



Jim Doyle
Governor

Karen E. Timberlake
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF QUALITY ASSURANCE
1 WEST WILSON STREET
P O BOX 2969
MADISON WI 53701-2969

Telephone: 608-266-8481
FAX: 608-267-0352
TTY: 888-241-9432
dhs.wisconsin.gov

Date: July 13, 2009

To: **Facilities Serving People with Developmental Disabilities (FDD)**

From: Alfred C. Johnson, Director
Bureau of Licensing, Technology and Education

Via: Otis Woods, Administrator
Division of Quality Assurance

Novel Influenza A (H1N1) / 2009
Considerations for Emergency Preparedness / Disaster Planning for Pandemic Influenza

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

The purpose of this memo is to:

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

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

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

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

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

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

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

REGULATORY REQUIREMENTS

Federal Standard: Infection Control

W455 There must be an active program for the prevention, control and investigation of infection and communicable diseases.

Federal Standard: Emergency Plan and Procedures

W438 (1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

PANDEMIC PLANNING

The above regulations are applicable to pandemic influenza. It is for these reasons that FDDs need to ensure that they have an emergency preparedness/disaster plan for pandemic influenza. If your agency does not have a plan for pandemic influenza, the DQA strongly recommends that you develop one now. The U.S. Department of Health and Human services has established a web site devoted to pandemic planning that includes planning checklists to assist providers in developing a plan and help identify what providers need to do to be prepared. This site is located at <http://www.pandemicflu.gov/plan/healthcare/healthcare.html>. Those providers with existing plans are encouraged to review them and make plans for their implementation. It is recommended that providers regularly monitor the Centers for Disease Control and Prevention

(CDC) and Wisconsin Pandemic Flu websites (listed at the end of this document) for current information.

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

INFECTION CONTROL

Definition of Influenza-like Illness:

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

Transmission:

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

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

Infection Control Measures:

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

The following infection control measures are recommended to prevent person-to-person transmission of ILI and to control outbreaks in healthcare facilities:

1. Surveillance – Routinely monitor patients and employees for symptoms consistent with ILI
 - Employees with confirmed, probable or suspected H1N1 influenza infection must stay at home and be removed from contact with patients or their environment for 7 days after the onset of illness **or** 24 hours after the resolution of fever and improvement of symptoms, whichever is longer.

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

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

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

7. Isolation Precautions

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

For clients:

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

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

For staff:

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

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

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

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

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

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

9. Environment – Routine cleaning and disinfection strategies used during influenza seasons can be applied to the environmental management of H1N1 influenza. Management of laundry, utensils and medical waste should also be performed in accordance with procedures followed for seasonal influenza.

RESOURCES:

Centers for Disease Control and Prevention

Wisconsin Pandemic Flu

Pandemic planning checklist for providers

Guidelines for antiviral treatment

Infection Control

Standard Precautions

Contact Precautions

Respiratory hygiene/cough etiquette

Respirators

CONTACTS:

Local Public Health Departments

For Regulatory Questions Only