Louisiana Department of Health
Annex 5: Louisiana Hospital Pandemic Influenza Plan

February 2019
Approval and Implementation

This Annex is hereby accepted for implementation and supersedes all previous editions.

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Date

3/7/19  
Date

3/7/19  
Date

March 7, 2019  
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Purpose, Scope, Situation Overview & Planning Assumptions

Purpose
The Louisiana Department of Health (LDH) Emergency Support Function-8: Health and Medical (ESF-8) has prepared this document as an annex to the Office of Public Health’s (OPH) Pandemic Influenza Plan.

Scope
This Annex describes how LDH ESF-8 provides guidance to and coordinates with hospitals in the event of a pandemic.

Situation Overview & Planning Assumptions
Pandemic influenza has the potential to affect all elements of society. A large number of cases will add burden to hospitals and other health care systems. Increased mortality during a severe pandemic is also of concern. Health and medical personnel, as well as, other critical infrastructure workers, i.e., law enforcement, fire, and public works will be susceptible to illness possibly imposing significant stress on critical infrastructure. The LDH ESF-8 will monitor information from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) as a pandemic unfolds. The effects within communities could be dramatic and of a longer duration than other disasters.

The following are healthcare planning assumptions related to pandemic influenza:

- High attack rates will place overwhelming demands on the healthcare system.
- The number of individuals seeking healthcare (inpatient and outpatient) is likely to exceed normal capacity.
- Healthcare providers, emergency response personnel, and public safety personnel will be equally or more likely to become infected than the general public.
- Staffing shortages among healthcare and other responding personnel are likely to occur due to illness of self or family, exhaustion, and fear of contagion.
- Staffing concerns are also likely among other essential industries, including utilities, transportation, telecommunications and information technology, mortuary services, food services, and public safety.
- Due to the expected widespread nature of an influenza pandemic, it is unlikely that resources will be diverted from other areas.
- The first wave of disease will likely occur during the fall with community outbreaks lasting 6-8 weeks.
- Hospital care will include a combination of respiratory support, including mechanical ventilation, and treatment of secondary bacterial pneumonia.
Concept of Operations

To facilitate the LDH ESF-8 Health and Medical response, nine planning regions for private and public hospitals were identified. These regions correspond with those used by Louisiana Department of Health. While planning begins at the local level, each individual hospital works within its region, each region reports to the state, and the state in-turn interfaces with the federal government. See

Appendix A: Map of Louisiana Department of Health (LDH)/OPH Regions

Local Coordination

All hospitals are ascribed to one of nine regions and are included as Healthcare Coalition partners. Hospitals are included in the development of regional plans and are an integral part of the regional response to emergencies.

Hospitals are responsible for developing and identifying their institutional Incident Command Structure (ICS) depending on the nature of the incident. Hospitals have also identified a point of contact, known as the Hospital Emergency Preparedness Coordinator. This member of the Hospital ICS or his/her designee is responsible for maintaining ongoing communications within the regional response.

Louisiana’s hospitals provide various levels of care to meet immediate medical needs of citizens every day and during disasters. A classification system of hospitals was identified based on capabilities provided. Hospitals serve voluntarily as one of three levels:

- Designated Regional Hospitals (DRH): These hospitals are large acute care facilities with emergency room capabilities and many subspecialty services. DRHs in each region are considered core members of the HCC and often assist HCC leadership with identification of regional projects, review of regional policies and plans, execution of trainings and participation in regional drills. They serve voluntarily and understand their role to provide additional capacity and resources in the initial emergency response of a mass casualty or event.
- Tier 1 Hospitals: These hospitals have emergency department capabilities 24/7.
- Tier 2 Hospitals: Hospitals that do not provide emergency room capabilities and are more single service in nature such as psychiatric, rehabilitation, and/or long-term acute service.

A count of Tier 1 and Tier 2 hospitals by region can be found in Appendix C: Count of Hospitals by Region.

Regional Coordination

Leadership for Hospital Emergency Preparedness and Response in each region is provided through hospital volunteers/representatives known as Hospital Designated Regional Coordinators (DRCs). See Appendix B: Designated Regional Coordinators.. Hospitals maintain their own plans and procedures but will coordinate with the Hospital DRCs to provide situational awareness, provide bed status information and relay resource status/requests to the LDH ESF-8. Likewise, each of the nine regions has an OPH Medical Director.
Hospital DRCs work in consultation and coordination with the OPH Regional Medical Director. The DRCs oversee and coordinate regional planning efforts working closely with pre-hospital and other healthcare providers and partner agencies. The OPH Medical Director provides clinical direction and counsel throughout all phase of an infectious disease outbreak.

**State Level Coordination**
The Regional Unified Medical Command reports to the State ESF-8 Health and Medical Section to forward needed information and assist in response activities. The State Health Officer or his designee serves as the Incident Commander for LDH ESF-8 activities and interfaces directly with other state emergency support functions and federal agencies. The LDH ESF-8 coordinates the response for requests with other ESFs and federal agencies. See the Louisiana ESF-8 Emergency Response Network Coalition Plan for more detail.

**State and Federal Coordination**
The Louisiana Department of Health as the state ESF8 lead provides coordination on behalf of the Louisiana and all other state agencies to the federal government DHHS and CDC.

**Planning, Response and Resource Coordination**
At the Federal level, the CDC will push forth guidance for healthcare workers and provide updates to existing pandemic guidance. The LDH-OPH is the lead agency for Pandemic Influenza Response, however, hospitals will play a critical role in the pandemic response. The DRCs will coordinate with hospital contacts to maintain situational awareness, provide visibility of bed availability and status of critical resources. The DRCs in turn relay this information to the state ESF-8 partners.

**Planning**
Groups and individuals involved in the hospital planning process should include:

- An internal, multidisciplinary planning committee with responsibility for pandemic influenza preparedness and response. The committee should include technical experts, persons with decision-making authority, and representatives from a range of response partners.
- A pre-existing all-hazards preparedness team.
- A response coordinator/incident commander to direct the facility’s planning and response efforts.
- A core group from the multidisciplinary planning committee to work with the response coordinator and assist with decision-making during the pandemic.

Hospital planning for pandemic influenza should consider concurrent public health, community, and healthcare planning efforts at the local, state, and regional levels. Some possible mechanisms for collaboration and coordination are to:

- Include a state or local health department representative as an ex-officio member on the hospital planning committee.
- Obtain copies of draft pandemic influenza plans from other local or regional hospitals to use as models.
• Work with other local hospitals, community organizations (e.g., social service groups), and the state or local health department to coordinate healthcare activities in the community and define responsibilities for each entity during a pandemic.
• Collaborate with hospital preparedness program contacts in the state or region.
• Include a hospital representative in local or regional planning efforts.
• Include representatives from safety-net providers in the local community (e.g., Federally Qualified Health Centers and rural community or rural health clinics).

The CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) have developed several tools that hospital and healthcare providers can refer to when developing and reviewing their pandemic plans. Hospital plans should include the following areas to maintain a state of readiness for each wave of patient surge that occurs: protecting and preparing hospital staff, implementing plans to address patient care issues and hospital operations, addressing equipment and supply needs, and providing for security. Additionally, ASPR Technical Resources Assistance Center Information Exchange (TRACIE) has developed several Topic Collections with content relevant to specific aspects of epidemic and pandemic influenza planning. The collections include:

• Alternate Care Sites
• Crisis Standards of Care
• Disaster Ethics
• Fatality Management
• Healthcare-Related Disaster Legal/Regulatory/Federal Policy
• Hospital Surge Capacity and Immediate Bed Availability
• Medical Countermeasures
• Non-pharmaceutical Interventions
• Pharmacy
• Resource Management
• Responder Safety and Health
• Virtual Medical Care

Plans should incorporate information from state, regional, tribal and local health departments, emergency management agencies/authorities, hospital associations, and suppliers of resources. In addition, hospitals should ensure that their pandemic influenza plans comply with applicable state and federal regulations and with standards set by accreditation organizations such as the Joint Commission.

Response
During a response, hospitals may consider employing innovative strategies to deal with patient surge including:

• Altered staffing patterns
• Fast-tracking discharges
• Updating and implementing triage protocols
• Setting up holding areas close to the Emergency Department
• Doubling patient room capacity
• Public messaging campaigns
• Increased collaboration with other provider types
• Patients and staff using masks
• Implementing staff vaccination campaigns
• Restricting visitors
• Just in time training for staff
• Partnering with state ESF-8 to provide consistent public messaging
• Developing/implementing closed Points of Dispensing plans for medical countermeasures
• Frequent monitoring of CDC advisories and guidance for healthcare providers
• Implementing Continuity of Operations Plans
• Reviewing Palliative Care and Crisis Standards of Care Guidelines
• Assessing the need for additional facility security

It should be noted that an 1135 waiver need not be considered as long as the facility continues to provide appropriate screening and care as outlined in the Center for Medicare & Medicaid Conditions of Participation. Facilities must meet all the conditions of participation for CMS and must comply with all state and county licensure and life safety code requirements.

Hospital Surveillance During an Influenza Pandemic
Healthcare providers and healthcare facilities will play an essential role in pandemic influenza surveillance. Routine hospital surveillance activities will need to be greatly enhanced during a suspected or confirmed pandemic influenza outbreak. Additional information will become critical for maintaining hospital functions. Information on specific variables will need to be tracked on a frequent basis. Hospitals should have:

• Procedures in place to facilitate laboratory testing on-site using proper biosafety levels and reporting of unusual influenza isolates through local and state health department channels. If appropriate methods or biosafety levels do not exist at the hospital, specimens should be shipped to the state health department.

• Predetermined thresholds for activating pandemic influenza surveillance plans.

• Mechanisms for conducting surveillance in emergency departments to detect any increases in influenza-like illness during the early stages of the pandemic

• Mechanisms for monitoring employee absenteeism for increases that might indicate early cases of pandemic influenza

• Mechanisms for tracking emergency department visits and hospital admissions and discharge/death of suspected or laboratory-confirmed influenza patients. This information will be needed to: 1) support local public health personnel in monitoring the progress and impact of the pandemic, b) assess bed capacity and staffing needs, and c) detect a resurgence in pandemic influenza that might follow the first wave of cases.

• Updated information on the types of data that should be reported to state or local health departments (e.g., admissions; discharges/deaths; patient characteristics such as age, underlying disease, and secondary complications; illnesses in healthcare personnel) and plans for how these data will be collected during a pandemic. State and local health departments will provide guidance on the scope and mechanism of reporting.

• Criteria for distinguishing pandemic influenza from other respiratory diseases.
Managing Surge
The CDC has a suite of tools available to help hospitals administrators prepare for the next pandemic. Among those is FluSurge2.0— a model that estimates the number of hospitalizations and deaths of an influenza pandemic (whose length and virulence are determined by the user) and compares the number of persons hospitalized, the number of persons requiring ICU care, and the number of persons requiring ventilator support during a pandemic with existing hospital capacity. To increase available bed capacity in the short term, hospitals within a region should consider the following:

- Review and revise admissions criteria for times when bed capacity is limited
- Streamline admission procedures to limit the number of patient encounters in the hospital (e.g., direct admission to an inpatient bed).
- Develop policies and procedures for expediting the discharge of patients who do not require ongoing inpatient care (e.g., develop plans and policies for transporting discharged patients home or to other facilities, create a patient discharge holding area or discharge lounge to free up bed space).
- Work with home healthcare agencies to arrange at-home follow-up care for patients who have been discharged early and for those whose admission was deferred because of limited bed space.
- Develop criteria or “triggers” for temporarily canceling elective surgical procedures and determining what and where emergency procedures will be performed during a pandemic. Determine which elective surgical procedures will be temporarily postponed.
- Determine whether patients who require emergency procedures will be transferred to another hospital or facility.
- Discuss with local and state health departments how bed availability, including available ICU beds and ventilators, will be tracked during a pandemic.
- Consult with hospital licensing agencies on plans and processes to expand bed capacity during times of crisis. These efforts should take into account the need to provide staff and medical equipment and supplies to care for the occupant of each additional hospital bed.
- Discuss with healthcare regulators whether, how, and when an “Crisis Standards of Care in Mass Casualty Events” will be invoked and applied to pandemic influenza. (See Appendix M, State Hospital Crisis Standards of Care Guidelines in Disasters).
- Develop policies and procedures for shifting patients between nursing units to free up bed space in critical-care areas and/or to cohort pandemic influenza patients.
- Expansion of critical care capacity by placing select ventilated patients on monitored or step-down beds; using pulse oximetry (with high/low rate alarms) in lieu of cardiac monitors; or relying on ventilator alarms (which should alert for disconnect, high pressure, and apnea) for ventilated patients, with spot oximetry checks.
- Conversion of single rooms to double rooms or double rooms to triple rooms, if possible.
- Reduction of the usual use of imaging, laboratory testing, and other ancillary services.
- At the time of the event, consider developing Mutual Aid Agreements (MAAs) or Memoranda of Understanding/Agreement (MOU/As) with other local facilities who can accept non-influenza patients that do not need critical care.
• Identify areas of the facility that could be vacated for use in cohorting influenza patients. Consider developing criteria for shifting use of available space based on ability to support patient-care needs (e.g., access to bathroom and shower facilities). Consider developing cohorting protocols based on a patient’s stage of recovery and infectivity.

• The use of cots and beds in flat space areas (e.g., classrooms, gymnasiums, lobbies) within the hospital for noncritical patients care.

Please refer to the OPH Pandemic Influenza Plan for additional information on the following topics:

• Infectious Disease Epidemiology
• Laboratory
• Vaccination
• Antiviral
• Emergency Medical Services
• Containment and Mitigation
• Mass Fatality

Resource Coordination
As the pandemic progresses, hospitals will face increasing shortages of supplies (e.g. personal protective equipment, durable medical supplies, etc.). Administrative measures such as estimating volume of supplies needed and establishing contingency plans for situations where supplies are limited will likely become necessary.

One of the key responsibilities of the hospital DRC is to assess the operational status of its regional hospitals and coordinate resources to meet the demands placed on the system.

Hospitals in Louisiana are currently using the ESF-8 Portal for capturing information during regional and statewide emergencies. This web-based system consists of several modules that capture the status of bed availability, hospital operational status and patient tracking. Under development is a resource module which will provide information about specific types of PPE, portable ventilators, pharmaceutical caches etc. and has the flexibility to create additional fields for monitoring event-specific resources. This data can be continuously monitored, and resources can be quickly assessed, monitored and redirected via statewide ESF-8 network. For more detailed information on resource coordination see the Louisiana ESF-8 Emergency Response Network Coalition Plan.

Communications
In a pandemic influenza event, communications between hospitals within each region, with the state, and with local communities will be of paramount importance. Hospital should work with public health officials, other government officials, neighboring healthcare facilities, and the press to ensure rapid and ongoing information-sharing and those messages to the public remain uniform and consistent at any given time. The Louisiana ESF-8 Hospital Network has identified several redundant communication systems namely:

• Primary system – Internet, email and text
• Secondary system – Telephone and fax
• Tertiary system – Two-way radios
All Tier 1 hospitals have at least one emergency two-way radio. The Louisiana Department of Health, Office of Emergency Preparedness, Designated Regional Coordinators and Designated Regional Hospitals are equipped with 700/800 MHz radios for statewide communications. Additional information can be disseminated via the Health Alert Network by blast fax.

Considerations for external communication should also be made in advance of a pandemic. Each hospital and each region should assign responsibility for external communication about pandemic influenza. With guidance from state or local health departments, determine the methods, frequency, and scope of external communications. In addition, identifying a person responsible for updating public health reporting (e.g., infection control), a clinical spokesperson (e.g., medical director), and a media spokesperson (e.g., public information officer) within each hospital may be necessary. The following are further recommendations that should be considered:

- Identification of points of contact among local media (e.g., newspaper, radio, television) representatives and public officials and community leaders
- Determination of how communications between local and regional healthcare facilities will be handled.
- Consult with state or local health departments on plans for coordinating or facilitating communication among healthcare facilities. In the absence of such a plan, consider organizing a meeting of local healthcare facilities to determine an optimal communications strategy.
- Identify key topics for ongoing communication (e.g., staffing needs, bed capacity, durable and consumable medical equipment and device needs and supplies of influenza vaccine and antiviral drugs).
- Assign responsibility within the hospital for communications with other healthcare facilities.
- Consult with local or state public health officials regarding the hospital’s role in communicating with the media and the public.
- Determine the type of hospital-specific communications (e.g., press releases, community bulletin board) that might be needed, and develop templates for these materials.
- Consult with local or state health departments on plans for a pandemic influenza hotline and/or website for public inquiries.
- Determine how public inquiries will be handled (e.g., refer callers to the health department; provide technical support for handling calls).
- Identify the types of information that will be provided by the hospital and the types of inquiries that will be referred to state or local health departments.

Intra-facility communications within facilities should also include redundancy options. These lines of communications may be tested during other types of emergencies, but it is important that hospital rosters, call lists, and necessary systems to support communications lines are reviewed and updated. Planning considerations for a pandemic should include how to keep administrators, personnel (including infection control staff and intake and triage staff), patients, and visitors informed of the ongoing impact of pandemic influenza on the facility and on the community.
Acronyms

ASPR  Assistant Secretary for Preparedness and Response
CDC   Centers for Disease Control and Prevention
DRC   Designated Regional Coordinator
DRH   Designated Regional Hospital
ESF-8 Emergency Support Function-8
ICS   Incident Command System
LDH   Louisiana Department of Health
OPH   Office of Public Health
TRACIE Technical Resources Assistance Center and Information Exchange
WHO   World Health Organization
Appendix A: Map of Louisiana Department of Health (LDH)/OPH Regions
## Appendix B: Designated Regional Coordinators

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<td>1</td>
<td>Cindy Davidson</td>
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<td>3</td>
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<tr>
<td>4</td>
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<td>5</td>
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<td>6</td>
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<td>7</td>
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<td>9</td>
<td>Keith Peek</td>
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## Appendix C: Count of Hospitals by Region

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Count as of December 2018