in preparedness and continue through recovery.
2. In addition to the specified tasks that this Appendix identifies and assigns to various work units, there are implied tasks that must be satisfactorily performed in order for the specified tasks to be completed successfully within the time frames that this Plan describes. One of the most important of these implied tasks is training. Training is not within the scope of this Appendix.

II. Situation

A. Risk Assessment

1. Influenza viruses have threatened the health of animal and human populations for centuries. Their genetic and antigenic diversity and their ability to mutate rapidly make it difficult to develop a universal vaccine or highly effective antiviral drugs. A pandemic occurs when a novel strain of influenza virus emerges with the ability to infect and efficiently spread among humans. Because humans lack immunity to the new virus, a worldwide epidemic, or pandemic, can result. Each of the three pandemics in the last century resulted in the infection of approximately 30% of the world's population and the death of 0.2%-2% of infected individuals. Conversely, this indicates that 98%-99.8% survived the pandemics.

2. Avian viruses were involved in all three 20th century pandemics. In terms of total death toll, the 1918 pandemic is generally regarded as the deadliest disease event in recorded history in such a compressed time frame. In 1997, the H5N1 avian influenza virus appeared in poultry in Hong Kong and infected 18 people, resulting in six deaths. Since then, the virus has spread among domestic and wild bird populations in Asia, Europe, and Africa, resulting in the loss of over 200 million birds. In addition to birds and poultry, this virus can infect other animals, including pigs, cats, and humans. Evidence strongly indicates that Highly Pathogenic Avian Influenza (HPAI) H5N1 is now endemic in parts of Asia having established a permanent ecological niche in poultry.
3. As of June 1, 2008, there have been close to 400 confirmed cases of human H5N1 infection from 12 countries, with a case-fatality rate of over 60%. This avian virus has met all prerequisites for the start of a pandemic, except one; the ability to spread efficiently in a sustained manner among humans. The current focus is on the possibility that the next pandemic might be due to H5N1, but it is possible that a different strain of influenza will result in a pandemic.

B. Vulnerability Assessment

1. Potential Global Impact of Pandemic Influenza
 - a. All nations face considerable challenges in mounting an unprecedented, coordinated global response to an influenza pandemic. Once a fully transmissible virus emerges to which there is no human immunity, its global spread is considered inevitable. Countries might, through measures such as border closures and travel restrictions, delay arrival of the virus, but they will not be able to stop it. Pandemics of the previous century circled the globe in six to nine months, at a time when the majority of international travel was limited to ship or rail. Given the speed and volume of current international air travel, the virus could spread more rapidly, possibly reaching all continents within a matter of weeks. Health officials expect that a substantial percentage of the world's population infected with the pandemic strain of the virus will require medical care.
 - b. Supplies of effective antiviral drugs, an important medical intervention for reducing illness and deaths during an influenza pandemic, will be inadequate in all countries at the start of a pandemic, and for many months thereafter. Vaccines are of particular concern, as they are generally considered the best countermeasure for protecting populations. Currently, effective vaccines cannot be produced in anticipation of a pandemic virus. Many resource-poor countries have limited supplies of infection control and supportive care material and may have no access to vaccines throughout the duration of a pandemic. Even countries with large investments in healthcare and public health infrastructures will face the challenges of scarce medicines and vaccines during a pandemic.

- c. Accurate predictions of mortality cannot be made before the pandemic influenza virus emerges and begins to spread. Death rates are largely determined by four factors: the number of people who become infected, the virulence of the virus, the underlying characteristics and vulnerability of affected populations, and the effectiveness of clinical interventions and preventive measures. Those countries that do not have effective medical care during inter-pandemic periods, for example, resulting in low rates of influenza vaccine coverage, are likely to experience more deaths from pandemic influenza.
 - d. Economic and social disruptions may be great. High rates of illness, hospitalization, and worker absenteeism are expected, and these will contribute to social and economic disruption. These disruptions may be greatest when rates of absenteeism impair essential services such as healthcare, public safety, power and other public utilities, food supply, transportation, and communications.
2. Potential Impact on the United States
- a. An estimated 36,000 influenza deaths and 226,000 hospitalizations occur each year in the United States as a result of seasonal influenza. Based on current models of disease transmission, a pandemic could infect 30% or more of the U.S. population and result in the deaths of 209,000 - 1,903,000 U.S. residents (See Table 1 and Table 2).

Table 1: Predictions of National Level Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic influenza Scenarios*

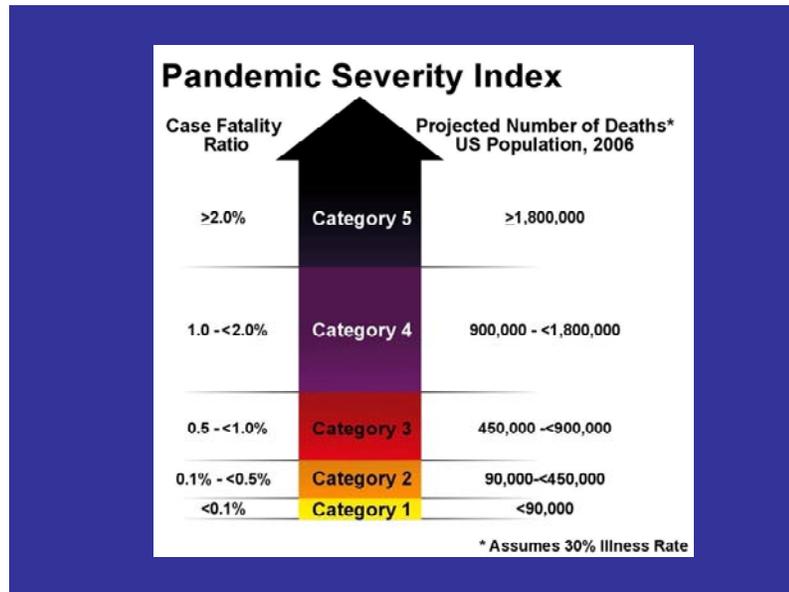
Characteristic	Moderate (1957/68-like)	Severe (1918-like)
Illness	90 million (30%)	90 million (30%)
Outpatient medical care	54 million (60%)	54 million (60%)
Hospitalization	865,000	9,900,000
Intensive Care Unit (ICU)	128,750	1,485,000
Mechanical ventilation	64,875	745,500
Deaths	209,000	1,903,000

*Estimates based on extrapolation from past pandemics in the United States. Note that these estimates do not include the potential impact of interventions not available during the 20th century pandemics. (<http://www.pandemicflu.gov/plan/pandplan.html> last accessed: March 2008)

- b. Following the Centers for Disease Control and Prevention's (CDC) Interim Guidance for Community Mitigation, this Appendix ties the scope and intensity of response in an influenza pandemic to the Pandemic Severity Index (PSI) once WHO Phase 6 characteristics are established. The similar well-known Saffir-Simpson scale for hurricane intensity is keyed to sustained wind speed. Category 5 hurricanes, with higher

winds, have much more destructive potential than Category 1 hurricanes. Similarly, Category 5 pandemics, with higher case-fatality rates, have the potential both for more illness and death and for more social disruption and economic impact than milder Category 1 or 2 pandemics (See Table 2, Pandemic Severity Index for a description of the Categories).

Table 2: Pandemic Severity Index



- c. A pandemic's impact will extend beyond human health. It will undermine many of the day-to-day functions within society and could significantly weaken the national economy and national security. Worker absentee rates due to illness, care giving, exposure avoidance, etc., are projected to reach 40% at the height of a pandemic.
- d. The longer it takes for an influenza pandemic to spread, the more likely it is that its effects can be mitigated by public health systems, prepared healthcare professionals, informed citizens, and proactive leaders. Ultimately, the center of gravity, where the application of resources will have the greatest impact, of the influenza pandemic response will be in local communities where coordinated efforts will be essential.
- e. As with other illnesses and diseases, disparities in access to healthcare will result in disproportionate morbidity and mortality. Efforts to distribute vaccines and antiviral drugs in disadvantaged or "at risk" populations may be hampered by limited availability of health resources. Real or perceived injustices may impede the acceptance and effectiveness of isolation and quarantine measures.

3. Potential Impact on Florida
 - a. In accordance with the U.S. Department of Health and Human Services (HHS) planning guidance, Florida is planning for a severe influenza pandemic similar to the pandemic that occurred in 1918-1919. The following tables estimate pandemic impacts on Florida.

Table 3: Severe Pandemic Influenza Impact in Florida Community Health Assessment Resource Tool Set (CHARTS), Florida 2008 Population Estimate of 19.23 million

Characteristic	Percentage	Florida
Attack Rate	30%	5.77 million
Seeking Treatment	60% of cases	3.46 million
Hospitalization Rate	10% of cases	577,000
Case-Fatality Rate	2%	115,400

Table 4: Impact on the Florida Healthcare System with No Antiviral Medication

Characteristic	Per Wave (Two Waves Total)	Florida
Cases	2.89 million	5.77 million
Hospitalized (10% of cases)	288,500	577,000
Surge Beds (20% of Hosp.)	57,700	115,400
ICU Beds – Total (15% of Hospitalized)	43,275	86,550
ICU-Ventilators (50% of ICU beds)	21,673	43,175
Case-Fatality Rate (2%)	57,700	115,400

Table 5: Impact on the Healthcare System with Antiviral Medication to Treat 20%-25% of Population*

Characteristic	Per Wave (Two Waves Total)	Florida
Hospitalized	72,125 – 144,250	144,250 - 288,500
Case-Fatality Rate	28,850	57,700

*Estimates a 50%-75% reduction in the number hospitalized. Estimates a 50% reduction in case-fatality rate.

- b. Estimates are that Florida's economic losses could approximate \$38.7 billion during a severe influenza pandemic representing a 5.74% drop in the State Domestic Product.
 - c. Tourism, entertainment, and food services could experience an 80% decline in business, while agriculture, construction, retail trade, finance, and insurance could face a 10% reduction. The healthcare and social assistance industries are projected to have an increased demand during the pandemic ("Pandemic Flu and the Potential for U.S.

Economic Recession-A State by State Analysis,” Trust for America’s Health. 2007).

- d. The impact from early rapid response and containment efforts could have associated disruptions at various ports of entry.

C. Planning Assumptions

These planning assumptions are based on federal planning assumptions for use in a severe case scenario.

1. Disease Control

- a. Introduction of pandemic influenza into Florida could come from a variety of sources. When it occurs, its virulence and infectivity is uncertain.
- b. If the pandemic occurs outside the U.S., the first U.S. cases are likely to occur within two to four weeks following recognition, absent effective intervention.
- c. Measures to control and contain pandemic influenza through enhanced Public Health surveillance, Rapid Response and Containment Protocol and border screenings will delay the appearance of a statewide epidemic by two to four or more weeks and reduce the overall rate of morbidity and mortality.
- d. Multiple waves of illness, periods during which community outbreaks take place across the country, could occur with each wave lasting up to 12 weeks.
- e. The seasonality of a pandemic cannot be predicted with certainty.
- f. An influenza pandemic will be a long term event, lasting from weeks or months, to over a year.
- g. An estimated 30% of the general population will become ill with influenza, of which 60% will seek outpatient medical care. It is expected that people who are not ill will also seek care.
- h. Isolation and quarantine at international ports-of-entry is a federal responsibility with state support and follow-up.
- i. A case fatality rate {(CFR) the proportion of ill people who die} equal to or greater than 2% could occur in a severe pandemic.
- j. Risk groups for complications and death from influenza will include infants and the elderly, but may also include others.
- k. A severe pandemic could result in the deaths of 209,000-1,903,000 U.S. residents or 115,400 Florida residents.
- l. Susceptibility to the pandemic influenza virus will be universal.
- m. Highest risk groups for severe and fatal infection cannot be predicted with certainty, but are likely to include infants, the elderly, pregnant women, and people with chronic medical conditions.
- n. Illness rates will be highest among school-aged children (about 40%) and decline with age. Among working adults,

- an average of 20% will become ill during a community outbreak.
- o. In a severe pandemic, absenteeism attributable to illness, the need to care for ill family members and fear of infection may reach 40% during the peak weeks of a community outbreak, with lower rates of absenteeism during the weeks before and after the peak.
 - p. The typical incubation period, the interval between infection and onset of symptoms, for influenza will be approximately two days.
 - q. In an affected community, a pandemic wave will last about six to eight weeks.
 - r. Increased public anxiety will cause increased psychogenic and stress-related illness compounding the strain on healthcare facilities.
 - s. Community mitigation strategies, if implemented effectively, are assumed to reduce the attack rate to 15%.
 - t. Some people infected with the virus will not have clinically significant symptoms but will develop immunity to subsequent infection. Despite any obvious symptoms, these same people, will be able to transmit infection to others at rates probably lower than those for people with full symptoms.
 - u. People who become ill will shed the virus and transmit infection up to one day before the onset of illness. Viral shedding and the risk of transmission will be greatest during the first two days of illness. For those that develop symptomatic illness, the greatest risk of transmission is early in the course of illness.
 - v. Children typically shed the greatest amount of virus and therefore, are likely to pose the greatest risk for disease transmission.
 - w. On average, an infected person will transmit infection to approximately 1.5 to 2 other people ($R_0=1.5-2$). This number will be lower during the latter part of a pandemic wave when many people are immune.
 - x. Infection is spread primarily by respiratory droplets, possibly with some contribution by short distance aerosols and by hand-to-face contact with contaminated surfaces.
 - y. Influenza virus can survive up to 48 hours on hard surfaces, but the time during which it remains infectious is unclear.
2. Public Health Services
- a. Some public health interventions, such as school closure, work closure, and quarantining household contacts of infected individuals are likely to increase rates of absenteeism from work.
 - b. Social and economic disruption may limit FDOH's ability to provide public health services, resulting in unintended consequences.

- c. Public health services will be reduced to those services determined to be life-saving, mission-essential, or life-sustaining.
 - d. The initial responsibility for a domestic pandemic response rests with state, local, and tribal authorities.
 - e. A pandemic will increase the demand for safety and public services, possibly creating sudden and potentially significant gaps in a community's ability to provide these services.
 - f. The State Emergency Operations Center (SEOC) will be manned at the "Alert Mode" upon declaration of WHO Phase 4 and U.S. Government (USG) Stage 2 (See Table 6).
 - g. Under certain scenarios included within WHO Phases 4-6 (USG Stages 2-6), the State Surgeon General will order that some of the less critical functions and activities within the FDOH be significantly reduced, or ceased, in order to permit a surge in efforts to accomplish FDOH's essential pandemic response functions, and to support critical local and tribal public health functions. The CDC and other federal agencies will find themselves in similar situations.
3. Antiviral Medications
- a. Antiviral drug availability will be what has been stockpiled before the pandemic.
 - b. Florida will receive a pro rata 2.5 million treatment courses of antiviral medications from the Strategic National Stockpile (SNS). Based on federal guidelines, these antivirals will be designated for treatment of the sick based on HHS priority groups.
 - c. Additional antiviral medications will likely not be available for prophylaxis in Florida.
 - d. Mathematical models suggest that early treatment, containment, control, and prevention strategies for pandemic influenza may be most effective when antiviral medications for treatment and pre- and post-exposure prophylaxis are included with non-pharmaceutical interventions.
4. Vaccines
- a. When the pandemic occurs, vaccine will not be available, or will be in short supply and will be allocated on a priority basis following federal guidelines from HHS.
 - b. Vaccine will be available for pandemic influenza prophylaxis approximately four to six months after the pandemic begins. Once the vaccine is produced, it will be available incrementally, based on U.S. production capability.
 - c. With the emergence of a novel influenza virus strain, all people identified for vaccination may need two doses of vaccine to achieve optimal antibody response.
 - d. The vaccine supply will be under the control of the federal government.

5. Resource Support
 - a. State, interstate, and federal assistance and resource support to local communities will be limited or unavailable.

III. Concept of Operations

- A. Alert, Notification, Activation, Deactivation
 1. Assessment
 - a. Ongoing surveillance activities will provide information to assess the current status of the pandemic. See Table 6 for various categorizations related to Pandemic Influenza and Table 7, Matrix of Surveillance Goals by Pandemic Period.

Table 6: Pandemic Influenza Classification Matrix

Source	Classification			
	Periods Phases	Inter-pandemic 1, 2	Pandemic Alert 3,4,5	Pandemic 6
WHO				
FDOH	Sub Phases	1,2	3A, 3B, 3C, 3D 4A, 4B, 4C, 4D 5A, 5B, 5C, 5D	6A, 6B, 6C, 6D
FDOH, DEM	Activation Levels	Level 3: Monitoring	Level 3: Monitoring Level 2: Partial Activation Level 1: Full Activation	
	Phases	Preparedness, Response, Recovery, Mitigation (→↓)		
CDC	Modes	Watch, Alert, Response, Recover (→↓)		
	Severity Index	-	-	1,2,3,4,5
	Intervals		Investigation Recognition	Initiation Acceleration Peak Transmission Deceleration Resolution
USG	Response Stages	0	1,2,3,4,5,6	
Florida National Guard	Phases	Prepare: Steady State	Respond: 1. Mobilize and Deploy 2. Decisive Operations 3. Transition	Recover: 4. Redeploy
Northern Command (NORTHCOM) Response to Pandemic Influenza Phases (Response, Virus, and Geography Driven)	Phases	0: Shape	1. Prevent 2. Contain 3. Interdict	4. Stabilize 5. Recover

Table 7: Matrix of Surveillance Goals by Pandemic Period

	Interpandemic Period		Pandemic Alert Period			Pandemic Period			
	1	2	3	4	5	6A	6B	6C	6D
Goals:									
Detect the onset, peak, and close of influenza seasons as well as determine community impact.	*	*	*	*	*				
Document circulating virus strain and changes in order to plan and implement control measures including vaccine development and/or emergence of antiviral resistance.	*	*	*	*	*	*	*	*	*
Determine geographic distribution and spread of circulating virus.	*	*	*	*	*	*	*	*	*
Ensure rapid characterization of the new virus subtype and early detection, notification and response to additional cases to document the presence of a novel virus in the population, to promptly locate 100% of the individuals with the new infection in order to take preventive action.	*	*	*	*	*	*			*
Detect and investigate individual cases of influenza-associated encephalitis and pediatric mortality.	*	*	*	*	*	*			*
Detect and report transmission of animal influenza virus to humans.	*	*	*	*	*				
Document presence or absence of person-to-person spread of a novel virus. Result will be to contain the new virus within limited foci or delay spread to gain time to implement preparedness measures, including vaccine development.				*	*	*			
Estimate mortality due to novel or pandemic influenza strains.					*	*	*	*	
Estimate morbidity due to novel or pandemic influenza strains.							*	*	
Monitor effectiveness of community-based control measures to minimize pandemic impact.							*	*	

- b. Florida divides several of the WHO phases to show that different events and responses will occur at different periods of the epidemic's development and subsequent decline(s). Subdivision of the WHO phases will provide for a more nuanced and measured response during the pandemic. (See Table 8).

Table 8: WHO Pandemic Sub-Phases and Key Events Requiring Intervention

FDOH Phase	WHO Phase	Description
1	1	
2	2	
3A	3	Disease in wild animals and birds in Florida
3B	3	Disease in poultry flocks in Florida
3C	3	Human cases in Florida, resulting from exposure outside Florida, minimal or no risk of human-to-human spread
3D	3	Human cases in Florida, resulting from exposure in Florida, minimal or no risk of human-to-human spread
4A	4	Disease in wild birds in Florida
4B	4	Disease in poultry flocks in Florida
4C	4	Human cases in Florida, resulting from exposure outside Florida, small risk of human-to-human spread
4D	4	Human cases in Florida, resulting from exposure in Florida, small risk of human-to-human spread
5A	5	Disease in wild birds in Florida
5B	5	Disease in poultry flocks in Florida
5C	5	Human cases in Florida, resulting from exposure outside Florida, moderate degree of human-to-human spread
5D	5	Human cases in Florida, resulting from exposure in Florida, moderate degree of human-to-human spread
6A	6	Human cases with potential for sustained person-to-person spread, scattered cases allow case-based control measures
6B	6	Human cases with sustained person-to-person spread, no vaccine available, community-based control measures
6C	6	Human cases with sustained person-to-person spread, vaccine available, community-based control measures plus selective vaccination, then widespread vaccination
6D	6	First wave of epidemic receding, recovery, alertness for next wave

- c. Florida's public health response during the various phases and stages of a pandemic will be drawn from seven key areas of intervention:
 - (1) laboratory tests
 - (2) surveillance
 - (3) case-based containment measures
 - (4) community-based mitigation
 - (5) isolation / quarantine
 - (6) access and distribution of SNS
 - (7) vaccine and antiviral distribution.
- d. Certain interventions such as lab tests and surveillance will span the duration of the pandemic, while others such as isolation / quarantine and antiviral distribution will be used only at specific points in the pandemic (see Table 9).
- e. Transition to later WHO phases and accompanying response interventions will be determined based on the number of laboratory confirmed individual cases, small case clusters and/or evidence of community spread. Florida will apply a layered approach to the implementation of the seven key interventions listed above in order to slow the progression of the pandemic as recommended by the CDC.

Table 9: Interventions By Pandemic Sub-Phase

Interventions and Phase	1	2	3A	3B	3C	3D	4A	4B	4C	4D	5A	5B	5C	5D	6A	6B	6C	6D
Key:			Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Scattered human cases	Widespread human cases, no vaccine	Widespread human cases, vaccine	Recovery
◆ Activity is not appropriate at this stage																		
◆◆ Activity is optional component of response at this stage																		
◆◆◆ Activity is important component of response at this stage																		
◆◆◆◆ Activity is core component of response at this stage																		
<i>Planning</i>	◆◆	◆◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
<i>Wild bird surveillance</i>		◆	◆◆◆	◆◆	◆	◆◆◆	◆◆◆	◆◆	◆◆	◆◆◆	◆◆◆	◆◆	◆◆	◆◆◆	◆			
<i>Domestic poultry surveillance</i>	◆◆	◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆			
<i>Surveillance for human impact</i>	◆◆	◆◆													◆◆◆	◆◆◆	◆◆◆	◆◆◆
<i>Surveillance for human cases</i>			◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆			
<i>Laboratory strain surveillance</i>	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆
<i>Public health laboratory support for interventions</i>			◆◆	◆	◆◆◆	◆◆◆	◆◆	◆	◆◆◆	◆◆◆	◆◆	◆	◆◆◆	◆◆◆	◆◆◆			◆◆
<i>Surveillance for disease in poultry workers</i>			◆◆	◆◆◆		◆◆◆	◆◆	◆◆◆		◆◆◆	◆◆	◆◆◆		◆◆◆	◆◆			
<i>Personal Protective Equipment (PPE) for poultry responders</i>			◆◆	◆◆◆		◆◆◆	◆◆	◆◆◆		◆◆◆	◆◆	◆◆◆		◆◆◆	◆◆			
<i>Antiviral prophylaxis for poultry responders</i>			◆◆	◆◆◆		◆◆◆	◆◆	◆◆◆		◆◆◆	◆◆	◆◆◆		◆◆◆	◆◆			
<i>Antiviral treatment of hospitalized human cases</i>					◆◆◆	◆◆◆			◆◆◆	◆◆◆			◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆
<i>Antiviral treatment of all human cases within 24 hours of onset</i>					◆◆◆	◆◆◆			◆◆◆	◆◆◆			◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆
<i>Prophylactic antiviral treatment of all household and other close contacts within 24 hours</i>					◆◆◆	◆◆◆			◆◆◆	◆◆◆			◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆
<i>PPE for healthcare workers (HCW)</i>					◆◆◆	◆◆◆			◆◆◆	◆◆◆			◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆
<i>Antiviral prophylaxis for all Healthcare Workers</i>															◆◆	◆◆◆	◆◆◆	
<i>Infection control in Healthcare Facilities</i>					◆◆◆	◆◆◆			◆◆◆	◆◆◆			◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆
<i>Directed voluntary isolation of cases at home</i>					◆◆◆	◆◆◆												◆◆

Table 9: Interventions By Pandemic Sub-Phase

Interventions and Phase	1	2	3A	3B	3C	3D	4A	4B	4C	4D	5A	5B	5C	5D	6A	6B	6C	6D
Key: Activity is not appropriate at this stage ♦ Activity is optional component of response at this stage ♦♦ Activity is important component of response at this stage ♦♦♦ Activity is core component of response at this stage			Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Scattered human cases	Widespread human cases, no vaccine	Widespread human cases, vaccine	Recovery
Self-isolation of cases																♦♦♦	♦♦♦	
Compulsory isolation of cases by CHD									♦♦♦	♦♦♦			♦♦♦	♦♦♦	♦♦♦			
Monitoring of contacts by CHD					♦♦♦	♦♦♦												
Directed voluntary quarantine of contacts									♦♦♦	♦♦♦			♦♦♦	♦♦♦				♦♦
Compulsory quarantine of contacts by CHD															♦♦♦			
Self-quarantine of contacts																♦♦	♦♦	
Support home management of ill people, keeping ill people out of healthcare facilities and medical offices.					♦♦♦	♦♦♦			♦♦♦	♦♦♦			♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦
Support the social expectation that people ill with respiratory symptoms will strictly self-isolate at home.																♦♦♦	♦♦♦	♦♦
Support the social expectation that people who become ill while away from home will take prescribed control measures and proceed directly home or to a healthcare facility.																♦♦♦	♦♦♦	♦♦
Develop practical measures in day-cares, schools, workplaces, colleges etc. to immediately detect and exclude people ill with influenza-like illness.					♦♦	♦♦			♦♦	♦♦			♦♦	♦♦	♦♦	♦♦♦	♦♦♦	♦♦
Provide community support for people who are confined to home to reduce breaches of isolation and quarantine.					♦♦	♦♦			♦♦	♦♦			♦♦	♦♦	♦♦	♦♦♦	♦♦♦	♦♦
Support organizational policies that support workers and students for staying home while ill, or with an ill family member.					♦♦	♦♦			♦♦	♦♦			♦♦	♦♦	♦♦	♦♦♦	♦♦♦	♦♦

Table 9: Interventions By Pandemic Sub-Phase

Interventions and Phase	1	2	3A	3B	3C	3D	4A	4B	4C	4D	5A	5B	5C	5D	6A	6B	6C	6D
Key: Activity is not appropriate at this stage ♦ Activity is optional component of response at this stage ♦♦ Activity is important component of response at this stage ♦♦♦ Activity is core component of response at this stage			Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Scattered human cases	Widespread human cases, no vaccine	Widespread human cases, vaccine	Recovery
Develop practical measures in day-cares, schools, workplaces, colleges, etc. to immediately detect and exclude people ill with influenza-like illness.													♦♦	♦♦	♦♦	♦♦	♦♦	♦♦
Provide ongoing prophylactic antiviral medications for healthcare workers, EMS workers, public health workers, agricultural and veterinary workers, and other first responders who are exposed repeatedly.													♦♦	♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦
Assure that appropriate PPE is provided for all those whose essential occupation puts them at increased risk for exposure and infection (e.g. HCWs, public safety workers, teachers, transit drivers, food store workers).					♦♦	♦♦			♦♦	♦♦			♦♦	♦♦	♦♦	♦♦♦	♦♦♦	♦♦
Provide antiviral prophylaxis promptly for all children in same classroom as a case or who have attended classes with a case.															♦♦♦	♦♦♦	♦♦♦	
Provide antiviral prophylaxis promptly for all members of a case's work group who have regular face-to-face with the case – goal would be 5 to 30 contacts per case.															♦♦♦	♦♦♦	♦♦♦	
Support temporary social changes that result in greatly reduced face-to-face interactions throughout the community, i.e. social distancing.															♦	♦♦♦	♦♦♦	
Schools: graded response including strict exclusion, targeted antiviral prophylaxis, reactive closure, and community-wide closure.													♦♦	♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦
Close theme parks, ocean cruises and other tourist attractions.																♦♦	♦♦	

Table 9: Interventions By Pandemic Sub-Phase

Interventions and Phase	1	2	3A	3B	3C	3D	4A	4B	4C	4D	5A	5B	5C	5D	6A	6B	6C	6D
Key: <i>Activity is not appropriate at this stage</i> ♦ <i>Activity is optional component of response at this stage</i> ♦♦ <i>Activity is important component of response at this stage</i> ♦♦♦ <i>Activity is core component of response at this stage</i>			Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Disease in wild birds	Disease in poultry	Imported human cases	Local human cases	Scattered human cases	Widespread human cases, no vaccine	Widespread human cases, vaccine	Recovery
<i>Build social support for recommended individual protective behavior changes.</i>					♦♦♦	♦♦♦			♦♦♦	♦♦♦			♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦
<i>Support employers and employees in maximizing the proportion of those who can work from home.</i>															♦	♦♦♦	♦♦♦	
<i>Acquire, stockpile and manage needed antiviral medications, PPE, and other supplies – recommend central control of at least the antiviral supply.</i>	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦
<i>Identify and use volunteers to extend community ability to carry out many essential functions.</i>	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦
<i>Identify government services, including DOH services, which can be put on hold so that unneeded workers can stay or work from home and available workers can focus on essential tasks.</i>															♦	♦♦♦	♦♦♦	
<i>Assure that enough antiviral medications are available and that they are used only for priority indications.</i>					♦♦♦	♦♦♦			♦♦♦	♦♦♦			♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦

2. Thresholds of WHO Phase Activities
 - a. WHO Phases 1 and 2, Interpandemic Period: Watch Mode
 - (1) Takes place when there is growing evidence of a threat.
 - (2) The State Surgeon General will alert Deputies, Division Directors, Bureau Chiefs, and office leaders of a developing situation as needed.
 - (3) Watch activities begin in the WHO Inter-Pandemic Phases 1 and 2, and may extend to Pandemic Alert Phases 3 and 4. Watch activities consist of the surveillance of wild birds, domestic poultry, and humans, as well as laboratory strain surveillance.
 - b. Novel Influenza Virus Laboratory Surveillance and Diagnostics
 - (1) Purpose
 - (a) Clinical and public health laboratories have multiple roles that vary with pandemic phase and laboratory type. These include:
 - (i) Assays for confirmation of etiology of ILI
 - (ii) Clinical healthcare
 - (iii) Influenza strain typing
 - (iv) Laboratory-based surveillance studies
 - (b) Clinical laboratories perform the assays and clinical healthcare using rapid, point of care testing to screen for influenza and monitoring patient clinical status with multiple health indicator assays.
 - (c) Public health laboratories perform confirmatory assays and influenza strain surveillance testing, support outbreak investigations, and conduct special surveillance studies, in an attempt to detect or identify novel, emerging viruses.
 - (2) Strategy

To collect information through laboratory-based surveillance and diagnostic testing to assist public health officials in their effort to prevent, treat, vaccinate, and respond to influenza in the community.
 - (3) Objectives
 - (a) Perform rapid detection and identification of novel influenza strains.
 - (b) Monitor circulating influenza strain types.
 - (c) Monitor respiratory disease etiology in the state across time and space.
 - (d) Provide laboratory guidance to county CHDs, healthcare providers, and laboratories.
 - (4) Action Items
 - (a) Update Bureau of Laboratories (BOL) Influenza Test Algorithm as new developments and CDC recommendations warrant.
 - (b) Stockpile testing reagents and laboratory supplies.

- (c) Assure information on appropriate specimen collection and shipping is available to CHDs and the medical community.
 - (d) Maintain updated call lists.
 - c. Components of Current Surveillance Activities
 - (1) Statewide and local activities will include collection and compilation of data from multiple partners. Information gathered will include:
 - (a) Laboratory testing
 - (b) Data and outbreak reports
 - (c) Syndromic surveillance
 - (d) Outpatient sentinel ILI surveillance by age group
 - (e) Sentinel influenza and pneumonia mortality surveillance (all ages)
 - (f) Reportable disease surveillance, including pediatric influenza-associated deaths, influenza-associated encephalitis, human cases due to novel influenza strains.
 - (2) The Division of Disease Control (DDC) will direct modification or enhancement to these routine systems during an influenza pandemic or pandemic alert periods.
 - (3) During the Pandemic Alert periods, individual human case reporting will follow traditional notifiable disease surveillance methods using the Merlin database. Epidemiology staff will utilize this system in the application of the following surveillance and investigation techniques in the event of a novel influenza virus:
 - (a) Reporting suspect and confirmed cases of novel strains of influenza utilizing Merlin.
 - (b) Collecting extended data on risk exposures and entering it into the Merlin Outbreak Module.
 - (c) Collecting case information from close contacts and entering this data into the Merlin Outbreak Module.
 - (d) Linking this data to confirmed cases that have been reported to Merlin.
 - (4) The Bureau of Epidemiology (BOE) and the Bureau of Community and Environmental Health will work collaboratively to develop a process for surveillance and investigation of animal-to-human and/or human-to-human disease transmission.
 - d. WHO Phase 3 Through Early Phase 6 Activities
 - (1) Alert Mode

Takes place once disease is detected in wild birds. Florida will transition from Watch Mode to Alert Mode. The primary interventions throughout Phases 3-5 will continue to be laboratory and surveillance activities. Other Alert activities will include: Surveillance, PPE and Antiviral prophylaxis for poultry and healthcare workers, antiviral treatment of all human cases and their close contacts within 24 hours, infection control in healthcare

- facilities, voluntary and compulsory isolation and quarantine, monitoring of contacts by CHD staff.
- (2) As imported or local human cases appear, case and community-based Interventions will be applied in an attempt to interrupt and or contain local human-to-human transmission.
 - (3) The CDC will contact the State Surgeon General to communicate the need to implement specific portions of the Appendix, such as Points of Entry Screening. This action is most likely to occur during WHO Phase 5.
 - (4) During the Alert Phase, FDOH employees will not change their normal work schedules or leave work unless directed to do so by the Executive Management Team (EMT).
 - (5) Once WHO or the CDC declares a pandemic, the DDC will monitor:
 - (a) Changes in the circulating virus, including development of antiviral resistance and shifts in the affected populations.
 - (b) Impacts on human health by conducting ongoing assessment of morbidity and mortality.
 - (c) Effects of community and population-based control measures, as applicable.
 - (6) In conjunction with recommendations from other public health partners, such as the CDC and WHO, FDOH will provide updated guidance to medical providers and CHDs on an ongoing basis. Surveillance activities will be contingent upon local, state, national, and international influenza activity at the time.
- e. Case and Community-Based Interventions
- (1) Concept
 - (a) The intent of FDOH case and community-based interventions is to interrupt and/or contain local human-to-human transmission of the novel influenza agent as part of a larger strategy to attempt to delay a full-scale influenza pandemic.
 - (b) If the influenza pandemic can be delayed long enough, an effective vaccine can be manufactured, distributed, and administered in time to save lives. Flattening out the epidemic curve can spread out the demand on healthcare facilities as well.
 - (c) If the public health authority controls the supply of antivirals, then access to antiviral medications can be a strong incentive for cases and contacts to come forward to be identified and treated by public health officials. The success of this strategy will depend on the effective statewide implementation of surveillance and containment measures.
 - (d) The local CHDs, with assistance from the DDC, will take the lead responsibility for organizing assets and disease control activities to intervene in individual

cases or small clusters of disease to delay the spread of the novel virus, allowing time for vaccine development and distribution.

(e) Objectives

- (i) Prevent those who are ill from infecting others.
- (ii) Prevent those infected or exposed from becoming ill.
- (iii) Prevent those not infected from becoming infected.

(f) Interventions

- (i) Isolate cases in the community or at point of entry through voluntary or compulsory measures.
- (ii) Monitor voluntary and/or compulsory quarantine.
- (iii) Receive and distribute antivirals and other medical countermeasures.
- (iv) Provide antiviral medications to people known to be infected, as well as to those who have been in contact with infected people.
- (v) Provide information to the public on measures to reduce transmission.

(g) Management

The Emergency Coordinating Officer (ECO), in coordination with the director of the DDC, shall oversee case and community-based interventions and maintain communication with the State Surgeon General and the Deputies.

(h) Voice Data and External Communications

The director of the DDC, in accordance with the DOH Emergency Operations Plan, Communication Annex, will work with the Office of Communications to establish a Technical Advisory Group (TAG) to:

- (i) Assist in formulating appropriate disease control messages.
- (ii) Disseminate information to FDOH staff, internal and external partners, including at minimum, elected officials, healthcare professionals, the lay public, people with disabilities, and people whose first language is not English.

(i) Coordinating Agencies

Establish and maintain relationships of trust and cooperation with public and private sector health professionals, organizations, and institutions including:

- (i) BOL
- (ii) Bureau of Statewide Pharmaceutical Services (BSPS)
- (iii) Office of Emergency Operations
- (iv) Office of Communications
- (v) Public Health Nursing
- (vi) Family Health Services
- (vii) CHDs

- (j) During Phase 6B, interventions are needed to control and mitigate an influenza pandemic after individual case-based interventions that were appropriate to Phase 6A are no longer effective, and before an effective vaccine is available in quantity, in Phase 6C. These interventions include community containment and related interventions to prevent people with disease from infecting others. The basis for these control measures is that reducing unprotected face-to-face contacts between people will reduce the likelihood of virus transmission. (See Table 10).
- f. Planning Assumptions and Recommended Interventions on Case and Contact Management
 - (1) At the start of the pandemic, no one in the population will have pre-existing immunity against the circulating strain.
 - (2) No well-matched vaccine will be available.
 - (3) Adequate supplies of antiviral medications will be made available to support this containment strategy.
 - (4) The amounts of antiviral medication needed for containment will be very small compared to the amount needed during the later community-based control measures phase.

Table 10: Recommended Interventions of Case-Based Containment Strategy

	Phase 3	Phase 4/5	Early Phase 6
Triggers	High-suspicion: act without waiting for lab result	High-suspicion: act without waiting for lab result	High-suspicion: act without waiting for lab result
	Moderate-suspicion: act without waiting for lab result if rapid testing shows influenza A is present, otherwise wait for lab confirmation	Moderate-suspicion: treat as Phase 3 pending lab result	Moderate-suspicion: treat as Phase 4/5 pending lab result
Management of case	Isolate in healthcare facility if in need of healthcare	Formal isolation order for case in hospital if in need of healthcare	Formal isolation order for case in hospital if in need of healthcare
	Self-isolate at home	Order formal isolation for case at home	Order formal isolation for case at home
	Treatment includes a full course of antiviral agent to which the virus is sensitive, if any	Treatment includes a full course of antiviral agent to which the virus is sensitive, if any	Treatment includes a full course of antiviral agent to which the virus is sensitive, if any
	CHD checks on patient location and status daily	CHD checks on patient location and status daily	CHD checks on patient location and status twice daily
Definition of contacts	Household members and others in similar prolonged face-to-face contact with the patient or meeting bird exposure criteria	People who have been in the same room with the patient or talking with the patient face-to-face for five minutes or more, or meeting bird exposure criteria	People who have been in the same room with the patient or talking with the patient face-to-face for five minutes or more, or meeting bird exposure criteria
Management of contacts	Locate all contacts, on and off-site	Locate all contacts, on and off-site	Locate all contacts, on and off-site

	Phase 3	Phase 4/5	Early Phase 6
	No activity restrictions for contacts	Immediate self-quarantine of all contacts to home	Formal quarantine order for all contacts to stay home or in designated location
	Instruct contacts to contact CHD immediately if symptoms develop	Instruct contacts to contact CHD immediately if symptoms develop	Instruct contacts to contact CHD immediately if symptoms develop
	-	CHD checks on location and status of all contacts daily	CHD checks on location and status of all contacts twice daily
	If any contacts have or develop symptoms suggesting influenza, manage case as Phase 4/5 infection until proven not to be H5N1	If contacts have or develop symptoms suggesting influenza, treat contact as a new case of Phase 4/5 infection and initiate contact tracing, until proven not to be H5N1	If contacts have or develop symptoms suggesting influenza, treat patient as a new case of Phase 6 infection and initiate contact tracing, until proven not to be H5N1
	Antivirals for all contacts, including exposed healthcare workers	Antivirals for all contacts, including exposed healthcare workers	Antivirals for all contacts, including exposed healthcare workers

- g. **Preconditions for Successful Implementations of Protocol Phases 3-5**
- (1) **Local Level Training**
All appropriate DDC staff (central office and CHDs) need to be trained on the protocol for rapid response to a contagious respiratory pathogen.
 - (2) **Accessibility and Response**
Designated FDOH staff member in every county as well as Central Office must be accessible by phone within 15 minutes to physicians, hospitals, CHDs, or others wanting to report a case of the novel influenza or to obtain a consultation, 24/7/365.
 - (3) **Surveillance, Case Response, and Laboratory Services**
Once Phase 4 has been declared:
 - (a) Each CHD must be able to actively ensure that every primary-care physician in the county, every emergency department (ED), and every freestanding urgent care clinic knows what to report and how to do so 24/7.
 - (b) CHD staff must also actively ensure that the same information about surveillance and management of cases and contacts is conveyed to:
 - (i) Jails
 - (ii) Prisons
 - (iii) Colleges and universities
 - (iv) Military schools
 - (v) Occupational health nurses
 - (vi) Clinics operating in their jurisdiction
 - (c) CHD staff must be able to activate their core response team within 15 minutes of receiving a high-suspicion case report.

- (d) The BOL must be prepared to handle potentially large volumes of tests for suspected cases of avian influenza as part of the case finding and containment strategies from all parts of the state in the early part of the pandemic.
- (4) Case Management
 - (a) All practicing physicians and healthcare facilities should know how to manage ill people and others in the office or healthcare setting; for example, staff, family, patients in the waiting area, and other patients, while awaiting further instructions from public health officials. The FDOH needs the full cooperation of the organized medical professions and healthcare facilities to facilitate the implementation of these measures.
- (5) Contact Elicitation and Management
 - (a) CHD staff with skills in partner elicitation and notification from their work with sexually transmitted diseases (STD), tuberculosis (TB), or HIV, as well as other communicable diseases, must be part of the core response team to enable rapid complete ascertainment of each new case's whereabouts, movements, exposures, and contacts.
 - (b) In accordance with the State's SNS plan, locals will implement protocols developed by Central Office for how and by whom prescriptions for antiviral medications for infected people and their contacts will be written and how the medication will be dispensed without delay.
 - (c) A ready supply of antivirals must be available for use in managing both cases and contacts at all locations where cases may occur.
 - (d) Every CHD must know how to invoke quarantine powers to isolate cases and quarantine or otherwise limit the movement of contacts including:
 - (i) Who has the authority?
 - (ii) Who has to be consulted?
 - (iii) Who is needed for enforcement?
 - (iv) How would enforcement occur?
- (6) Support and Management of Quarantined People
 - (a) Using interagency collaboration managed through its Emergency Operation Center (EOC), every CHD must know how its community will provide needed support to numerous households containing isolated and/or quarantined people for food, necessary supplies, communication, child care, elder care, etc.
- h. WHO Phase 6 Transition to Community Mitigation Measures
 - (1) The case-based interventions described in this Appendix will be implemented with individual cases or small clusters of disease due to a novel influenza agent. This case-based intervention strategy will continue as long into Phase 6

as practical in terms of public health staffing capabilities. Interventions will be discontinued as the community mitigation measures are put into effect.

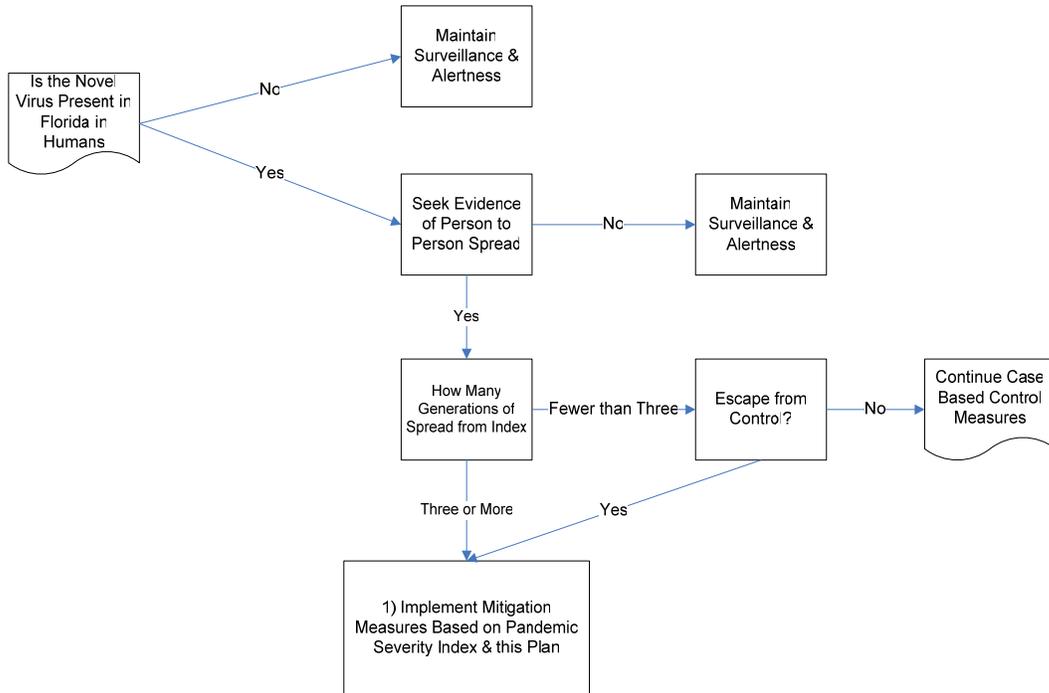
- (2) Activities will continue to include laboratory tests, surveillance, voluntary and compulsory isolation and the use of antivirals. Additional activities will include the restriction of public events, reduction of transmission among those seeking treatment at healthcare facilities and the communication of information to the public.
- (3) The CDC has published Interim Guidance for Community Mitigation, accessible at:
<http://www.pandemicflu.gov/plan/community/mitigation.html>
- (4) Response operations are designed to be consistent with the CDC Guidance as adapted to Florida conditions.
 - (a) The Guidance assumes that the world, including the United States, is in a WHO Phase 6 pandemic situation.
 - (b) Trigger events are provided in the Guidance for initiating the recommended community mitigation measures in any given state or metropolitan area.
 - (c) The recommended measures actually implemented would depend on the PSI at the time.
 - (d) More vigorous control measures would be recommended if the PSI is high (4 or 5), with a high mortality rate in infected people, than if it is low.
 - (e) The CDC's trigger conditions for initiating Community Mitigation Measures are described as a laboratory-confirmed cluster of cases and evidence of community spread (i.e., epidemiologically linked cases from more than one household).

i. Operational Aspects

- (1) Once a decision has been made by public health officials to shift from case-based to community-based control measures, a series of decision criteria will guide the implementation of various components of the overall strategy described in this Appendix. The CDC has provided Interim Guidance for Community Mitigation, and this section is consistent with the CDC's guidance.
- (2) Table 11 outlines the determinants for using community containment interventions. At each decision point, consider:
 - (a) What information is needed?
 - (b) Who are the key personnel?
 - (c) What is the scope of authority for decision makers?
- (3) Partnership entities involved in decision making may include:
 - (a) Emergency Support Function (ESF) 8
 - (b) Law enforcement
 - (c) First Responders
 - (d) Other government service workers
 - (e) Utilities

- (f) Transportation industry
- (g) Local businesses
- (h) Schools and school boards
- (i) Colleges and universities
- (j) Governor and elected officials

Table 11: Threshold Determinants for the Use of Community Containment Interventions



j. Community Mitigation Strategies

(1) Implementation

Table 12 illustrates the Community Mitigation Strategies for social distancing during Phase 6B and uses the following definitions:

(a) Generally Not Recommended

Unless there is a compelling rationale for specific populations or jurisdictions, social distancing measures are generally not recommended for entire populations as the consequences may outweigh the benefits.

(b) Consider

Important to consider these alternatives as part of a prudent planning strategy, considering characteristics of the pandemic, such as:

- (i) Age-specific illness rate
- (ii) Geographic distribution
- (iii) Magnitude of adverse consequences

These factors may vary globally, nationally, and locally.

(c) Recommend

Generally accepted as an important component of the planning strategy.

Table 12: Summary of the Community Mitigation Strategy by Pandemic Severity

Community Mitigation Measures by Pandemic Severity Index	Severity Index 1	Severity Index 2 or 3	Severity Index 4	Severity Index 5
Interventions in CDC's Table				
Voluntary isolation of ill at home (adults and children)	Recommend	Recommend	Recommend	Recommend
Voluntary quarantine of household members in homes with ill people (adults and children)	Generally not recommended	Consider	Recommend	Recommend
If available, antiviral treatment of cases as available and indicated	Recommend	Recommend	Recommend	Recommend
If available, antiviral prophylaxis of household members if effective, feasible, and quantities sufficient	Generally not recommended	Consider	Recommend	Recommend
Dismissal of students from schools and school-based activities	Generally not recommended	Consider \leq 4 weeks	Recommend \leq 12 weeks	Recommend \leq 12 weeks
Closure of child care programs	Generally not recommended	Consider \leq 4 weeks	Recommend \leq 12 weeks	Recommend \leq 12 weeks
Reduce out of school contacts and community mixing by school-age children	Generally not recommended	Consider \leq 4 weeks	Recommend \leq 12 weeks	Recommend \leq 12 weeks
Decrease number of social contacts at workplace (e.g. teleconferences and other alternatives to face-to-face meetings)	Generally not recommended	Consider	Recommend	Recommend
Increase distance between people (e.g. reduce density in public transit, workplace)	Generally not recommended	Consider	Recommend	Recommend
Modify, postpone, or cancel selected public gatherings to promote social distance (e.g. stadium events, theater performances)	Generally not recommended	Consider	Recommend	Recommend
Modify workplace schedules and practices (e.g. telework, staggered shifts)	Generally not recommended	Consider	Recommend	Recommend
Florida Interventions				
Infection control in health-care facilities and alternate treatment sites	Recommend	Recommend	Recommend	Recommend
Support home (rather than hospital) management of ill people	Consider	Recommend	Recommend	Consider
Support behavior of going home immediately if ill	Consider	Recommend	Recommend	Recommend

Community Mitigation Measures by Pandemic Severity Index	Severity Index 1	Severity Index 2 or 3	Severity Index 4	Severity Index 5
Provide information to support isolation of ill people at home	Recommend	Recommend	Recommend	Recommend
Provide community support for those staying at home while ill or quarantined	Consider	Recommend	Recommend	Recommend
Support institutional policies that encourage desired behaviors	Consider	Recommend	Recommend	Recommend
Reinforce exclusion of ill people from day cares, school, workplaces, colleges, etc.	Consider	Recommend	Recommend	Recommend
Recommend barrier and other personal protective measures for those occupationally exposed	Recommend	Recommend	Recommend	Recommend
If available, provide pre-exposure antiviral prophylaxis for those occupationally exposed, if antivirals available	Generally not recommended	Consider	Recommend	Recommend
If available, antiviral post-exposure prophylaxis for exposed children at school	Generally not recommended	Recommend	Recommended when schools open	Generally not recommended
Strict exclusion of ill students and staff from day cares, schools, colleges, etc.	Recommend	Recommend	Recommended when schools open	Generally not recommended
If available, provide post-exposure prophylaxis for exposed coworkers	Generally not recommended	Consider	Consider	Consider
Close theme parks, cruises, and other tourist attractions	Generally not recommended	Generally not recommended	Consider	Recommend
Encourage individual protective behavioral changes such as masks on the ill, selective use of masks by the well in crowded settings, and hand-washing	Recommend	Recommend	Recommend	Recommend
Respirators for use by individuals for whom close contact with an infectious person is unavoidable.	Recommend	Recommend	Recommend	Recommend

k. **Categories of Interventions**

- (1) The Interventions applied during Phase 6B fall into three categories:
 - (a) Interventions that reduce the opportunities for people who are ill to infect others.
 - (b) Interventions that reduce the likelihood that people who have been potentially exposed to infection develop disease.
 - (c) Interventions that reduce the likelihood that those who are not infected and not identifiably exposed become infected.
- (2) The choice of which interventions to implement depends on the estimated category of the pandemic, based on the PSI.

- (3) Choice of non-pharmaceutical interventions will generally follow the guidance in Table 12 excerpted from the CDC Interim Guidance, but this Appendix also provides guidance about the recommended use of antiviral medications by category.
- (4) The interventions that require use of antivirals will be undertaken in a manner consistent with national priorities for antiviral use. If the virus responsible for the outbreak is resistant to the available antivirals, then none of the interventions that require antivirals will be possible and the remaining interventions will necessarily receive more emphasis.
 - (a) These interventions cannot be carried out by CHD staff acting alone. The main role of public health organizations during this phase of the response will be to assure that clear messages are received by all citizens, and to build and maintain public support for and compliance with the needed interventions.
 - (b) The most logistically difficult of these recommended operational aspects is assuring that all people ill with the novel virus get a prompt course of their therapeutic antiviral medication, and assuring that all of their contacts get a prompt course of prophylactic antiviral medication. This combination of interventions is likely to be very effective in reducing community spread, if carried out completely and in concert with the other recommended interventions. Achieving this goal without also providing medication to a large number of people who are not candidates for it will require numerous entities within each community to work closely and creatively together.

I. Monitoring, Isolation, and Quarantine

(1) Concept

The local CHDs, with assistance from the DDC, will take the lead responsibility for organizing disease control assets and activities to monitor the spread of a novel virus, and then intervene to delay the spread of the novel virus. These acts will entail gaining and maintaining the cooperation of public health and private sector health professionals, organizations, and institutions.

(2) Objectives

- (a) Monitor for, then identify outbreaks and analyze trends through surveillance.
- (b) Prevent those who are ill from infecting others.
- (c) Prevent those infected or exposed from becoming ill.
- (d) Prevent those not infected from becoming infected.

(3) Interventions

- (a) Isolation or quarantine of cases through voluntary or compulsory measures.
- (b) Provision of information to the public on measures to reduce transmission.

- (c) Restriction or limitation of public events, including reduction of transmission among those seeking care at medical facilities.
- (d) Targeted use of antivirals when available.
- (4) Management
 - (a) The ECO, in coordination with the director of the DDC, shall:
 - (i) Oversee monitoring, isolation, and quarantine activities.
 - (ii) Maintain communications with the State Surgeon General, Deputies and CHDs.
- (5) Voice Data and External Communications

The director of the DDC, in accordance with the DOH Emergency Operations Plan, Crisis and Risk Communications Annex, will work with the Office of Communications to establish a TAG for assistance in formulating appropriate messages and dissemination of information within the department and external to the department, including at minimum, elected officials, healthcare professionals, the lay public, people with disabilities, and people whose first language is not English.
- (6) Coordinating Agencies
 - (a) BOL
 - (b) Office of Emergency Operations
 - (c) Office of Communications
 - (d) Public Health Nursing
 - (e) Family Health Services
 - (f) CHDs
- (7) Purpose
 - (a) The overall purpose of isolation and quarantine activities is to provide a method with which to limit the spread and reduce the mortality/morbidity in communities in the early stages of an influenza pandemic (Phases 3, 4, and 5, and the early part of Phase 6).
 - (b) Containing the virus is the ultimate goal.
 - (c) The use of voluntary and mandatory monitoring with isolation and quarantine can limit viral transmission and reduce the number of cases that occur before a vaccine becomes available.
 - (d) The most recent FDOH Isolation and Quarantine Annex is the overall guidance for the use of these strategies as mandatory interventions for the containment of diseases. This Annex outlines the procedures to be used during a pandemic to implement legally mandated isolation and quarantine.
- (8) Triggers for Action
 - (a) The triggers for implementation of the case-based monitoring, isolation and quarantine procedures described in this Plan are declarations by WHO and the CDC that the world, including the United States,

is in WHO Phases 3, 4, 5, or 6 of an influenza pandemic.

- (b) The transition from case-based (including isolation and quarantine) to community-based control measures will generally occur when the number of cases and contacts exceeds the capacity of the public health system to respond on a case-by-case basis.

(9) Uses of Monitoring, Isolation, and Quarantine Interventions during Case-Based and Community-Based Control Measure Implementation

(a) Isolation and Quarantine as Part of Case-based Control Measures

- (i) The interventions named 'isolation' and 'quarantine' as well as monitoring, will be implemented differently at different phases of the epidemic.
- (ii) Table 13 describes how case isolation and contact quarantine will be used during the early phases of a pandemic, including the beginning of Phase 6. These measures will be implemented under the leadership of CHDs with the cooperation and support of other components of their local EOC.
- (iii) The use of monitoring, isolation and quarantine differs depending on the phase of the epidemic, becoming more stringent as the risk of widespread transmission from each case goes up later in the course of the pandemic.
- (iv) Implementation of legally mandated isolation and quarantine orders will require close partnerships and cooperation with law enforcement at the local and state levels. Federal law enforcement resources, including the National Guard, may also be available in some situations.

Table 13: Case-Based Control: Uses of Monitoring, Isolation and Quarantine

	Phase 3	Phase 4/5	Phase 6
Management of case	Isolate in healthcare facility if in need of healthcare (Active Monitoring without Activity Restriction)	Formal isolation order for case in hospital if in need of healthcare (Active Monitoring with Activity Restriction)	Formal isolation order for case in hospital if in need of healthcare (Active Monitoring with Activity Restriction)
	Self-isolate at home	Order formal isolation for case at home	Order formal isolation for case at home
	CHD checks on case location and status daily	CHD checks on patient location and status daily	CHD checks on patient location and status twice daily
Management of contacts	Locate all contacts, on and off-site	Locate all contacts, on and off-site	Locate all contacts, on and off-site
	No activity restrictions for contacts (Passive Monitoring)	Immediate self-quarantine of all contacts to home (Active Monitoring without required Activity Restriction)	Formal quarantine order for all contacts, to stay home or in designated location (Active Monitoring with Activity Restriction)
	Instruct contacts to contact CHD immediately if symptoms develop	Instruct contacts to contact CHD immediately if symptoms develop	Instruct contacts to contact CHD immediately if symptoms develop
		CHD checks on location and status of all contacts daily	CHD checks on location and status of all contacts twice daily

(10) Isolation and Quarantine as Part of Community-Based Control Measures

As the pandemic continues and grows in Phase 6:

- (a) The number of importations of disease into Florida will get larger.
 - (b) There will be increased spread within the state from unrecognized cases, contacts who are not identified and located, etc.
 - (c) As case-based containment, led by CHD staff, is no longer effective or feasible, transition into a community-based control and mitigation approach will be made. In this approach, it is still critical for disease control that individual cases are isolated and their contacts (as far as possible) stay home. These measures will be exclusively voluntary and self-directed, and will be only one part of an overall strategy to reduce face-to-face interactions so that transmission of the virus can be reduced.
- m. Interstate and International Ports of Entry
- (1) Concept
Response activities at ports of entry (POE) will involve investigating reports of ill travelers with ILI to identify and evaluate individuals with a high likelihood of being infected with novel influenza virus.
 - (2) Objective
Delay the entry of novel influenza viruses into Florida.

(3) Interventions

(a) Prior to the occurrence of cases in the United States, international travelers infected with pandemic influenza may simultaneously arrive at multiple POE. However, some POE are more likely to be the site of importation and will require staff augmentation.

(b) Travel-related interventions can be classified as pre-departure measures, en route measures, and arrival measures.

(c) Pre-Departure Measures

Effective host country/host state health screening of individuals prior to departure may reduce the risk of travelers exposing fellow travelers, aircraft and vessel crews, and others to pandemic influenza. This activity would include:

- (i) Developing pre-departure measures and identifying the necessary staffing resources.
- (ii) Screening for signs of illness (e.g., temperature scanning) and for risk factors (e.g., contacts, travel history).
- (iii) Restricting movement of potentially exposed individuals for one incubation period prior to international travel.

(d) En Route Measures

Given the short incubation period of influenza and the length of some international flights, some travelers with influenza will develop their first symptoms during their journey. When combined with pre-departure exit screening, this strategy would detect those who developed signs of illness while en route. Procedures may include:

- (i) Training of flight and vessel crews to detect and manage ill travelers.
- (ii) Moving an ill person away from other travelers and, if possible, placing a surgical mask on the ill person.
- (iii) Emphasizing the importance of hygiene measures, such as hand hygiene.
- (iv) If a mask is not available, covering coughs and sneezes with a tissue or cloth, and proper disposal of these items.
- (v) Reporting illness or death of traveler(s) by the ship captain, aircraft commander, bus driver, or railroad conductor to the Quarantine Station, if international, or to state/local health authorities, if interstate.

(e) Arrival Measures

Arrival screening may serve as an important additional layer of containment if adequacy and effectiveness of previous containment measures cannot be assured, and may help identify individuals

who became ill during travel. Arrival screening can be imposed as a precautionary measure. Arrival measures include:

- (i) Isolating and performing diagnostic testing (especially with a rapid diagnostic test, when available) of travelers with ILI.
- (ii) Quarantining potentially exposed travelers until definitive testing is complete or antiviral prophylaxis is given.
- (iii) Educating travelers on pandemic influenza. Local authorities will report ill international travelers to the DDC which will, in turn, notify the CDC Quarantine Station. Pursuant to Title 21 CFR Part 240.25, reports of interstate travelers will go to "local health authorities," who in turn will transmit the report to the DDC. Arrival screening will place additional demands on the CDC Quarantine Station personnel, Customs and Border Protection officers, as well as FDOH employees statewide.

n. Strategic National Stockpile (SNS) and Other Federally Held Critical Medical Assets

(1) Concept

The decision to request federally held critical medical assets will be a collaborative effort among local, state, and federal officials in accordance with State Emergency Response Team procedures as well as the as the DOH Emergency Operations SNS Annex.

(2) Objectives

Sustainment of healthcare systems.

(3) Interventions

(a) Push Packages

Caches of medical assets including selected pharmaceuticals, medical supplies, and equipment that are available for immediate deployment (delivered within 12 hours of request) for response to an incident.

(b) Managed Inventory

Additional supplies from various sources that are available for deployment in support of a continued response (24 to 36 hours and beyond from request).

(c) Antivirals

State allocation of federal stockpile.

(d) Federal Medical Stations (FMS)

Equipment for the provision of non-acute care provided in 50 bed modules for use for:

- (i) Special Needs Shelters
- (ii) Alternate Medical Treatment Sites
- (iii) Quarantine sites

The FMS provides equipment, supplies, and pharmaceuticals, but does not provide personnel.

- (e) Other federal assistance will be requested in accordance with State Emergency Response Team (SERT) procedures.
- (4) Management
 - As per existing SNS and other state medical countermeasures deployment plans.
- (5) Voice Data and External Communications
 - The director of the DDC, in accordance with the DOH Emergency Operations Plan, Crisis and Risk Communications Annex, will work with the Office of Communications to establish a TAG for assistance in formulating appropriate messages and dissemination of information within the department and external to the department, in accordance with established SERT procedures, including at minimum, elected officials, healthcare professionals, the lay public, people with disabilities, and people whose first language is not English.
- (6) The FDOH SNS Annex is incorporated by reference into the current Pandemic Influenza with the following adjustments:
 - (a) While existing SNS logistical and operational systems will be used to receive, manage, and distribute antivirals, currently, antivirals are not considered part of the federal SNS.
 - (b) In anticipation of need, the federal government may deploy antivirals and other medical countermeasures to Florida without a request from the state.
 - (i) Anticipated need medications will be received, managed, and distributed by the BSPS.
 - (ii) Other non-pharmaceutical medical countermeasures will be received, managed, and distributed as directed by the Office of Emergency Operations or the ESF 8 Health and Medical Operations section.
- o. State Level SNS Annex Activation and Changes to the State SNS Annex Specific to Pandemic Influenza
 - (1) Incident treatment protocol decisions will be made by a member of the executive staff with prescriptive authority (M.D. or D.O.). This authority may be delegated to physicians with prescriptive authority in the DDC.
 - (a) The state ECO will appoint technical specialists to the ESF 8 Planning Section to assist with the allocation of material based on the degree of impact, resources available, and requests made.
 - (b) Potential Allocation Methodologies
 - (i) County population
 - (ii) Per staffed hospital bed
 - (iii) Hospital catchment area
 - (iv) Population density
 - (v) Region based on percent of state population total
 - (vi) Physician density

Table 14: Pharmaceutical Distribution Methodology

Target Population	Location	Mechanism
Most severely ill	Hospitals	RSS to hospitals
Ill presenting to the hospital seeking treatment	Clinics associated with hospitals	RSS to hospitals
Ill in the community attempting to access a healthcare provider	Other healthcare system treatment centers	Drug wholesalers
Ill in the community attempting to access a healthcare provider	Physicians	Drug wholesalers
Ill in the community attempting to access a healthcare provider	Clinics associated with CHD/CMS	BSPS

p. WHO Mid to Late Phase 6 Activities

(1) Antiviral and Vaccine Distribution

(a) Concept

The FDOH mobilizes its resources, including the BSPS, the Bureau of Immunization, and CHDs to distribute antivirals and vaccines to public health and private sector healthcare practitioners for efficient delivery to affected populations.

(b) Objective

Rapid deployment of available antivirals and vaccines.

(c) Activities will continue to include laboratory tests, surveillance, voluntary and compulsory isolation and the use of antivirals. Additional activities will include the restriction of public events, reduction of transmission among those seeking treatment at healthcare facilities and the communication of information to the public.

(d) Interventions

(i) The BSPS Central Pharmacy will order product from an approved manufacturer or distributor following that vendor's ordering protocols, or from a Receiving, Staging, and Storing (RSS) site following the protocols in the FDOH SNS Annex.

(ii) Vaccine shipments may be sent from a manufacturer, distributor, or the CDC to a single location or to multiple locations.

(iii) Any location receiving shipments of vaccine must be permitted or authorized to be in possession of legend/prescription-only drugs. These locations have been permitted by the Board of Pharmacy as a pharmacy, drug wholesaler, or drug distributor, or are the offices of licensed medical practitioners who are authorized to prescribe medications including legend drugs (M.D., D.O., A.R.N.P., P.A.).

- (iv) All orders for pharmaceuticals to support response to pandemic influenza at the local level must be submitted pursuant to the existing standard ordering procedures to initiate the request. Once ESF 8 approves that request, it will forward the order to the appropriate BSPS pharmacy logistics specialist, who will then facilitate the delivery of pharmaceuticals to the requesting sites.
- (v) Managers of each vaccine receiving point (e.g., BSPS Central Pharmacy, RSS, CHDs and Children's Medical Services [CMS]) will develop primary, secondary, and tertiary plans for vaccine distribution. These plans will also address storage, security, and transportation issues.
- (e) Storage
 - Facilities that will store pharmaceuticals (vaccine or antivirals) will environmentally maintain these items pursuant to the manufacturer's recommendations.
- (f) Security
 - Facilities that will store pharmaceuticals will be in a secure location with internal product access limited only to authorized personnel.
- (g) Transportation
 - BSPS will coordinate with ESF 8 logistics and the state SEOC/ESF 1 (Transportation), ESF 13 (Military Support) and ESF 16 (Law Enforcement) for transportation of pharmaceuticals to RSS/Logistical Staging Area (LSA) or alternative sites. If military support is necessary, ESF 8 and BSPS will coordinate with ESF 13 (National Guard). Pharmaceuticals will require temperature control while being transported.
- (h) Pharmaceutical Return and Recovery
 - (i) Each CHD/CMS will develop plans to retain pharmaceuticals at its locations, if necessary.
 - (ii) Each CHD/CMS will report to BSPS and the Bureau of Immunization any remaining unused pharmaceuticals when requested to do so.
 - (iii) When the products expire, each CHD/CMS will utilize the third party reverse distributor process for expired returns unless otherwise instructed by the FDOH.
- (i) Reporting of Adverse Events
 - The system currently in use for reporting adverse drug events to influenza vaccine is the Vaccine Adverse Events Reporting System (VAERS). For adverse reactions to antiviral medications, MedWatch is used. Any change in reporting procedures will be communicated during the pandemic.

- (j) Management
 - (i) The director of the DDC, in coordination with the ECO, shall oversee case and community containment activities, including the use of stockpiled pharmaceuticals and will maintain communications with the State Surgeon General, Deputies and CHD directors and administrators.
 - (ii) All ordering entities must report any pharmaceutical transfers (e.g., to another CHD/CMS), or receipts (e.g., from another CHD/CMS, from a manufacturer) to the BSPS Central Pharmacy.
- (k) Voice Data and External Communications

The director of the DDC, in accordance with the DOH Emergency Operations Plan, Crisis and Risk Communications Annex, will work with the Office of Communications to establish a TAG to develop appropriate messages and dissemination of information within the department and external to the department, including at minimum, elected officials, healthcare professionals, the lay public, people with disabilities, and people whose first language is not English.

B. Command and Coordination

- 1. Normal Business Operations
 - a. During normal day to day operations when the risk of human disease from a novel and potentially pandemic virus in Florida is low - WHO Levels 3 and 4, U.S. Government Stages 0-2, and Pre-pandemic Interval for investigation and recognition, command of the emerging event shall be maintained by the Division of Disease Control and coordinated and communicated as appropriate with the internal and external partner agencies.
- 2. State Emergency Operations Center Partial/Full Activation
 - a. Within the scope of the SERT activation for the pandemic, the State Surgeon General may serve in a Unified Command Role with the State Coordinating Officer to develop the strategic and operational direction for overall response and recovery actions conducted pursuant to the Florida Comprehensive Emergency Management Plan Annex F - the State of Florida Pandemic Influenza Plan.
 - b. When the risk of human disease from a potential pandemic virus in Florida has increased - WHO Level 5, US Government Stages 2 and 3, and Pandemic Interval - Initiation, the SERT will be activated to a Level 2: Partial Activation and the State ESF 8 activated. Through this activation level and any subsequent Level 1 activation, operational command and coordination responsibilities for the ESF 8 response shall be the responsibility of the State ESF 8 Emergency Coordinating Officer. This command and coordination function shall be executed through the ESF 8 Incident Command Structure (ICS) developed consistent with the scope, size and requirements of the event. The ECO shall

request technical specialists and ICS Functional staff, as needed, from ESF 8 agencies to serve within ESF 8 in response to the pandemic through recovery and planning for subsequent waves.

- c. During the active pandemic phase, in Florida, the SEOC will be fully activated and be responsible for the command, coordination, and support of multiple local responses and application of state assets to support the local response. State resources mobilized through these actions would then be available and placed under the command of the local Unified Command and/or MAC.
- d. Additionally, it is recognized that due to the statewide concurrent impact of the pandemic, state ESF 8 command and control may be expanded and executed on a broader scale, consistent with the roles and responsibilities as outlined in this annex.

C. Communication

1. Risk Communications

- a. The Office of Communications, with the technical assistance from disease control technical specialists working in the ICS structure, will establish and maintain public confidence through implementation of its Crisis and Risk Communications Annex.
- b. The Office of Communications will participate in the Joint Information Center (JIC) operation of the SEOC, and will coordinate its work and messages with all domestic levels of public information outlets.
- c. The director of the disease control branch or division of the ICS structure, will work with the Office of Communications to establish a TAG for assistance in formulating appropriate messages and dissemination of information within the department and external to the department, including at minimum, elected officials, healthcare professionals, the lay public, people with disabilities, and people whose first language is not English.

2. Intra-agency and Interagency Communications

- a. Human
See SERT Pandemic Influenza Annex
- b. Non-Human
 - (1) Concept
During the preparedness phase, the Division of Environmental Health will work with partners on avian and animal surveillance, disease control efforts, and serve as an FDOH liaison for zoonotic response and recovery activities.
 - (2) Objective
Prevent or minimize zoonotic avian influenza transmission to humans in Florida.
 - (3) Intervention
The ESF 8 incident command structure is responsible for:
 - (a) Human disease surveillance.
 - (b) Human disease control, including providing recommendations for vaccines and antivirals.

- (c) Recommendations on personal protective equipment (PPE).
- (d) Support activities related to the education of animal disease responders on appropriate PPE.
- (e) Facilitating animal responder access to vaccines, antivirals, and PPE.
- (f) Providing safe handling and disposal guidelines for infected birds.
- (g) Testing, treating, quarantine or isolation of human cases, identifying their contacts and monitoring, quarantine or isolation of those contacts.
- (h) Collection of dead wild birds for testing is the primary responsibility of the Fish and Wildlife Conservation Commission (FWC) in collaboration with the United States Department of Agriculture (USDA) Wildlife Services. CHDs may become involved in bird collection surge activities.
- (i) Coordination of human disease investigations associated with a commercial poultry outbreak of Avian Influenza (AI) with ESF 17 (Department of Agriculture and Consumer Services [DOACS]). When the outbreak response is managed by a Unified Command system, human case surveillance and reporting is coordinated by Epidemiology Strike Teams working in the Incident Command structure (see operational protocol).
- (j) Human cases with animal exposure should be interviewed using the animal contact case report form. The surveillance data should be entered into the Merlin Outbreak Module. Human cases and human and animal case contacts are managed per the case-based containment section of the FDOH pandemic influenza appendix.

D. Emergency Management Roles and Responsibilities

This section contains anticipated job actions to be performed in relation to a Pandemic Influenza response. Different or additional responsibilities might become necessary and will be determined as needed. (See also the DOH Emergency Operations Plan [EOP] which is incorporated by reference)

1. Preparedness

a. CDC Watch Phase WHO Phases 1 and 2

(1) Deputies, Division Directors, Bureau Chiefs, Office Directors

- (a) Review needed competencies to ensure that staff received sufficient training to meet mission requirements.
- (b) Conduct exercises to test plans and staff capabilities and knowledge.
- (c) Conduct COOP exercises to test plans and systems.

(2) Bureau of State Laboratories

The BOL receives samples for detection of respiratory viruses from multiple sources throughout the year. Specimens are evaluated by assays that are appropriate to the study type.

- (a) CHDs will recruit community-based physicians to participate in the CDC/WHO Influenza Sentinel Physician Network. Specimens from select patients with ILI are submitted to the BOL for virus detection and influenza strain typing. Results are reported to the CDC, the submitter, and the BOE. Selected samples are forwarded to the CDC for additional studies.
- (b) The BOL will work closely with CHD epidemiologists to detect and type respiratory viruses in reported outbreaks.
- (c) Suspect Cases of Avian or Other Novel Influenza Virus. If approved by the BOE, the BOL will conduct appropriate testing and will send samples to the CDC for additional or confirmatory testing on patients suspected of infection with a non-seasonal influenza virus.
- (d) The BOL regularly receives influenza isolates from commercial and hospital laboratories that do not have sub-typing capability, with a request for typing.
- (e) The BOE and CHDs will review laboratory surveillance data and will maintain contact with potential specimen providers.

b. CDC Watch Phase-Surveillance WHO Phase 3-4

- (1) CHDs will recruit additional sentinel providers to submit specimens for viral isolation and strain typing. The BOL will distribute guidelines electronically to hospitals, healthcare providers and clinical laboratories describing how to request testing for novel influenza virus online.
- (2) CHDs will request specimens from outbreaks of respiratory illness for submission to the BOL. Each CHD epidemiology unit will be provided with specimen collection kits (swabs, shipping boxes, directions) for rapid sampling from suspect cases of novel influenza.
- (3) The BOL will continue to perform influenza testing as for Phase 1 and 2, will increase intra-laboratory cross training of staff, and will have supplies and reagents for the potential increase in testing. The BOL will provide guidance on specimen collection and shipping to clinical laboratories, and consults with the BOE and CHDs.
- (4) The BOE will use the current clinical case definition and travel history to determine if testing for Influenza A H5 is appropriate. At this time, no testing is to be performed for Influenza A H5, unless authorized by the BOE.

(5) The BOE will ensure that the most current guidelines on specimen submission are posted on its website.

c. CDC Alert Phase

Takes place after the CDC contacts the State Surgeon General to communicate the possible need to implement specific portions of the FDOH and SERT Pandemic Influenza Plan, most likely during WHO Phase 5. Additionally, the DOH EOP, State Comprehensive Emergency Management Plan (CEMP) and Pandemic Influenza Appendix will be activated by the State Coordinating Officer. During this Alert Phase, the following people and units will take the following actions (Note: team members should not switch work schedules or leave work unless directed to do so by leadership):

(1) State Surgeon General

- (a) Inform the Office of the Governor, DEM, other department leadership, and CHD directors/administrators of the status of the incident and progression of pandemic influenza preparedness efforts as appropriate.
- (b) As per the State EOP, may convene all or a portion of a DOH Executive Management Team (EMT).
- (c) Activate the DOH COOP plan as needed.
- (d) Provide formal authority and responsibility for pandemic influenza operations to the EMT, and performance expectations of the Deputies and their subordinate divisions, bureaus, and offices in relation to the EMT.
- (e) Designate Executive Medical Advisor to provide technical consultation to state policy and decision makers.

(2) Chief of Staff

- (a) Direct the DDC to coordinate pandemic preparedness activities across the department, including intensified trainings and targeted exercises to test plans and skill sets. This action will include implementation of the department's Crisis and Risk Communication Annex for pandemic influenza.
- (b) Coordinate pandemic influenza preparedness activities for departmental executive leadership.
- (c) Review COOP plans prior to their implementation to ensure common understandings, levels of accountability, and seamless performance standards.

(3) Deputies

- (a) Supervise pandemic influenza preparedness activities within their areas of responsibilities. This will include coordination of efforts with and among CHDs.
- (b) Review COOP plans to meet the Chief of Staff's directions.

- (c) Update call lists if not already done.
 - (d) Advise staff of the situation.
 - (e) Begin to evaluate the work situation for the possibility of staff being reassigned from their jobs for a period of 7-10 days.
- (4) Office of the General Counsel
- (a) Collaborate with the DEM and the Governor's Office General Counsel on development of executive order language.
 - (b) Assign on-call staff to EMT.
 - (c) Develop public health model orders to support response to an influenza pandemic.
 - (d) Review legal authority and language related to local quarantine authority, and disseminate guidance to CHD leadership and attorneys as applicable, county government leadership (political and civil), and law enforcement. In this latter area, coordinate efforts with, and possibly through, the Office of the Governor and Attorney General.
- (5) Division of Disease Control
- (a) Provide overall guidance to the DDC's Central Office Bureaus as well as to CHDs.
 - (b) Coordinate with the BSPS, BOL, Division of Family Health Services, CMS, DEMO, CHDs, and other offices on activities involved in pandemic influenza response efforts to ensure development of logistical plans for receiving, storing, deploying, and retrieving pharmaceuticals, medical equipment, and supplies.
 - (c) Provide technical assistance to the Office of Communications.
 - (d) Provide technical assistance to and coordinate with Poison Control Centers.
 - (e) Implement pandemic influenza preparedness activities appropriate to the Alert Phase within the division's areas of responsibilities.
 - (f) Ensure a mechanism for daily reporting of cases to national authorities, including information on the possible source of infection.
 - (g) Serve as the ESF 8 liaisons for SERT in pandemic influenza preparedness activities.
 - (h) Monitor federal guidance and develop Florida-specific prioritization strategies for various levels of influenza vaccine and antiviral drug availability.
 - (i) Within seven days of an alert, ensure that staff have the competencies necessary to perform assigned roles and responsibilities during a pandemic response.
 - (j) Within 10 days of an Alert, prepare to implement (if directed to do so by command staff) appropriate COOP plans to ensure continuation of mission-essential or life-sustaining departmental services.

- (k) Within 10 days of an Alert, review and test, in conjunction with the BSPS and DEMO, the ordering, receiving, shipping, dispensing, storage, and retrieval procedures that the department will use for various levels of vaccine and antiviral drugs.
 - (l) Within 10 days of an Alert, review the procedures for reporting adverse events through the VAERS.
 - (m) Translate science-based concepts into recommendations for actions and interventions.
 - (i) Circulate recommendations to relevant work units for comment.
 - (ii) Provide the recommendations to the EMT.
 - (n) Provide technical assistance in public health and healthcare system interventions to internal and external response partners.
 - (o) Work closely with the Office of Communications in the development of accurate, appropriate risk communications messages to the target audience.
- (6) Bureau of Epidemiology
- (a) Investigate influenza outbreaks in conjunction with CHDs.
 - (b) Provide consultation to CHDs and healthcare providers, as needed, on suspect novel influenza cases, including those suspected to be due to animal to human transmitted influenza.
 - (c) Develop protocols for using surge capacity epidemiology staff for surveillance activities.
 - (d) Work with CHDs and BOL to coordinate influenza testing.
 - (e) Work with external partners (FWC, DOACS, and the USDA) to remain informed of coordination efforts related to non-human animal disease control.
 - (f) Disseminate the case definition established by the CDC and/or WHO.
 - (g) Establish a system for revising the pandemic case definition, given the availability of additional clinical information (WHO will recommend global case definitions according to different global phases).
 - (h) Distribute targeted educational materials to healthcare providers about novel and pandemic influenza.
 - (i) Continue to provide updated case definitions, protocols, or algorithms for case finding, inclusive of clinical data and travel or exposure history.
 - (j) Develop materials and help educate healthcare providers, veterinarians, and animal disease responders about pandemic influenza strains.
- (7) BOE, Communications
- (a) Identify and enumerate communication groups.
 - (b) Communicate regularly with key response partners.

- (c) Facilitate the implementation of a statewide syndromic surveillance system.
 - (d) Facilitate a coalition of surveillance system partners.
 - (e) Continue work with CHDs to recruit medical providers to participate in Florida Sentinel Influenza Provider Network (FSIPN).
 - (f) In conjunction with the BOL and partner agencies, provide guidance to hospital and clinical laboratories for testing people for influenza when a novel strain is suspected.
 - (g) Facilitate dissemination of pandemic influenza-related materials to CHDs, partner agencies, and the public.
 - (h) Ensure a mechanism for daily reporting of cases to national authorities, including information on the possible source of infection.
- (8) BOE, Surveillance Systems
- (a) Ensure that surveillance systems are in place to detect aberrations, which may indicate the presence of a novel influenza virus in humans.
 - (b) Within two days of an Alert, field test protocols for enhanced statewide pandemic human and non-human influenza surveillance and reporting.
 - (c) Monitor statewide syndromic surveillance data through either local or statewide syndromic surveillance systems.
 - (d) Maintain updated pandemic influenza screening protocol and screening criteria on the BOE website.
 - (e) Develop protocols for using surge capacity epidemiology staff for surveillance activities.
 - (f) Enhance surveillance to include the monitoring of the following groups:
 - (i) People involved in culling birds or animals infected with influenza (single cases and/or clusters).
 - (ii) Other people exposed to birds or animals infected with influenza; for example, farmers, and veterinarians (single cases or clusters).
 - (g) Monitor National Retail Data Monitor (NRDM) data to detect aberrations in sales of over-the-counter (OTC) pharmaceuticals statewide.
 - (h) Monitor BioSense surveillance data.
 - (i) Monitor mortality trends as reported by four Florida cities reporting data to the CDC's 122 Mortality Surveillance Cities (Jacksonville, Miami, St. Petersburg, and Tampa).
 - (j) Access local syndromic surveillance systems to monitor respiratory and ILI in various locations across the state.
 - (k) Maintain and monitor the Pneumonia and Influenza Mortality Surveillance System.

- (l) Maintain and enhance Merlin and the Merlin Outbreak Module to facilitate the reporting and management of cases and contacts during outbreaks.
- (m) Implement system enhancements developed for electronically reporting laboratory influenza surveillance data to CHDs via Merlin.
- (n) Work with BOL and the private sector to implement system enhancements for the receipt of influenza results from hospital laboratories.
- (o) Maintain the Florida Pneumonia and Influenza Reporting System (FPIRS).
- (p) Establish a system for monitoring antiviral use and adverse events that may be attributed to their use.
- (q) Work with Bureau of Immunization to establish a system for:
 - (i) Monitoring vaccine usage for routine and pandemic strain influenza vaccines, if these are available.
 - (ii) Monitoring adverse vaccine events attributed to the pandemic strain vaccine, if available.
 - (iii) Collecting data for later use in the calculation of vaccine effectiveness for the pandemic strain vaccine.
 - (iv) Monitoring pneumococcal vaccine use and adverse events associated with its use.
 - (v) Monitoring hospital admissions for suspected or confirmed cases of pandemic strain influenza.
- (9) BOE, Analysis and Decision Making
 - (a) Establish/refine a mechanism for data aggregation and interpretation for decision making.
 - (b) Determine and report weekly state-level influenza activity to the CDC and disseminate to CHDs.
 - (c) Establish criteria to indicate when to move from one level of surveillance to a higher or lower level, as well as indicators for movement from case-based control measures to community-based control measures.
 - (d) Consider how recovered cases can be identified by occupation (healthcare workers or workers in designated essential services) in order to facilitate the development of a cadre of skilled workers presumed to be immune.
 - (e) Analyze excess deaths attributable to pneumonia and influenza.
 - (f) Aggregate and interpret animal disease exposure case reports to determine the need for modified infection control guidelines.
- (10) Bureau of Laboratories
 - (a) In conjunction with the DDC and partner agencies, provide guidance to hospital and clinical laboratories

- for specimen collection, handling, and transport when a novel strain is suspected.
 - (b) Procure appropriate reagents from the CDC or other appropriate resources to detect and identify the novel virus strain.
 - (c) Partner with local private sector labs that do not have virus strain identification capacity to obtain and use rapid antigen testing kits.
 - (d) Implement pandemic influenza preparedness activities appropriate to Alert Phase within their areas of responsibilities.
 - (e) Within seven days of an Alert, ensure that staff have the competencies necessary to perform assigned roles and responsibilities during a pandemic response.
 - (f) Within 10 days of an Alert, review and test the Statewide Laboratory Surge Plan to ensure functionality in a pandemic influenza event.
 - (g) Within 10 days of an Alert, prepare to implement (if directed to do so by command staff) appropriate COOP plans to ensure continuation of mission-essential, life-saving, or life-sustaining departmental services.
- (11) Bureau of Statewide Pharmaceutical Services
- (a) Develop, document, and implement pandemic influenza preparedness activities within their areas of responsibilities.
 - (b) Within 10 days of an Alert, review and test plans and procedures in conjunction with the DDC and DEMO, for ordering, receiving, shipping and dispensing, in addition to the storing and retrieval procedures that the department will use for various levels of vaccine and antiviral drug availability.
 - (c) Within seven days of an Alert, review and refine contingency plans related to antibiotic and other pharmaceutical shortages.
 - (d) Within seven days of an Alert, ensure that staff have the competencies necessary to perform assigned roles and responsibilities during a pandemic response.
 - (e) Within 10 days of an Alert, prepare to implement (if directed to do so by EMT) appropriate COOP plans to ensure continuation of mission-essential, life-saving, or life-sustaining departmental services.
- (12) Division of Family Health Services
- (a) Review contingency plans for distribution of WIC, and other childhood nutritional items.
 - (b) Review educational materials to distribute to client families.

- (c) Review COOP plans and prepare to implement on order of the FDOH EMT.
- (13) Division of Emergency Medical Operations
 - (a) Review plans for logistical support of the DDC and BSPS.
 - (b) Review COOP plans and prepare to implement on order of the EMT.
 - (c) Review hospital, outpatient, and medical surge plans with the Agency for Health Care Administration (AHCA) and private sector healthcare providers.
 - (d) Review plans with Emergency Management Assistance Compact (EMAC) partners.
- (14) Children's Medical Services
 - (a) Appoint liaison to FDOH EMT.
 - (b) Review COOP plans and prepare to implement on order of the FDOH EMT.
 - (c) Provide educational materials to local CMS offices for distribution to client families.
 - (d) Review plans with appropriate CHD ICs.
- (15) County Health Departments
 - (a) In conjunction with local emergency management and community partners, review and test local plans to assess existing healthcare resources and coordinate responses with key stakeholders at the local level.
 - (b) Implement pandemic influenza preparedness activities appropriate to the Alert Phase within their areas of responsibilities.
 - (c) Investigate influenza outbreaks in the county in conjunction with BOE. In the case of a novel influenza strain, one case is considered an outbreak.
 - (d) Report individual human cases through established methods used for notifiable disease surveillance.
 - (e) Work with the county's healthcare community to heighten response activities and monitor the impact of the pandemic on healthcare facilities and systems and communicate regularly with key response partners.
 - (f) Identify and recruit private practice physicians and those who work in walk-in clinics in areas where hard to reach people reside, and remote areas within the county, to serve as sentinel physicians.
 - (g) Assist in identifying and recruiting medical providers willing to participate in FSIPN.
 - (h) If available at the CHD, monitor the local Syndromic Surveillance System daily for detection of respiratory infection or ILI data. If a syndromic surveillance system is in place, develop written response protocols for detected aberrations in syndromic surveillance data.

- (i) Register for access to NRDM, if not already done, to view county specific OTC medication data.
- (j) Consult with BOL on collection of specimens for influenza and suspected novel influenza testing.
- (k) Make contact with every laboratory in the county that tests for respiratory viruses to ensure that they contact the CHD immediately if they get a request for testing for the novel strain of influenza or receive a specimen for such testing. Facilitate the transfer of specimens to an appropriate BOL facility.
- (l) Develop partnerships with schools and large businesses to monitor ILI rates and school/work absenteeism.
- (m) Work with hospitals in the development of an operational plan that will interface with local and state public health emergency plans.
- (n) Identify points of contacts at airports, sea ports, bus and train stations, and other forms of mass transit for communication of information.
- (o) Establish and implement, as indicated, a public information call-in/rumor control telephone number and/or website.
- (p) Communicate with medical examiners (ME) to request reporting of reportable influenza deaths.
- (q) Ensure epidemiologic investigation of pediatric influenza deaths and influenza-associated encephalitis of county residents in conjunction with the BOE.
- (r) Report October through May County Influenza Activity Levels via EpiCom.
- (s) Help educate healthcare providers about novel and pandemic influenza.
- (t) Provide local audiences with targeted, up-to-date information on the occurrence of novel human influenza viral infections.
- (u) Educate the public on the symptoms of influenza, including what to do if they suspect cases, clusters, or outbreaks of infection.
- (v) Within seven days of an Alert, ensure that staff have the competencies necessary to perform assigned roles and responsibilities during a pandemic response.
- (w) Review COOP and other contingency plans for sustainment of essential community services and anticipated shortages of critical resources.
- (x) Within 10 days of an Alert, prepare to implement appropriate COOP plans to ensure continuation of mission-essential, life-saving, or life-sustaining departmental services.

- (16) Division of Environmental Health
 - (a) The Zoonotic and Vector-borne Disease Program will serve as a liaison between FDOH, DOACS, and FWC in the monitoring of avian influenza in birds.
 - (b) Develop and update guidelines in conjunction with state partner agencies that will ensure the safety of the food supply and mitigate the risk of exposure from wildlife.
 - (c) Implement pandemic influenza preparedness activities appropriate to the Alert Phase within their areas of responsibilities.
 - (d) Within seven days of an Alert, ensure that staff have the competencies necessary to perform assigned roles and responsibilities during a pandemic response.
 - (e) Ensure the continuation of mission-essential or life-sustaining departmental services.
- (17) All Other Divisions, Bureaus, Offices, and A.G. Holley Hospital
 - (a) Implement pandemic influenza preparedness activities as appropriate to the Alert Phase within their areas of responsibilities.
 - (b) Within seven days of an Alert, ensure that staff have the competencies necessary to perform assigned roles and responsibilities during a pandemic response.
 - (c) Within 10 days of an Alert, implement appropriate COOP plans (as directed by the department EMT) to ensure continuation of mission-essential, life-saving, or life-sustaining departmental services.

2. Response

- a. WHO Phase 5 or 6 (Pandemic Alert Period) CDC Response Phase
 - (1) State Surgeon General
 - (a) Regularly brief the Governor of the phase and status of the event.
 - (b) Regularly brief other elected officials of the status of the event.
 - (c) Direct the EMT and Chief of Staff regarding implementation of COOP plans.
 - (2) Office of Communications
 - (a) Continue to implement the Pandemic Influenza Appendix and Crisis and Risk Communications Annex.
 - (b) Participate in JIC operations.
 - (c) Designate PIO to support ESF 8 and ESF 14.
 - (d) Coordinate and develop effective and accurate public, healthcare provider, private sector, and political leadership messages.
 - (e) Provide periodic updates on the event status to FDOH divisions, bureaus, CHDs, CMS clinics, and A.G. Holley Hospital.

- (f) Assist CHD PIOs with their local risk communications efforts.
- (g) Monitor information flow, analyze message effectiveness, and initiate corrective measures to address rumors and misinformation.
- (3) Office of the General Counsel
 - (a) Implement Executive Order routing, if requested to do so by senior leadership.
 - (b) Assist local CHDs regarding isolation and quarantine orders, as requested.
 - (c) Maintain event specific legal documentation.
 - (d) Serve as liaison to the Attorney General and other state agency legal staff.
- (4) Division of Disease Control
 - (a) The Division of Disease Control will identify staff with appropriate skills and experience who can be activated to carry out necessary functions within the ICS structure.
- (5) Bureau of Epidemiology
 - (a) The Bureau of Epidemiology will identify staff with appropriate skills and experience who can be activated to carry out necessary functions within the ICS structure.
 - (b) The Bureau of Epidemiology will provide access to surveillance systems maintained by the bureau to support Pan Flu command structure needs.
- (6) Bureau of State Laboratories
 - (a) The Bureau of Laboratories will identify staff with appropriate skills and experience who can be activated to carry out necessary functions within the ICS structure.
 - (b) The Bureau of Laboratories will provide access to laboratory facilities, equipment, and supplies maintained by the bureau to support Pan Flu command structure needs.
- (7) County Health Departments
 - (a) Continue and intensify surveillance efforts undertaken in prior phase, to include:
 - (i) Soliciting first responders to assist with community surveillance.
 - (ii) Increasing surveillance of incoming travelers from infected regions at POE.
 - (b) Request epidemiologic surge capacity staff to support phones, data entry, and investigations.
 - (c) Increase review of syndromic surveillance data for respiratory disease surveillance to twice daily.
 - (d) Establish system to monitor workforce absenteeism among staff in essential service jobs.
 - (e) Enhance surveillance to include monitoring of the following groups:

- (i) Healthcare workers caring for patients with suspected or confirmed pandemic strain influenza infection (single cases and/or clusters).
 - (ii) Laboratory workers handling clinical specimens from patients with suspected or confirmed pandemic strain influenza infection (single cases and/or clusters).
 - (iii) School students.
 - (iv) Mortuary workers.
 - (f) Vital Statistics offices' reports of county deaths on a daily (instead of weekly) basis using the Florida Pneumonia and Influenza Mortality Reporting System (FPIMRS).
- b. WHO Phase 6 Pandemic Response
- (1) State Surgeon General
 - (a) In conjunction with the State Coordinating Officer (SCO), regularly brief the Governor of the phase and status of the event.
 - (b) Regularly brief other elected officials of the status of the event.
 - (c) Serve as a member of the state Unified Command staff, as directed by the Governor.
 - (d) Direct the EMT and Chief of Staff regarding implementation of COOP.
 - (2) Executive Management Team (EMT)
 - (a) Advise the Surgeon General and SCO on possible impacts of control measures on the operations of the rest of the agency.
 - (3) Chief of Staff
 - (a) Provide oversight of routine FDOH and COOP operations.
 - (b) Coordinate with Deputies and Division Directors the temporary re-assignment of staff to support necessary department functions.
 - (4) Deputies
 - (a) Supervise COOP activities within their jurisdictional areas.
 - (b) Coordinate the backfill and mutual support to other Deputies, divisions, bureaus, and offices, to ensure continuation of core FDOH operations.
 - (5) Office of Communications
 - (a) See above.
 - (6) Office of the General Counsel
 - (a) See above.
 - (7) Division of Disease Control

The Division of Disease Control will identify staff with appropriate skills and experience who can be activated to carry out necessary functions within the ICS structure.

 - (a) The Division of Disease Control will maintain other disease control activities consistent with the DOH COOP plan.

(8) Bureau of Epidemiology

The Bureau of Epidemiology will identify staff with appropriate skills and experience who can be activated to carry out necessary functions within the ICS structure. Such functions may include:

- (a) Monitor and trend impact, change in epidemiology, clinical presentation, and virologic features.
- (b) Conduct respiratory disease surveillance system monitoring twice daily.
- (c) Monitor vital statistics and MEs for mortality surveillance.
- (d) Consult with BOL to determine whether to limit or discontinue both routine and early warning surveillance testing.
- (e) Assess the effectiveness of interventions.
- (f) Implement system for monitoring antiviral use and adverse events that may be attributed to antiviral use, if applicable.
- (g) Work with Bureau of Immunizations to implement a system for:
 - (i) Monitoring vaccine usage for routine and pandemic strain influenza vaccines, if these are available.
 - (ii) Monitoring adverse vaccine events attributed to the pandemic strain vaccine, if available.
 - (iii) Collecting data for later use in the calculation of vaccine effectiveness for the pandemic strain vaccine.
 - (iv) Monitoring pneumococcal vaccine use and adverse events associated with its use, if this vaccine is available and being used.
- (h) The Bureau of Epidemiology will provide access to surveillance systems maintained by the bureau to support Pan Flu command structure needs.

(9) Bureau of Laboratory Services

The Bureau of Laboratories will identify staff with appropriate skills and experience who can be activated to carry out necessary functions within the ICS structure. Such functions may include:

- (a) Implement the Laboratory Surge Plan, as appropriate, to ensure specimen testing capacity and capability is not exceeded.
- (b) Work with the DDC in surveillance and reporting operations.
- (c) Implement COOP plans, as necessary.
- (d) Shift testing priorities as required by the event and specimen volume.
- (e) Continue to perform surveillance testing on a select number of specimens in collaboration with the BOE and CHDs.

- (f) Inform public and private labs and the healthcare community of policy shifts in specimen testing.
 - (g) Sentinel surveillance and outbreak investigation testing will continue following the first wave of the pandemic and any additional subsequent waves.
 - (h) Continue to test specimens for genetic shifts.
 - (i) The Bureau of Laboratories will provide access to laboratory facilities, equipment, and supplies maintained by the Bureau to support Pan Flu command structure needs.
- (10) Bureau of Statewide Pharmaceutical Services
The Bureau of Statewide Pharmacy Services will identify staff with appropriate skills and experience who can be activated to carry out necessary functions within the ICS structure, which may include:
- (a) Work on allocation and apportionment issues.
 - (b) Support SNS and Managed Inventory operations.
 - (c) Support ordering, receiving, shipping, dispensing, storage, and retrieval of vaccines and antivirals, based on state and federal guidelines.
 - (d) Monitor for antibiotic and other pharmaceutical shortages and implement contingency plan(s) for maintaining adequate supplies.
 - (e) Monitor utilization and implement re-supply plans for redistribution of vaccines and antivirals, as necessary.
 - (f) Provide a staff member who can serve as the ordering officer for requisitioning of antivirals under HHS managed antiviral contracts.
 - (g) Provide access to pharmaceuticals, facilities, equipment, and supplies maintained by the bureau to support Pan Flu command structure needs.
- (11) Division of Emergency Medical Operations
- (a) Upon mobilization of the SERT, the ECO will assume the role of lead for ESF 8.
 - (b) The ECO will direct and coordinate incident response activities per the instructions of the department's EMT.
 - (c) The ECO will serve as the entity authorizing official for requisitioning of antivirals under HHS managed antiviral contracts.
 - (d) Implement COOP plans, as needed.
- (12) County Health Departments
- (a) Continue to implement appropriate response activities as defined in local pandemic influenza plans and as directed by the FDOH EMT.
 - (b) Implement CHD COOP plans as directed.
 - (c) Conduct select individual case or outbreak investigations, as needed, to guide prevention and control recommendations.

- (d) Work with the BOE to assess the effectiveness of community-based disease control interventions, including:
 - (i) Antivirals.
 - (ii) Vaccine, when available.
 - (iii) Social distancing.
 - (e) School closures, as applicable.
 - (f) Collect aggregate data on the number of patients seen meeting case definition, as provided by the BOE, from healthcare providers.
 - (g) Work with community partners to support aggregate monitoring of morbidity and mortality.
 - (h) In conjunction with the BOE and DDC, provide regular updates to key response partners on local disease trends as they become available, including:
 - (i) Case incidence as well as morbidity and mortality.
 - (ii) Range of clinical presentations and other characteristics of the circulating strain(s).
 - (iii) Risk factors associated with increased morbidity and mortality.
 - (iv) Local populations that may be at increased risk.
 - (i) Levels of absenteeism in public services designated as essential.
- (13) All Other Divisions, Bureaus, Offices, and A.G. Holley Hospital
- (a) Implement pandemic influenza response activities within areas of responsibility.
 - (b) Implement appropriate COOP plans to assure continuation of mission-essential, life-saving, or life-sustaining departmental services.
 - (c) Assign staff to support state/county health and medical response as directed by the Chief of Staff.
3. Recovery/Mitigation Phase between Waves and End of Pandemic
- a. The FDOH response efforts will be scaled down in an appropriate and proportionate way based on the course of the pandemic and the reduction of illness within the state. Divisions and bureaus will gradually re-establish routine operations as per existing FDOH COOP plans.
 - b. Divisions and bureaus involved in response efforts will actively participate in the development and review of the After Action Report (AAR) and other mitigation efforts. FDOH recovery operations will be guided by the following principles:
 - (1) Identify those organizational functions that are key and essential to be performed throughout the pandemic period.
 - (2) Temporarily assign staff, particularly those who have recovered from the pandemic influenza virus, to fill essential positions.

- (3) Identification of FDOH employees for pandemic influenza vaccinations in priority sequence, based upon risk factors and criticality for mission accomplishment.
 - (4) Identification of those employees who are likely to be long-term absentees, such as those who must be caregivers for children who are not in school due to school closings.
 - (5) Develop or adapt COOP plans to accommodate absences to enable work to continue.
 - (6) Implement disaster behavioral health services, as necessary, being proactive in implementation.
 - (7) Phased return to normal staffing and normal conduct of business based on prevalence of the pandemic and availability of staff. In compliance with Department of Management Services (DMS) guidance, the department will give consideration to staff for return to their regular activities.
 - (8) Update job descriptions of deceased employees and others who do not return to work. Expedite the recruitment and hiring processes to fill these vacancies.
 - (9) Assist CHDs in their recovery, as necessary and within department resources.
- c. Position Specific Roles and Responsibilities
- (1) State Surgeon General
 - (a) Provide recommendation to the Governor when an Executive Order may be rescinded.
 - (b) Stand down the EMT and the EMT staff.
 - (2) Chief of Staff
 - (a) Direct normalization from COOP implementation activities.
 - (b) Direct the development of a consolidated and comprehensive AAR to be submitted to the State Surgeon General within 90 days of the declaration of the end of the Executive Order.
 - (3) Deputies
 - (a) Implement recovery activities within their areas of responsibility.
 - (b) Ensure that AARs are completed within areas of responsibility.
 - (4) Office of Communications
 - (a) Continue Crisis and Risk Communications Annex implementation for Recovery Phase.
 - (b) Compose and submit AAR to Chief of Staff.
 - (5) Division of Disease Control
 - (a) In conjunction with the BOL, continue surveillance program to detect antigenic drift variants or re-assortment viruses for detection of possible changes in the original pandemic strain.
 - (b) In conjunction with the BSPS, implement plan for the recovery of unused vaccine, antivirals, antibiotics,

- and other pharmaceuticals in collaboration with DEMO.
- (c) Compose and submit AAR to Chief of Staff.
- (6) Bureau of Statewide Pharmaceutical Services
 - (a) In conjunction with the Bureau of Immunization and in coordination with DEMO, implement a plan for the recovery of unused vaccine, antivirals, antibiotics and other pharmaceuticals.
 - (b) Compose and submit AAR to Chief of Staff.
- (7) Bureau of State Laboratories
 - (a) Continue to test specimens for genetic shift, drift, or recurrence of infection.
 - (b) Compose and submit AAR to Chief of Staff.
- (8) Division of Emergency Medical Operations
 - (a) Assist DDC and BSPS in the recovery of antivirals and vaccines.
 - (b) Compose and submit AAR to Chief of Staff.
- (9) County Health Departments/Children's Medical Services
 - (a) Return to pre-pandemic operations.
 - (b) Compose and submit AAR to Chief of Staff.
- (10) All Other Divisions/Bureaus/Offices/ and A.G. Holley Hospital
 - (a) Return to normal operations as appropriate.
 - (b) Compose and submit AAR to Chief of Staff.

IV. Continuity of Government (COG)

In compliance with the direction of the Governor, DOH Executive Leadership shall serve to ensure Continuity of Government. See FDOH Continuity of Government Plan.

V. Continuity of Operations Plan (COOP)

- A. Concept

The local CHD/CMS may implement COOP plans that prioritize the delivery of essential services, using a tiered approach.
- B. Objective

Maintain essential core public health services interventions.
- C. Tier I (First priority)
 - 1. Division of Disease Control
 - a. Immunizations
 - (1) Tetanus and Diphtheria [(Td) acute]
 - (2) Rabies Post Exposure Prophylaxis (PEP)
 - (3) Hepatitis A/B
 - (4) Pneumovax, childhood (outbreak only)
 - b. Tuberculosis (TB)
 - (1) Treatment
 - (2) Directly Observed Therapy (DOT) for cases only

- c. HIV-AIDS Drug Assistance Program (ADAP)
 - (1) Treatment
 - d. Sexually Transmitted Diseases
 - (1) Treatment only
 - e. Bureau of Epidemiology
 - (1) Urgent cases only
 - 2. Medical Services
 - a. Family Planning
 - (1) Provide appropriate Family Planning (FP) method only (most expeditious way)
 - b. WIC
 - (1) Certification and check issuance only
 - c. Adult health
 - (1) Acute care only
 - (2) Triage
 - d. Pediatrics
 - (1) Acute care only
 - e. Maternity
 - (1) Routine care
 - 3. Environmental Health
 - a. Rabies
 - (1) Bite investigations
 - b. Water
 - (1) Bacteriological testing
 - c. Child/Group care
 - (1) Inspections
 - d. Onsite Sewage Treatment and Disposal System (OSTDS)
 - (1) Repair inspections
 - (2) Permits
 - 4. Administrative
 - a. Vital Statistics
 - (1) Current birth records
 - (2) Current death records
 - b. Finance
 - (1) Medicaid billing
 - (2) Accounts receivable
 - (3) Accounts payable
 - (4) Purchasing Cards
 - (a) Purchases
 - (b) Current inventories
 - c. Information Technology
 - (1) Keep all networks and phone systems operational
 - d. Human Resource
 - (1) Payroll
 - (2) Critical vacancies
- D. Tier II (Second Priority)
 - 1. Division of Disease Control
 - a. Immunizations
 - (1) All childhood resumed

- b. Tuberculosis
 - (1) Rule out TB in contacts
 - c. HIV-AIDS Drug Assistance Program (ADAP)
 - (1) Take case reports for new cases
 - (2) High-risk counseling/testing
 - d. Sexually Transmitted Diseases
 - (1) Follow-up pregnant females
 - e. Bureau of Epidemiology
 - (1) Investigate for reportable diseases
 - 2. Medical Services
 - a. Healthy Start
 - (1) Highest risk screenings
 - b. School Health
 - (1) Dependant on whether school open
 - c. WIC
 - (1) Certifications, age 1-5
 - 3. Environmental Health
 - a. Complaint Response
 - (1) Programs with enforcement actions
 - b. Onsite Sewage Treatment and Disposal System (OSTDS)
 - (1) New inspections
 - c. Inspections
 - (1) Begin prioritization
 - 4. Administrative
 - a. Vital Statistics
 - (1) Work with funeral directors for records
 - b. Purchasing
 - (1) Supplies inventory
 - c. Information Technology
 - (1) Hardware procurement and replacement
- E. Staff will wear appropriate PPE when in direct contact with clients.
- F. DOH operations will be coordinated by the Executive Management Team as outlined in the DOH, Emergency Operations Plan, and COOP Plan. CHD directors/administrators shall oversee COOP plans within their areas of responsibility, maintaining communication with the State Surgeon General and Deputies.

VI. Authorities and References

- A. Authorities
 - 1. Section 120.54, *Florida Statutes (F.S.)*
 - a. State Agencies
 - (1) Allows state agencies to adopt temporary emergency rules when there is immediate danger to public health, safety, or welfare, without going through the normal rule-making process.

2. Section 381.003, *F.S.*
 - a. Governor/Division of Emergency Management:
 - (1) Allows Governor to declare a state of emergency.
 - (2) Gives Governor direction and control of emergency management.
 - (3) Allows Governor and division to delegate authority to carry out critical functions to protect the peace, health, safety, and property of the people of Florida.
3. Section 381.0011, *F.S.*
 - a. FDOH
 - (1) Authorizes the department to administer and enforce laws and rules relating to the control of communicable disease.
 - (2) Authorizes the department to declare, enforce, modify, and abolish quarantine of people, animals, and premises.
 - (3) Authorizes the department to specify the conditions and procedures for imposing and releasing a quarantine order.
4. Section 381.0012, *F.S.*
 - a. FDOH
 - (1) Authorizes the department to maintain the necessary legal action; request warrants for law enforcement assistance; and directs state and county attorney, law enforcement, and city and county officials, upon request, to assist the department to enforce the state health laws and rules adopted under Chapter 381, *F.S.*
5. Section 381.00315, *F.S.*
 - a. FDOH
 - (1) Authorizes the State Surgeon General to declare public health emergencies and issue public health advisories.
6. Section 768.28, *F.S.*
 - a. State Agencies
 - (1) Protects state employees who administer immunizations as part of their official duties.

VII. Plan Review and Maintenance

- A. Director of the Division of Disease Control, will:
 1. Take the lead in revising the pandemic influenza plan.
 2. Complete the pandemic influenza plan review, and update annually, or more frequently as needed.
- B. Other Divisions, Bureaus, and Offices
 1. Assist the DDC as tasked by the Director of the DDC.

C. Record of Updates

Update	Status
V.11.2	Approved 03/2009
V10.4 Authorized by Secretary	Completed 09/2006
V10.0 Draft	Completed 09/2006
Develop Technical Appendices	Completed 03/2006
V9.1	Completed 02/2006
Develop Flu Aid Tables for Vulnerability Analysis	Completed 13/2005
Cross Reference Nov. 2005 HHS Plan	Completed 11/2005
Develop Preparedness, Response and Recovery Matrices	Completed 11/2005
Incorporate "White Paper" Planning Recommendations	Completed 09/2005
Incorporate CHD Advisory	Completed 03/2005
Compare WHO Phases to Phase of Emergency Management	Completed 11/2005
Convert to Standard Format	Completed 06/2005
Update Pandemic Influenza Plan V8.0	Completed 03/2004

VIII. Addenda

A. Acronyms and Abbreviations

AAR	After Action Report
AHCA	Agency for Health Care Administration
AI	Avian Influenza
ARNP	Advanced Registered Nurse Practitioner
BOE	Bureau of Epidemiology
BOL	Bureau of Laboratories
BSPS	Bureau of Statewide Pharmaceutical Services
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHARTS	Community Health Assessment Resource Tool Set
CHD	County Health Department
CMS	Children's Medical Services
COOP	Continuity of Operations
COG	Continuity of Government
DDC	Division of Disease Control
DEM	Division of Emergency Management
DEMO	Division of Emergency Medical Operations
D.O.	Doctor of Osteopathic Medicine
DOACS	Department of Agriculture and Consumer Services
DOT	Directly Observed Therapy
DSNS	Division – Strategic National Stockpile (CDC)
ECO	Emergency Coordinating Officer
ED	Emergency Department
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EMT	Executive Management Team
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESF	Emergency Support Function

ESF-8	Emergency Support Function 8: Health and Medical Services
ESF-14	Emergency Support Function 14: Public Information
FDA	Food and Drug Administration
FDOH	Florida Department of Health
FLNG	Florida National Guard
FMS	Federal Medical Station
FPIRS	Florida Pneumonia and Influenza Reporting System
F.S.	Florida Statute
FSIPN	Florida Sentinel Influenza Provider Network
FWC	Florida Fish and Wildlife Conservation Commission
H5N1	Hemagglutinin subtype 5 Neuraminidase subtype 1 (influenza virus)
HAN	Health Alert Network
HCW	Healthcare Worker
HHS	Health and Human Services
HIV – ADAP	Human Immunodeficiency Virus – AIDS Drug Assistance Program
HMO	Health Maintenance Organization
HPAI	Highly Pathogenic Avian Influenza
IC	Incident Commander
ICU	Intensive Care Unit
ILI	Influenza Like Illness
IT	Information Technology
JIC	Joint Information Center
JIS	Joint Information System
LSA	Logistical Staging Area
M.D.	Medical Doctor
ME	Medical Examiner
NRDM	National Retail Data Monitor
OSTDS	Onsite Sewage Treatment and Disposal Systems
OTC	Over The Counter
P.A.	Physician Assistant
PEP	Post-Exposure Prophylaxis
PI	Pandemic Influenza
PIO	Public Information Officer
POE	Points Of Entry
PPE	Personal Protective Equipment
PSI	Pandemic Severity Index
R/O	Rule Out
RRC	Rapid Response and Containment
RSS	Receiving, Staging, and Storing Site
SEOC	State Emergency Operations Center
SERT	State Emergency Response Team
SNS	Strategic National Stockpile
STD	Sexually Transmitted Disease
TAG	Technical Advisory Group
TB	Tuberculosis
TBD	To Be Developed/Determined
Td	Tetanus and Diphtheria
U.S.	United States
USG	United States Government

USDA	United States Department of Agriculture
VAERS	Vaccine Adverse Event Reporting System
VS	Vital Statistics
WHO	World Health Organization
WIC	Women, Infants, and Children

B. Glossary of Terms

Activation Levels: These levels reflect the operational stage of the State Emergency Operations Center in reaction to an actual or anticipated event.

Alert Phase: Takes place after the CDC contacts the State Surgeon General to communicate the possible need to implement specific portions of the Florida Department of Health and SERT Pandemic Influenza Plan.

Antiviral Medication: Medications for use in treating viral infections, in this case influenza. Influenza antivirals include Zanamivir and Oseltamivir.

Asymptomatic: The period when an infected patient will not experience any symptoms.

Avian Influenza: Influenza-type virus found in both wild and domestic birds.

Case-Based Containment: Restrictions applied to individuals to reduce disease spread.

Community-Based Containment: Restrictions placed on communities to reduce disease spread.

Contact (of a case): A person or animal that has been in such association with an infected person or animal or contaminated environment as to have the opportunity to acquire the infection.

Continuity of Operations Plan (COOP): A plan to ensure that critical operations continue in the case of catastrophic events.

Contaminated: The presence, or the reasonably anticipated presence, of blood or other potentially infectious materials on an item or surface.

Cough Etiquette: Infection control procedures that emphasize covering coughs in tissues or sleeves, and frequent cleaning of hands.

Critical Infrastructure: Systems and assets, whether physical or virtual, so vital to the United States that the incapacity or destruction of such system and assets would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those systems.

Decontamination: The use of physical or chemical means to remove, inactivate, or destroy pathogens on surfaces or items to the point where the pathogens are no longer capable of transmitting infectious particles, and the surface or item is rendered safe for handling, use, or disposal.

Epidemiology: The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control health problems.

Essential Function: Functions that are absolutely necessary to keep an agency or business operating during an influenza pandemic, and critical to survival and recovery.

First Wave: The initial outbreak of influenza in the population. This could last four to eight weeks, and be followed by two to three subsequent waves.

Florida Emergency Mortuary Operations Response System (FEMORS): An organization that responds to and advises on mass fatality incidents using trained personnel from multiple state and local agencies. Online at: <http://www.femors.org>.

Hand Washing Facilities: A facility providing an adequate supply of running potable water, soap, and single use towels or hot air drying.

Health Alert Network (HAN): A nationwide system that communicates vital health information and the infrastructure that supports the dissemination of health information at the state and local levels, online: <http://www2a.cdc.gov/HAN/Index.asp>.

Infection Control: Measures taken to prevent further infections and the spread of disease. These precautions include separate waiting facilities, pre-arranged triage mechanisms, spatial separation, use of personal protective equipment, and encouragement of respiratory hygiene.

Interpandemic Phase: The period when no new virus subtypes are detected in humans; surveillance is used to assess seasonal burden of influenza.

Isolation: Measures taken to segregate ill and infectious people to prevent disease transmission to others.

Joint Information Center (JIC): A place where public information officers of agencies affected by an event work together to provide coordinated/consolidated public information as quickly as possible to promote effective and timely review and release of information to the public.

Joint Information System (JIS): A system in which multiple agencies coordinate their message/response to an event without being physically located at a specific site.

Medical Surge: Increased need for medical personnel in a catastrophic health event or pandemic.

Mode: A given condition of functioning, a status.

Morbidity: The measure or rate of disease occurrence.

Mortality: The measure or rate of death.

Novel Influenza Virus: A new strain of influenza with limited to no immunity, and has the potential to create a pandemic.

Occupational Health: Branch of medicine concerned with protecting the safety, health, and welfare of people engaged in work or employment.

Pandemic Influenza (PI): Spread of influenza over a wide geographic area affecting much of the human population.

Personal Protective Equipment (PPE): Specialized clothing or equipment worn by an employee for protection against a hazard. These items may include: disposable gloves, protective clothing, rubber or polyurethane boots, safety goggles, and particulate respirators.

Phases: Progressive stages of disease progression of a pandemic influenza.

Prophylaxis: Measures taken to prevent disease. Primary prophylaxis prevents the development of disease, while secondary prophylaxis refers to when the disease has already developed, but measures are taken to protect against the worsening of the patient's condition.

Quarantine: Segregation of people who are currently well, but who have been exposed to an infectious disease agent.

Rapid Response and Containment: Immediate measures (e.g., isolation and quarantine, treatment, and prophylaxis) that are taken to control and contain disease spread.

Recovery Phase: Takes place when the response efforts are scaled down in an appropriate and proportionate way based on the course of the pandemic and the reduction of illness within the state. Divisions, bureaus, and units will gradually re-establish routine operations as per existing FDOH COOP plans. Divisions, bureaus and units involved in response efforts will actively participate in the development and review of the After Action Report.

Respiratory Protection: Procedures and equipment that are used to protect personnel from breathing in infectious particles (e.g., wearing respirators).

Response Phase: Takes place at the point where preparedness evolves to response. Indicates that staff are needed to support incident activities. Team members will report fully prepared to focus only on incident activities.

Second Wave: A subsequent outbreak of influenza that occurs after the first wave has diminished. May last four to eight weeks, and potentially followed by a third wave.

Pandemic Severity Index (PSI): A proposed classification scale for reporting the severity of influenza pandemics in the United States. The PSI accompanied by a set of guidelines intended to help communicate appropriate actions for communities to follow in potential pandemic situations. Released by the U.S. Department of Health and Human Services (HHS) on February 1, 2007, the PSI is designed to resemble the Saffir-Simpson Hurricane Scale classification scheme.

Sheltering in Place: Procedures that involve individuals isolating themselves within their homes.

Social Distancing: Steps taken to reduce face-to-face interactions throughout the community.

Strategic National Stockpile (SNS): Large quantities of medicines and medical supplies retained at the federal level for shipment to the local level in response to a public health emergency.

Surveillance: Measures and procedures used to monitor and assess the progression of disease occurrence.

Surge: Describes the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community.

Symptomatic: The stage of infection when a patient shows symptoms.

Tamiflu (Oseltamivir): Antiviral drug that is used for treatment and prophylaxis of both Influenza type A and type B.

Threshold Determinant: A change of significant intensity to evoke a response.

Transmission-Based Precautions: Infection control procedures that are instituted in a hospital setting to prevent the spread of disease based on how the disease is transmitted.

Trigger: Initiate or start.

Vaccines: Preparations of killed or modified microorganisms that can stimulate an immune response in the body to prevent future infection of a similar type.

Vector: An insect or any living carrier that transports an infectious agent from an infected individual, or its wastes, to a susceptible individual, or its food or immediate surroundings.

Viral Shedding: The release of virus from a host.

Virulence: The inherent ability of an infectious agent to cause illness or disease.

Watch Mode: Takes place when there is growing evidence of a threat. The State Surgeon General will assemble Deputies, Division Directors, Bureau Chiefs, and office leaders to provide notification of a developing situation.

Wave: Periods during which community outbreaks occur across a country, each lasting two to three months.

Zoonotic: Diseases which are communicable from animals to humans.

C. Table(s) of Organization (To Be Developed)

D. Responsibility Matrix (see Table 15)

Table 15: Pandemic Influenza Roles and Responsibilities by FDOH Organizational Unit and Emergency Management Phase

Trigger Events	SEOC Activation Level 3, ESF 8	Executive Office (1)	All Divisions/ Bureaus/ CHD/CMS/ A.G. Holley	Division of Emergency Operations (DEMO) (2)	Division of Disease Control (DDC)	Division of Environmental Health	Bureau of Laboratories (BOL)	Bureau of Statewide Pharmaceutical Services (BSPS)	County Health Departments (CHDs)
<p>1. Preparedness activities</p> <p>Emergency Management Preparedness Phase</p> <p>WHO Inter-Pandemic Phases 1 and 2, and Pandemic Alert Phases 3 and 4</p>	<p>Level 3: Monitoring</p>	<p>Inform Governor, FDEM, and other leaders of preparedness status.</p> <p>Disseminate expectation of department's role in preparedness.</p> <p>Direct development of plans including continuity of operations of mission critical and life-sustaining services.</p>	<p>Implement activities as per plan.</p> <p>Ensure staff is trained to perform assigned response roles.</p> <p>Develop and maintain COOP plans.</p>	<p>Develop and maintain FDOH EOP Pandemic Influenza Appendix.</p> <p>Develop and maintain logistical plans for pharmaceuticals and medical supplies and equipment.</p> <p>Responsible for coordination of ESF 8 resources.</p>	<p>Ensure surveillance systems and procedures are in place to detect aberrations in need of interventions.</p> <p>Provide guidance to partners on testing persons for influenza.</p> <p>Disseminate case definition.</p>	<p>Serve as liaison to Department of Agriculture and Consumer Services & Florida Fish and Wildlife Commission.</p> <p>Develop and maintain guidelines to ensure safety of food supply.</p>	<p>Review and test Laboratory Surge Capacity Plan.</p> <p>Provide guidance to partners for specimen collection, handling, and transport.</p> <p>Procure reagents from CDC.</p>	<p>Review and test plans for vaccine and antiviral drug management.</p> <p>Develop contingency plans for pharmaceutical shortages.</p>	<p>Develop and test community-based response plan.</p> <p>Assess healthcare resources and develop contingency plans.</p>

Table 15: Pandemic Influenza Roles and Responsibilities by FDOH Organizational Unit and Emergency Management Phase

Trigger Events	SEOC Activation Level 3, ESF 8	Executive Office (1)	All Divisions/ Bureaus/ CHD/CMS/ A.G. Holley	Division of Emergency Operations (DEMO) (2)	Division of Disease Control (DDC)	Division of Environmental Health	Bureau of Laborator- ies (BOL)	Bureau of Statewide Pharmaceutical Services (BSPS)	County Health Departments (CHDs)
<p>1. Preparedness activities (continued)</p> <p>Emergency Management Preparedness Phase: Preparedness</p> <p>WHO Inter-Pandemic Phases 1 and 2, and Pandemic Alert Phases 3 and 4</p>		<p>Establish workgroup to coordinate preparedness activities.</p> <p>Review and revise Crisis Risk Comm. Annex.</p> <p>Participate in development of Executive Order language.</p> <p>Coordinate interstate comm. activities.</p>			<p>Monitor federal guidance on priority groups for antiviral and vaccine distribution.</p> <p>Review and test plans for vaccine and antiviral drug management.</p> <p>Review procedures for reporting adverse events.</p>		<p>Partner with private labs to obtain and use rapid antigen testing kits.</p>		

Table 15: Pandemic Influenza Roles and Responsibilities by FDOH Organizational Unit and Emergency Management Phase

Trigger Events	SEOC Activation Levels 1-2 ESF 8	Executive Office (1)	All Divisions/ Bureaus/ CHD/CMS/ A.G. Holley	Division of Emergency Operations (DEMO) (2)	Division of Disease Control (DDC)	Division of Environmental Health	Bureau of Laboratories (BOL)	Bureau of Statewide Pharmaceutical Services (BSPS)	County Health Departments (CHDs)
<p>2. Response activities</p> <p>Emergency Management Response Phase: Response</p> <p>WHO Pandemic Alert Phases 3 and 4 and Pandemic Phases 5 and 6</p>	<p>Level 2: Partial Activation or Level 1, Full Activation.</p>	<p>Inform Governor of phase and status of event.</p> <p>Serve in Unified Command as designated by Governor.</p> <p>Direct FDOH Pandemic Influenza response.</p> <p>Serve at JIC.</p> <p>Coordinate and review public health messages.</p>	<p>Implement response activities.</p> <p>Implement COOP plans.</p> <p>Assign staff to support state health and medical response through ESF 8.</p>	<p>Serve as lead for ESF 8 on SERT.</p> <p>Implement COOP plans for ESF 8.</p>	<p>Inform and provide information to executive staff when surveillance system has detected aberration.</p> <p>Direct surveillance activities.</p> <p>Distribute case definition to partners.</p> <p>Implement disease control interventions.</p>	<p>Serve as liaison to Department of Agriculture and Consumer Services and Florida Fish and Wildlife Commission.</p>	<p>Implement Laboratory Surge Capacity Plan.</p>	<p>Support distribution and re-supply of antivirals and vaccines through ESF 8.</p> <p>Monitor pharmaceutical shortages and implement contingency plans.</p>	<p>Implement local response plans.</p> <p>Assign staff to participate with health and medical system response.</p>

Table 15: Pandemic Influenza Roles and Responsibilities by FDOH Organizational Unit and Emergency Management Phase

Trigger Events	SEOC Activation Level 3, ESF 8	Executive Office (1)	All Divisions/ Bureaus/ CHD/CMS/ A.G. Holley	Division of Emergency Operations (DEMO) (2)	Division of Disease Control (DDC)	Division of Environmental Health	Bureau of Laborator- ies (BOL)	Bureau of Statewide Pharmaceutical Services (BSPS)	County Health Departments (CHDs)
<p>2. Response activities (continued)</p> <p>Emergency Management Response Phase: Response</p> <p>WHO Pandemic Alert Phases 3 and 4 and Pandemic Phases 5 and 6</p>		<p>Monitor information flow and initiate rumor control measures.</p> <p>Develop or refine Declaration of Public Health Emergency Order.</p> <p>Assist CHDs with isolation and quarantine orders.</p>			<p>Monitor vaccine coverage.</p> <p>Distribute vaccines to high-priority groups.</p> <p>Implement adverse events reporting.</p>				

Table 15: Pandemic Influenza Roles and Responsibilities by FDOH Organizational Unit and Emergency Management Phase

Trigger Events	SEOC Activation Levels 2-3 ESF 8	Executive Office (1)	All Divisions/ Bureaus/ CHD/CMS/ A.G. Holley	Division of Emergency Operations (DEMO) (2)	Division of Disease Control (DDC)	Division of Environmental Health	Bureau of Laboratories (BOL)	Bureau of Statewide Pharmaceutical Services (BSPS)	County Health Departments (CHDs)
Recovery Activities WHO Pandemic Phase 6	Level 2: partial Activation or Level 3: Monitoring	Inform Governor when Executive Order is no longer needed. Implement recovery activities within FDOH. Coordinate AAR completion within 90 days.	Assess staff availability and ability to resume normal operations. Implement plans to return to normal operations. Develop AAR as directed.		Implement plan for recovery of unused vaccine.	Maintain liaison with Department of Agriculture and Consumer Services and Florida Fish and Wildlife Commission.	Maintain testing to detect antigenic drift, shift, or virus changes.	Implement plan for recovery of unused vaccines, antivirals, and other pharmaceutical products.	
Mitigation Activities WHO phases 1 or 2	Level 3: Monitoring	Establish workgroup to implement mitigation actions.	Participate in Pandemic Influenza Appendix revision. Implement mitigation activities.	Coordinate revision of Pandemic Influenza Appendix.					

E. Notification/Call-Down Lists (required) maintained within each Division, Bureau or Office

- F. Standard Operating Guidelines
See Pandemic Influenza Operations Manual

- G. Others, as needed (e.g., checklists, forms, flowcharts, database locations and layouts, maps)

H. Pandemic Influenza Antivirals and Vaccines

1. Antiviral Planning Assumptions

- a. The primary source of antiviral drugs for a pandemic response will be the federal supply of antiviral drugs that have been stockpiled as part of the CDC's SNS.
- b. The CDC will identify priority groups for antivirals based on multiple factors, including the amount of drug that is stockpiled (See Table 16, Antiviral Priority Groups).
- c. Current indications are that treatment with a neuraminidase inhibitor (Oseltamivir [Tamiflu®] or Zanamivir [Relenza®]) will decrease the duration of illness, the risk of pneumonia, and hospitalization rates by approximately 50%-70% and mortality by approximately 50%.
- d. Generally, antiviral treatment should begin within the first 48 hours after the onset of symptoms in order to be effective.
- e. Antiviral resistance to the adamantanes (amantadine and rimantadine) may limit use during a pandemic.
- f. Florida has a small, state-held stockpile, tentatively earmarked for use as outlined in the Case-Based Containment Strategy and the Zoonotic Avian Influenza Surveillance and Response Protocol.
- g. The CDC Division of the Strategic National Stockpile Program (DSNS) pandemic influenza response will begin as the pandemic enters WHO Pandemic Phase 4, starting with a "push" of antivirals to the states. This push may comprise a portion or the total of Florida's allocation, 2.5 million courses of antivirals. Approximately 80% of this allocation is oseltamivir [Tamiflu®] (oral), 20% is zanamivir [Relenza®] (inhaled).
- h. As of October 2007, no pediatric formulations of antivirals are available in the SNS.
- i. Current stockpiling only allows the state of Florida to treat the first five or six priority groups as outlined in the HHS Pandemic Influenza Plan (See Table 16, Florida Antiviral Priority Groups). This number is insufficient to treat all who are anticipated to fall ill and prophylaxis is not likely to be continued after shifting response from a Case-Based Containment Strategy to a Community-Based Containment Strategy.
- j. Antiviral distribution will likely be to hospitals and treatment centers for dispensing to inpatients or treatment of the ill. Antiviral inventories must be closely controlled. Dispensing must adhere to the priority group guidance that the department receives (See Table 17, Pro Rata Distribution of Antivirals by County).

2. Vaccine Planning Assumptions

- a. Vaccine production will require four to six months from the time the pandemic vaccine strain is selected.

- b. Only vaccines manufactured in the U.S. will be available for purchase during a pandemic.
- c. The CDC will establish priority groups for initial and sequential distribution. Priority groups are divided into occupationally-defined groups and risk-based groups. (See Table 18, Prioritization of Pandemic Influenza Vaccine)
- d. Priority groups for pre-pandemic and pandemic vaccination are currently under review. Priority group recommendations are subject to change based on epidemiological information once a pandemic begins.
- e. Availability of FDA approved pandemic vaccine will be a function of both manufacturing capacity and use of adjuvants. The amount of vaccine produced monthly will cover 1.5% of the population with two doses (See Table 23, Anticipated County Allocation for Pandemic Influenza Vaccine)
- f. Medical material to support the administration of vaccine will be the responsibility of the administering entity.
- g. A pandemic vaccination program will take place over several months and require vaccinating large numbers of people. Pandemic vaccine distribution and administration programs will follow existing protocols in a multi-phase operation:
 - (i) Phase 1: Vaccination with stockpiled pre-pandemic vaccine, conducted by public health.
 - (ii) Phase 2: Vaccination with pandemic vaccine, conducted by public health (or designees).
 - (iii) Phase 3: Vaccination with pandemic vaccine, conducted by the private sector.
- h. Maintaining sufficient staffing for the vaccination effort will be a key challenge given the anticipated duration of the pandemic vaccination program. Delegation of vaccine to other institutions or agencies when appropriate (and as directed by BSPS) will help ensure that public health personnel are available for other activities.

Table 16: Florida Antiviral Priority Groups

Priority Group	Estimated Population*	Strategy **	Number of Antiviral Courses			
			For Target Group	Rationale	Cumulative	
1	Hospitalized	658,897	T	494,173	Consistent with medical practice and ethics to treat those with serious illness and who are most likely to die.	494,173
2	Emergency Medical Service (EMS) providers and other direct care HCW	757,217	T	198,770	Healthcare workers are required for quality medical care. There is little surge capacity among healthcare sector personnel to meet increased demand.	692,943
3	High-risk outpatient	156,488	T	41,078	Groups at greatest risk of hospitalization and death; immunocompromised people cannot be protected by vaccination.	734,021
4	Critical-event personnel	206,935	T	54,320	Groups are critical for an effective public health response to a pandemic.	788,341
5	Increased-risk outpatient	5,329,134	T	1,398,898	Groups are at high risk for hospitalization and death.	2,187,239
6	Outbreak response in nursing homes and other residential settings	N/A	PEP	55,000	Treatment of patients and prophylaxis of contacts is effective in stopping outbreaks; vaccination priorities do not include nursing home residents.	2,242,239
7	HCWs in emergency departments (EDs), intensive care units (ICUs), dialysis centers, and EMS providers	78,685	P	1,258,963	These groups are critical to an effective healthcare response and have limited surge capacity. Prophylaxis will best prevent absenteeism.	3,501,202
8	Infrastructure workers	635,613	T	166,848	Infrastructure groups that have impact on maintaining health, implementing a pandemic response, and maintaining societal functions.	3,668,050
9	Other outpatients	11,088,941	T	2,910,847	Includes others who develop influenza and do not fall within the above groups.	6,578,897
10	Highest-risk outpatients	81,751	P	1,308,014	Prevents illness in the highest-risk groups for hospitalization and death.	7,886,910
11	Other HCWs with direct patient contact	678,532	P	10,856,513	Prevention would best reduce absenteeism and preserve optimal function.	18,743,423

Adapted from National Vaccine Advisory Committee Antiviral Drug Priority Group Recommendations, HHS Pandemic Influenza Plan Appendix D.

* 2007 population data estimates from Florida CHARTS and priority group population estimated as a comparative ratio to NVAC population estimates for priority groups nationwide.

**Strategy is defined as: T= Treatment, 1 course (twice daily dosing for 5 days); PEP= Post Exposure Prophylaxis, 1 course (once daily dosing for 10 days); P= Prophylaxis, 16 course (assumed to be once daily dosing for 80 days per wave, 2 waves)

Table 18: Vaccination and Target Groups for a Severe Pandemic

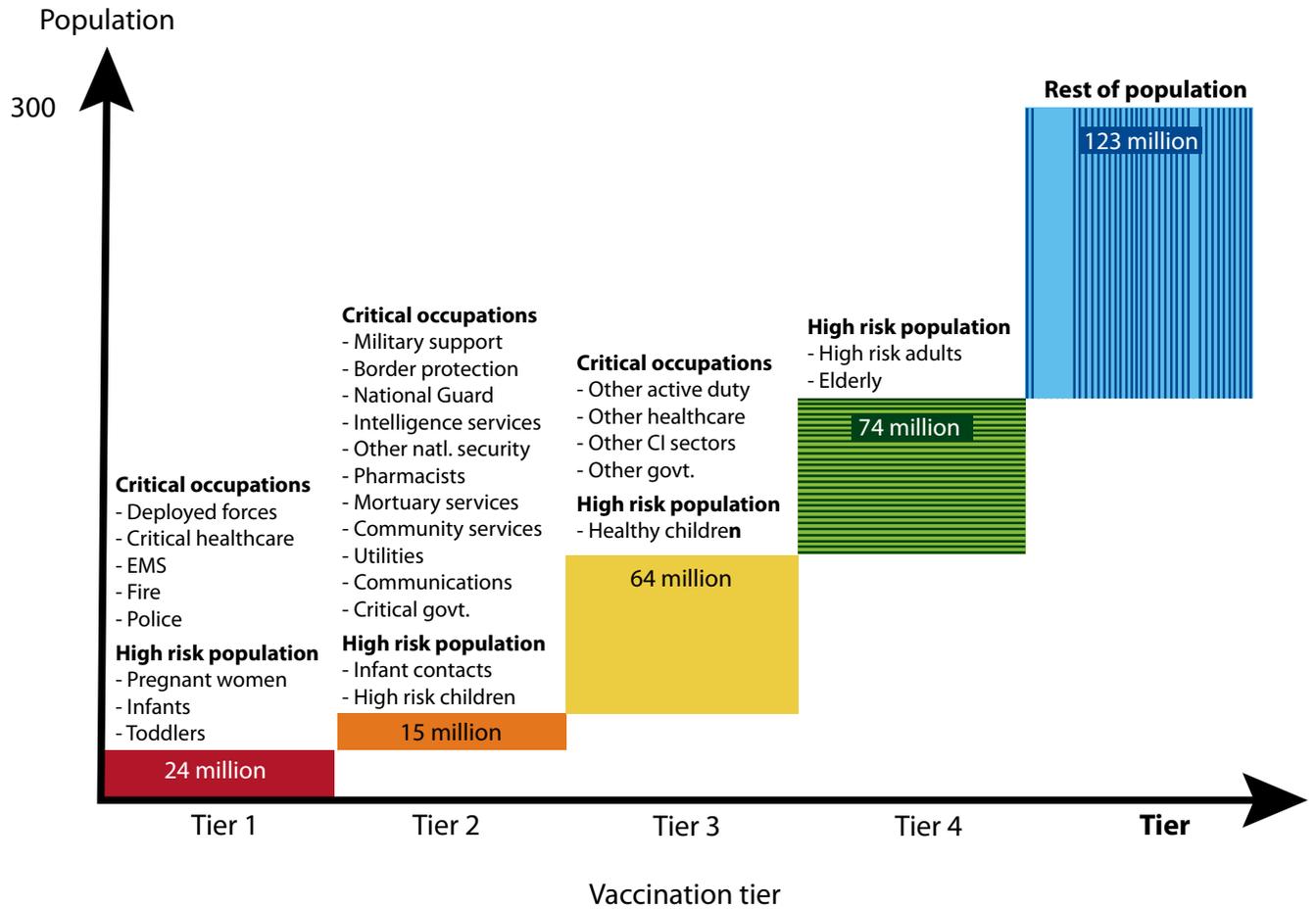


Table 19: Sub-Prioritization of Vaccination among Tier 1 Target Groups when Vaccine Supply is Limited

Priority	Group	Rationale	Estimated Population
1	Front-line inpatient and hospital-based health care workers (persons essential for maintaining function in emergency departments, intensive care units, and other front-line medical and nursing staff)	Critical role in providing care for the sickest persons; highest risk of exposure and occupational infection	1,000,000
2	Deployed and mission-critical personnel	Essential role in national and homeland security: high risk due to living conditions and possibly geographic location	700,000
3	Front-line Emergency Medical Service Personnel (those providing patient assessment, triage, and transport).	Provide critical medical care including procedures such as intubation that increase risk of aerosol exposure and occupational infection	8000,000
4	Front-line outpatient health care providers (physicians, nurses, respiratory therapy; includes public health personnel who provide outpatient care for underserved groups)	Effective outpatient care is critical to decrease the burden on hospitals; high risk of exposure and occupational infection	1,000,000
5	Front-line fire and law enforcement personnel	Essential to public order and safety; less substantial and more predictable risk of exposure	1,000,000
6	Pregnant women and infants 6-11 months old	High-risk documented in prior pandemics and annually; reflects public values to protect children; vaccination of a pregnant woman also will protect the infant; infants 6-11 months old are at high-risk and antiviral drugs are not FDA-approved for children <1 year old	5,150,000*
7	Others in Tier 1 (includes Tier 1 health care workers not vaccinated previously in hospitals, outpatient settings, home health, long-term care facilities, and public health; emergency service providers; manufacturers of pandemic vaccine, antiviral drugs, and other key pandemic response materials; and children 12-35 months old)	Includes people in critical settings who have less exposure and toddlers who are less at risk of severe disease or death than younger infants and who are able to receive antiviral treatment based on FDA approval of antiviral drugs	14,100,000**

*Because infants would be expected to receive one-half a regular vaccine dose, the number of adult vaccine dose-equivalents for this group would be about 4,125,000

**Toddlers 12–35 months old may receive a lower vaccine dose; thus, the number of adult vaccine dose-equivalents for this group may be less

Table 20: Target Groups in Homeland and National Security

Tier (severe pandemic)	Group	Definition	Estimated Group Size*	Rationale
1	Deployed and mission critical personnel	Military forces and other mission critical personnel not limited to active duty military or USG employees; includes some diplomatic and intelligence service personnel, and public and private sector functions identified by federal agencies as unique and critical to national security	700,000	Critical to protect national security; unable to tolerate projected pandemic personnel loss and fulfill mission; potential greater risk of infection due to geographic location and crowded living or working conditions
2	Essential support and sustainment personnel	Military and other essential personnel needed to support and sustain deployed forces	650,000	Maintaining function is essential to mission success for deployed personnel; risk of infection may be less from geographical location and living conditions
2	Intelligence services	Critical personnel in the intelligence community serving at domestic and international posts	150,000	Essential to homeland and national security; opportunities for social distancing limited because of inability to telework due to need for secure facilities; some personnel may be at increased risk based on geographical location
2	Border protection personnel	Critical personnel in agencies providing U.S. border security, including but not limited to Customs and Border Protection, Border Patrol, Immigration and Customs Enforcement, Transportation Security Administration, and Coast Guard personnel	100,000	Essential to homeland security; in close contact with many potential infected people throughout a pandemic; limited ability to apply social distancing strategies
2	National Guard personnel	National Guard personnel not included above who are likely to be activated to maintain public order during a pandemic or to support pandemic response services or critical infrastructure	500,000	Likely to be activated in a pandemic to support critical response or community functions; may be at increased risk of exposure and infection based on mission

Table 20: Target Groups in Homeland and National Security (contd)

Tier (severe pandemic)	Group	Definition	Estimated Group Size*	Rationale
3	Remaining active duty military and essential support personnel	Active duty personnel not included in higher priority groups and essential support personnel	1.5 million	Important to national and homeland security

*Estimates of group size from Department of Defense, Department of Homeland Security, and from working group representatives from other federal agencies

Table 21: Target Groups in Health Care and Community Support Services

Tier (severe pandemic)	Group	Definition	Estimated Group Size *	Rationale
1	Public health personnel	Public health responders at federal, state, and local levels	300,000	Essential to implementing the pandemic response, including the vaccination program and other pharmaceutical and non-pharmaceutical response measures; also provide care for poor and underserved populations; personnel have a high risk of exposure to people with pandemic illness
1	Inpatient health care providers	Includes two-thirds of personnel at acute care hospitals who would be identified by their institution as critical to provision of inpatient health care services; primarily will include people providing care with direct patient exposure but also will include people essential to maintaining hospital infrastructure	3.2 million	Maintaining quality inpatient health care is critical to reducing mortality from pandemic influenza and from other illnesses that will occur concurrently with the pandemic; inpatient health care burden will be markedly increased during a pandemic; studies show health outcomes are associated with staff-to-patient ratio; personnel have high risk of exposure, including to infectious aerosols; infected health care personnel may transmit infection to vulnerable people hospitalized for non-influenza illnesses
1	Outpatient and home health care providers	Includes two-thirds of personnel identified by their organization at outpatient facilities, including but not limited to physicians' offices, dialysis centers, urgent care centers, and blood donation facilities; and skilled home health care personnel	2.5 million	Maintaining outpatient and home health care is critical to reducing pandemic mortality and morbidity and reducing the burden on inpatient services; outpatient health care burden will be markedly increased during a pandemic; personnel have high risk of exposure, possibly including infectious aerosols; infected health care personnel may transmit infection to vulnerable people receiving care for non-influenza illness

Table 21: Target Groups in Health Care and Community Support Services (contd)

1	Health care personnel in long-term care facilities (LTCFs)	Includes two-thirds of personnel at LTCFs identified by their organization as critical to the provision of care	1.6 million	Essential to provide care to more than 3 million people in LTCFs who are particularly vulnerable to influenza illness and death; risk of pandemic outbreaks in LCTFs may best be reduced by vaccinating staff and limiting exposure of residents to infection; if outbreaks occur, personnel have high risk of exposure, possibly including to infectious aerosols
2	Community support service personnel (emergency management and community and faith-based support organizations)	Personnel from community organizations including the Red Cross who will provide essential support and have direct contact with people and families affected during community pandemic outbreaks, and emergency management personnel who coordinate pandemic response and support activities	600,000	Community level support will be critical for people who are ill and isolated in their homes or are complying with recommendations for voluntary household quarantine during community pandemic outbreaks, for elderly people who live alone and may be afraid of going out during a pandemic, for people who are homeless, and for other vulnerable populations; support may include providing food and medications, as well as other social and mental health services; personnel will be at high risk of exposure to ill people and, if infected could transmit illness to a high-risk population
2	Pharmacists	Includes pharmacists dispensing drugs at retail locations (note that pharmacists in hospitals or outpatient centers may be targeted as part of those groups)	150,000	Essential to dispense medications for pandemic influenza and other illnesses; may have increased exposure risk to people with pandemic infection
2	Mortuary services personnel	Includes funeral directors	50,000	Increased burden likely during a pandemic; may have increased occupational exposure to ill family members of deceased people
3	Other important health care personnel	Includes groups that provide important health care services but are at less occupational risk, such as laboratory personnel	300,000	Personnel provide important health care services but are not in as close contact with ill people and at less risk of occupational infection

*Estimates of group size from Department of Health and Human Services. Community social service provider estimate assumes 300,000 volunteers from national organizations (e.g., Red Cross) and additional allocation of 1 per 1000 population.

Table 22: Vaccine Allocation for Target Groups in Critical Infrastructure

Tier (severe pandemic)	Group	Definition	Estimated Group Size *	Rationale
1	Emergency services personnel – EMS, fire, law enforcement, and corrections	Includes groups supporting emergency response and public safety. EMS personnel include those who are fire department-based, hospital-based or private; fire fighters include professionals and volunteers; law enforcement includes local police, sheriff’s officers, and State troopers; and corrections officers include those at prisons and jails	2 million	Provide critical public safety and emergency response services; contribute to pandemic response activities by maintaining public order and contributing to medical care services; increased occupational risk for emergency medical services due to exposure to people with pandemic illness
1	Manufacturers of pandemic vaccine and antiviral drugs,	Includes critical personnel required for ongoing production of pandemic medical countermeasures to support a pandemic response	50,000	Reducing pandemic health impacts requires production of pandemic vaccine and antiviral drugs
2	Communications/ IT, Electricity, Nuclear, Oil & Gas, and Water sector personnel, and Financial clearing and settlement personnel	Personnel who are critical to support essential services provided by the defined sectors	1.75 million	These sectors provide products and services that generally cannot be stored, are required for community health and safety, and are essential to the functioning of other critical infrastructure sectors
2	Critical government personnel – operational and regulatory functions	Federal, state, local, and tribal government employees and contractors who perform critical regulatory or operational functions required for essential operations of other CI sectors	400,000	Government personnel are critical for implementing and monitoring components of the pandemic response, and performing regulatory or operational functions essential to critical infrastructures that protect public health and safety and preserve security

Table 22: Vaccine Allocation for Target Groups in Critical Infrastructure (contd)

3	Banking & Finance, Chemical, Food & Agriculture, Pharmaceutical, Postal & Shipping, and Transportation sector personnel	Personnel who are critical to support essential services provided by the defined sectors	3.0 million	These sectors provide essential products and services; however compared with Tier 2 sectors, products can more likely be stored, facilities and personnel are more fungible and better able to maintain essential functions with high absenteeism, and other strategies can be implemented to protect workers
3	Other critical government personnel	Federal, State, local and tribal government employees and contractors who perform important government functions included in agency continuity-of-operations plans	400,000	Continuity of key government functions is important to support communities and critical infrastructures

*Group sizes for critical infrastructure sectors are estimated as 25% of the workforce in Tier 2 sectors and 7.5% of the workforce in Tier 3 sectors. These estimates track generally with estimates from the NIAC report, The Prioritization of Critical Infrastructure for a Pandemic Outbreak in the United States (www.dhs.gov/niac) and with estimates provided by the Department of Homeland Security. Estimates for federal, state, local, and tribal government personnel are 5% of workers in Tier 2 and 5% in Tier 3

IX. Annexes

X. Appendices

A. Hazard-Specific Plan(s)