

Guam Pandemic Influenza Plan

DRAFT

Division of Public Health
Department of Public Health and Social Services

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GUAM PANDEMIC INFLUENZA PLAN

**DIVISION OF PUBLIC HEALTH
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES**

**BUREAU OF STATISTICS AND PLANS
P.O. BOX 2050
Hagatna, Guam 96932**

ACKNOWLEDGMENTS

Department of Public Health and Social Services (DPHSS) Pandemic Influenza Planning Committee

Arthur U. San Agustin, MHR
Suzanne A. Sison, DDS
Gil Suguitan
Cynthia Naval
Josephine T. O'Mallan
Annette Aguon
Lourdes Duguies
Claire Baradi
Roselie Zabala
Linda Unpingco Denorcey
Margarita Gay
Marlene Carbullido
Masatomo T. Nadeau
Charlene San Nicolas
Janet B. Cruz
MaryLou Loualhati
Margaret Bell

Acting Director, DPHSS
Acting Chief Public Health Officer
Bioterrorism Preparedness and Response Program
Bioterrorism Preparedness and Response Program
Bureau of Communicable Disease Control
Bureau of Communicable Disease Control
Bureau of Communicable Disease Control
Bureau of Communicable Disease Control
Bureau of Professional Support Services
Bureau of Primary Care Services
Bureau of Family Health and Nursing Services
Bureau of Family Health and Nursing Services
Division of Environmental Health
Division of Senior Citizens
Health Professional Licensing Office
Office of Emergency Medical Services
Office of Maternal and Child Health Services

Past DPHSS Members:

Ronald Balajadia
Severino David
Janice Yatar

Immunization Program, DPH
Bureau of Professional Support Services
Bureau of Family Health and Nursing Services

Consultants:

Robert Haddock, DVM
Michael O'Leary, MD, MPH
Vasiti Uluiviti
William Brandshagen
Zenaida Lebita

Epidemiologist
Epidemiologist, Centers for Disease Control
PIHOA Regional Laboratory Coordinator
Bureau of Professional Support Services
Bureau of Professional Support Services

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I. PURPOSE

The purpose of this plan is to provide a guide for the Guam Department of Public Health and Social Services (DPHSS) and other Territorial agencies for detecting and responding to a pandemic influenza. The plan describes disease surveillance, emergency management, vaccine and antiviral delivery, laboratory and communications activities, as well as how multiple agencies should work together to respond to such an event.

If confronted with pandemic influenza, the priorities of the DPHSS will be to assure the continuation and delivery of essential public health services while providing assistance to meet emergency needs of the affected population. This plan establishes the framework and guidelines for ensuring an effective system of health and medically related emergency management is in place to contain adverse outcomes of an influenza pandemic.

The Guam Pandemic Influenza Plan represents an evolutionary process that shall be periodically reviewed and updated as new information and guidelines from the World Health Organization (WHO) or the U.S. Centers for Disease Control and Prevention (CDC) are available to ensure the assumptions, resources, priorities, and plans are consistent with current knowledge and changing infrastructure. In addition, in the event of a pandemic, the judgments of the public health leadership, based on the epidemiology of the current virus, and the extent of its spread within the population of Guam and the region, may alter or override anticipated strategies and plan.

II. POLICIES

- A. Employees will have a working knowledge of this plan and identified roles.
- B. Appropriate information will be shared with the public.
- C. Information will be shared with health and medical organizations, physicians and emergency management agencies at appropriate levels.
- D. DPHSS resources will be utilized before requesting assistance from other sources.
- E. DPHSS will adhere to appropriate medical and ethical practices when allocating scarce resources.

III. BACKGROUND

Influenza viruses are unique in their ability to cause infection in all age groups on a global scale. In addition to the highly transmissible nature of influenza, the virus can change its antigenic structure, resulting in novel sub-types that have never occurred in humans before. Major shifts in the viral sub-types are associated with influenza pandemics. The 1918 influenza pandemic caused more than 20 million deaths worldwide and caused the death of approximately 5% of Guam's population (this would be equivalent to approximately 8,400 deaths on Guam today). The pandemics of 1957 and 1968 resulted in lower mortality rates due in part to antibiotic therapy for secondary bacterial infections and more aggressive supportive care. They both, however, were associated with high rates of morbidity and social disruption.

Pandemic influenza is a unique public health emergency and community disaster. It is considered a highly probable and inevitable event that no one can predict when it will occur. There may be little warning, but most experts agree there will be one to six months between

identification of a novel virus and widespread outbreaks in the United States. Outbreaks will occur simultaneously throughout the United States and the effect on individual communities will last from six to eight weeks or more. Depending on where the pandemic starts, Guam may be affected sooner or later than the continental United States.

Pandemic influenza has the potential of affecting all elements of society. A large number of cases will add burden to hospitals and other health care systems already stressed with the normal day to day crisis. Mortality is usually markedly increased. Health and medical personnel as well as other infrastructure workers, i.e. law enforcement, fire, public works, will not be immune. The effects on our communities could be staggering.

IV. ASSUMPTIONS

For planning purposes, the worst-case scenario is being projected. If the situation does not fully develop, the response can be adjusted. The following assumptions are made:

- A. Pandemic influenza has occurred every 11 to 39 years in the 20th century. Based on history of the 20th century, we would expect an influenza pandemic within the next few years.
- B. A novel influenza virus strain will likely emerge in a country other than the United States, but a novel strain could emerge first in the U.S.
- C. With the emergence of a novel influenza virus strain, it is likely that all persons will need two doses of vaccine, with 30-day intervals between doses, to achieve optimal antibody response.
- D. Although there may be isolated unaffected pockets, the pandemic is likely to affect all geographic areas of Guam.
- E. The emergency response element will require the substantial interaction of agencies beyond DPHSS.
- F. During the 2004 flu season, approximately 4,354 doses of influenza vaccine were distributed and administered by the DPHSS Immunization Program (2.9% of Guam's civilian population), which will not necessarily provide the specific type of protection needed.
- G. Guam's tourists and other visitors will create a potential vaccination target population of nearly one-third more than that of the island's permanent resident population.
- H. When the pandemic occurs, vaccines and medicines will be in short supply and will have to be allocated on a priority basis. Current vaccine manufacturing procedures dictate that a minimum of 6-8 months would elapse before tens of millions of doses would become available for distribution; thus, it is possible that no vaccine will be available during the early course of the pandemic.
- I. According to CDC guidelines, total vaccine supply will be under the control of the federal government, with states and territories receiving an allotment.
- J. The federal government has assumed responsibility for devising a liability program for vaccine manufacturers and persons administering the vaccine.
- K. Response to the demand for services will require non-standard approaches, including:
 - 1. Discharge all but critically ill hospital patients.
 - 2. Expansion of hospital "capacity" by using all available space and "less than code compliance beds".

3. Increase of patient ratio to hospital staff.
 4. Recruitment of volunteers who can provide non-medical services under the general supervision of health and medical workers.
 5. Relaxation of practitioner licensure requirements as deemed appropriate.
 6. Utilization of general purpose and special needs shelters as temporary health facilities.
- L. The federal government has assumed responsibility for developing “generic” guidelines and information templates, including fact sheets, triage and treatment of influenza patient’s protocols, and guidelines for the distribution and use of vaccines and antiviral agents that can be modified at the state and local level. Until these are developed and available, the state has the responsibility to develop such guidelines for its citizens.
- M. Secondary bacterial infections following influenza illness may stress antibiotic supplies.

In addition to the above assumptions, it is felt there may be as little as one to six months warning before outbreaks begin in the U.S. and Guam, if the pandemic emerges in another country. The pandemic may occur during time periods not normally associated with our usual influenza season, and the pandemic strain may attack categories of people at different rates than those that normally occur during typical influenza seasons.

V. RESPONSIBILITIES

- A. DPHSS will seek an Executive Order from the Governor in order to activate state/local resources for the pandemic response.
- B. DPHSS Director will assume the role of Incident Command at the Emergency Operations Center (EOC) and provide leadership to other agencies and resources in the management of this type of event.
- C. DPHSS will assist in the identification and the coordination of provision of resources needed by local health and medical systems to cope with the emergency.
- D. The Division of Public Health will identify and coordinate planning with key stakeholders through the Pandemic Influenza Committee (PIC) made up of representatives from the Chief Public Health Office, Bureau of Communicable Disease Control (BCDC), Bureau of Family Health and Nursing Services (BFHNS), Bureau of Professional Support Services (BPSS), and Bureau of Primary Care Services (BPCS). Other key stakeholders for involvement in planning include the Guam Memorial Hospital Authority (GMHA), Guam Office of Homeland Security (GHS)/Office of Civil Defense (OCD), Guam Public School System (GPSS), Guam Medical Society (GMS), Guam Nurses Association (GNA), Department of Mental Health and Substance Abuse (DMHSA), Guam International Airport Authority (GIAA), Customs and Quarantine Agency (CQA), U.S. Customs and Border Protection (CBP) and other related agencies and/or entities necessary to mobilize efforts to respond to the crisis.
- E. DPHSS will be responsible for developing plans to assess existing health care resources, coordinate responses with key stakeholders, and develop contingencies for anticipated shortages of essential services.
- F. DPHSS will also be responsible for promoting inter-pandemic routine influenza and pneumococcal vaccination to designated high-risk groups.

- G. The DPHSS Central Laboratory will provide expertise in early identification of the presence and type of influenza and inform physicians of procedures for requesting laboratory confirmation of suspected influenza cases.
- H. The DPHSS Epidemiologist will conduct surveillance of influenza and related disease activity and provide continuous information of its course and impact upon the population.
- I. The DPHSS Communications Office, in collaboration with the Joint Information Center (JIC) at GHS/OCD will keep the public informed during all phases of the pandemic.
- J. DPHSS will seek a Public Health Order from the Governor restricting administration of vaccine/antivirals to priority groups only (Appendix P).

VI. CONCEPT OF OPERATIONS

The DPHSS Director shall assume command for directing the response to the influenza pandemic. At the point where resources outside DPHSS are needed or the provision of essential community services are being affected as a result of the pandemic, the DPHSS Director with the guidance and assistance of the Pandemic Influenza Committee (PIC) will recommend to the Governor the activation of the EOC.

The EOC shall be utilized to track missions, acquire resources, document costs and coordinate response activities among the major territorial agencies/organizations. The general methods of operation shall be undertaken as provided in this plan and the Guam Emergency Response Plan. In responding to the influenza pandemic, the DPHSS will have lead responsibility and the OCD (the Emergency Management Agency) will have a support role.

If emergency powers are needed, the DPHSS Director in consultation with the PIC, shall draft a Governor's Executive Order declaring a state of emergency exists and specifying the emergency powers necessary or appropriate to cope with the emergency. If it appears that significant expenditures will be required to respond to this emergency, the DPHSS Director and the GHS Advisor will jointly recommend, and the Governor will request, a presidential disaster declaration. If granted, this declaration may make federal funding available.

In addition to public health, the general strategy of the plan is to protect the infrastructure so to ensure the health and medical community, as well as government and business, will continue to function. This decision will require allocation and redirection of scarce resources where needed to maintain optimal functioning and health of society.

VII. EMERGENCY MANAGEMENT PLAN

The GHS/OCD prepares and maintains a comprehensive Guam Emergency Response Plan, which provides for an emergency management system that includes a broad range of preparedness, response, recovery, and mitigation responsibilities. The primary focus of this document is to outline roles, responsibilities, and appropriate actions taken as a result of an emergency or disaster.

The OCD coordinates with local and federal elected officials and liaises with agency heads and cabinet officers, providing a key link with the Governor and staff. When an emergency or a disaster overwhelms local governmental resources, assistance may be requested from federal resources through the OCD, which then activates the Response Activity Coordinators (RAC).

The RAC consist of representatives of core Government of Guam agencies, voluntary organizations, and the military organizations on island.

The EOC, in almost all disasters, maintains direction and control while serving as the central clearinghouse for disaster-related information and requests for assistance from local government. After an area has been impacted by a major disaster, the state continues to provide support to local communities through response and recovery operations. In the case of presidential declared disasters, federal and local governments jointly coordinate recovery efforts from a Disaster Field Office.

VIII. PANDEMIC PHASE CHART

Pandemic planning is divided into several phases, from early identification of a novel virus to resolution of pandemic cycling. These phases are determined and announced by CDC in collaboration with the WHO. The Guam Pandemic Influenza Plan follows the same phase guidelines, prescribing necessary activities and identifying responsible parties by pandemic phase. These declared and defined phases will help ensure a consistent and coordinated response by national, state, and local agencies in the event of an influenza pandemic event. The intent is for all activities listed in this document to be initiated during the assigned pandemic phase. Some activities will, of course, continue during subsequent phases.

The pandemic phase table below is based on the phases outlined in the WHO's "Global Influenza Preparedness Plan", Geneva, Switzerland, 2005.

WHO PANDEMIC PHASE	PERIOD	DEFINITION
PHASE 1	Interpandemic Period	No indication of any new virus types.
PHASE 2	Interpandemic Period	New virus type detected in animals but not in humans.
PHASE 3	Pandemic Alert Period	New influenza strain in a human but no (or rare) human-to-human spread.
PHASE 4	Pandemic Alert Period	Small cluster(s) with limited human-to-human transmission anywhere.
PHASE 5(A)	Pandemic Alert Period	Larger cluster(s) of human-to-human transmission but still localized to a single country/region without direct flights to Guam.

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PHASE 5(B)	Pandemic Alert Period	Larger cluster(s) of human-to-human transmission but still localized to a single country with direct flights to Guam.
PHASE 6(A)	Pandemic Period	Increased and sustained human-to-human transmission in multiple countries/regions near Guam (Philippines, Hawaii, Indonesia, Japan, Taiwan) but not Guam.
PHASE 6(B)	Pandemic Period	Pandemic reaches Guam.
PHASE 6(C)	Pandemic Period	<i>End of First Wave.</i> Activity in initially affected regions/countries stopped; cases still occurring elsewhere and on Guam.
PHASE 6(D)	Pandemic Period	<i>End of First Wave.</i> Activity in initially infected regions/countries stopped; cases much decreased or absent on Guam based on local surveillance data.
PHASE 6(E)	Pandemic Period	<i>Second Wave.</i> Second outbreak in a region, 3-9 months after first wave.
	Post Pandemic Period	Pandemic transmission over, likely 2-3 years after onset; immunity to new virus type is widespread in the population.

IX. PANDEMIC PHASES

A. PHASE 1. (Interpandemic Period. No indication of any new virus types)

During “normal” influenza seasons, influenza viruses antigenically related to recently circulating viruses continue to evolve and cause disease during annual epidemics at the level of local community, state, nation or continent. Activities during this phase are directed at maintaining the infrastructure of health and medical resources and strengthening those resources where possible to prepare for years of higher incidence of influenza. Activities that should be pursued, or considered, and will ultimately enhance the health system’s ability to handle an influenza pandemic are as follows:

Surveillance

1. Routine collection of morbidity data from health care providers, including military providers.
2. Weekly summary of syndromic surveillance data from the GMHA-Emergency Department (ED) Patient Log Book.
3. Routine collection of animal morbidity and mortality data by Territorial Veterinarian.
4. Routine inspection by CQA at ports of entry (GIAA and Port Authority of Guam).

Vaccine Delivery

1. Maintain a system for distribution of vaccines through the DPHSS Immunization Program.
2. Develop a strategic plan through the DPHSS Immunization Program, Community Health Centers (CHC - Northern Region Community Health Center (NRCHC) and Southern Region Community Health Center (SRCHC), and Vaccines for Children (VFC) Providers for management of vaccine delivery and administration during an influenza pandemic.
3. Develop a plan for prioritized administration of influenza vaccine in the event of inadequate supplies through the DPHSS Immunization Program.
4. Identify existing vaccine storage capability through the DPHSS Immunization Program and CHCs.
5. Identify partners, such as CHCs and GMHA, which will assist with short-term emergency storage needs.
6. Identify partners in the community that can assist with mass immunizations.
7. Promote increased influenza and pneumococcal vaccine coverage levels in traditional high-risk groups through local associations with assistance from DPHSS Immunization Program and Health Education.
8. Encourage the GMS and other physicians and healthcare professionals, associations and organizations to promote increased influenza and pneumococcal vaccine coverage levels in high-risk groups.
9. Ensure that adverse events following vaccination are reported through the Vaccine Adverse Events Reporting System (VAERS).

Laboratory Plan

1. Maintain inventory of laboratory supplies.
2. Maintenance of laboratory equipment.
3. Establish guidelines for collection and transport of human specimens for the laboratory diagnosis of pandemic influenza infection.
4. Establish guidelines to notify physicians of laboratory testing and criteria for submitting specimens.
5. a) Purchase at least 4 kits (25 tests per kit) of influenza A & B.
b) Maintain 1 kit at all times.
6. Establish a list of reference laboratories for the confirmation of H5N1 strain.

Antiviral Agents

1. Keep track of updates in the development, evaluation, production, and availability of antiviral agents in the U.S.
2. Maintain list of vendor sources of antiviral agents.
3. Make planning decisions for acquisition and procurement of antiviral agents.
4. Develop a strategic plan through the DPHSS Central Pharmacy for the management, use and rapid distribution of antiviral drugs, in accordance with CDC guidelines.
5. Identify existing storage capability through the DPHSS Central Pharmacy and CHCs.
6. Establish list of priority populations involved in pandemic response activities and maintenance of critical services and health infrastructure for antiviral prophylaxis.
7. Update and maintain treatment and prophylactic guidelines in the use of antiviral agents as recommended by CDC.

Isolation and Quarantine

1. Review and collate existing laws and regulations pertaining to isolation and quarantine applicable to pandemic influenza response.
2. Monitor current recommendations and collaborate with other partners in reviewing and updating plans for isolation and quarantine measures.
3. Identify resources available to educate the public on proper handwashing, cough and sneeze etiquette, as well as, on appropriate use of masks and other protective measures when in self-quarantine.

Communications and Education

1. Provide educational information on pandemic influenza and the significance of such an event on the island.
2. Establish a means of rapid communication between CHCs and local health providers.
3. Develop templates for news releases in event of pandemic.
4. Maintain an updated list of media representatives.

Emergency Operations

- Maintain a state of preparedness.

B. PHASE 2. (Interpandemic Period. New virus type detected in animals but not in humans)

Surveillance

1. Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Routine collection of animal morbidity and mortality data by Territorial Veterinarian, and laboratory testing of unusual mortalities among reservoir species.
4. Routine inspection by CQA staff at ports of entry (GLAA and Port Authority of Guam).
5. Coordinate with the DPHSS Communications Office to provide education and recommendations to health care facilities, health care providers, and the general public regarding the prevention, detection, and control of influenza.

Vaccine Delivery

- Continue preparedness stage.

Laboratory Plan

1. Local physicians notified of laboratory testing available and criteria for submitting specimens.
2. Laboratory testing for influenza A and B of human patients with symptoms of the flu and history of contact to infected animals.
3. If positive for influenza A or B, specimen will be sent to CDC for pandemic influenza testing.

Antiviral Agents

1. Review options for procurement of antiviral agents.
2. Review current information on the use, effectiveness, safety, and the development of drug resistance of antiviral agents.
3. Initiate order of antiviral agents for stockpile, if available.

Isolation and Quarantine

1. Ensure that DPHSS and all partner agencies including first responders, epi investigators, health care and law enforcement personnel have adequate PPE supplies.
2. Monitor current recommendations and collaborate with other partners in reviewing and updating plans for isolation and quarantine measures.
3. If funds are available, requisition for printing of educational materials, i.e. posters on proper handwashing, and cough and sneeze etiquette.

Communications and Education

1. Prepare public information releases in conjunction with the Office of Epidemiology and Research.
2. Prepare and keep ready a list of potential questions, with available answers.
3. Review and revise, as needed, drafts of public information documents.
4. Meet with media representatives to devise a plan for collaborative dissemination of regular, relevant and timely surveillance data.
5. Post weekly summary data to the DPHSS web site for information dissemination.
6. Review current electronic and telecommunications capabilities for rapidly compiling, transmitting and disseminating data.

Emergency Operations

- Continue preparedness stage.

- C. **PHASE 3.** (Pandemic Alert Period. New influenza strain in a human but no (or rare) human-to-human spread)

Surveillance

1. Routine collection of morbidity data.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Routine collection of animal morbidity and mortality data by Territorial Veterinarian, and laboratory testing of unusual mortalities among reservoir species.
4. Coordinate with CQA and airlines to provide current health information to travelers who visit countries where avian or animal influenza strains that can infect humans (e.g. avian influenza A [H5N1]) with pandemic potential have been reported.
5. Continued coordination with the DPHSS Communications Office, to provide education and recommendations to health care facilities, health care providers, and the general public regarding the prevention, detection, and control of influenza.

Vaccine Delivery

1. Continue preparedness stage.
2. Follow progress in development of effective vaccine for new virus.

Laboratory Plan

1. Laboratory testing for influenza A and B of human patients with symptoms of the flu and history of contact to infected animals.
2. If positive for Flu A, specimen will be sent to CDC for pandemic influenza testing.

Antiviral Agents

1. Continue to assess status of available antiviral agents and strategies for use.

2. Follow-up procurement of antiviral drugs.
3. Develop a tracking system to report and monitor adverse events in persons who will be given antiviral therapies.

Isolation and Quarantine

1. Ensure that DPHSS and all partner agencies including first responders, epi investigators, health care and law enforcement personnel have adequate PPE supplies.
2. Monitor current recommendations and collaborate with other partners in reviewing and updating plans for isolation and quarantine measures.
3. Coordinate with DPHSS Communications Office in educating the public on proper handwashing, cough and sneeze etiquette, and if necessary, on appropriate use of masks and other protective measures such as when in self-quarantine.
4. Identify list of possible sites, facilities, equipment, and other resources that may be used for isolation and quarantine purposes, both at ports of entry and in the community.
5. Identify necessary support services and supplies in the event of activation of isolation and/or quarantine plans.
6. Identify methods and other measures to facilitate and encourage self-quarantine should such become necessary.

Communications and Education

1. Establish contact with media representatives.
2. Communicate to the community the influenza disease potential and local plan of action.
3. Provide updates for the public in conjunction with the surveillance and vaccine delivery functions.

Emergency Operations

1. Continue preparedness stage.
2. Identify and develop communication with agencies required to mobilize in the event of pandemic activity.
3. Review and update Mass Fatality and Psychosocial Response Plans.

D. PHASE 4. (Small cluster(s) with limited human-to-human transmission anywhere)

Surveillance

1. Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Enhanced surveillance by assigning personnel to assist in the daily collection and review of absenteeism data from:
 - a) Schools
 - b) Childcare Centers and Pre-Schools
 - c) Private clinics of their healthcare workers

- d) Government of Guam departments and agencies
- e) Facilities catering to senior population (Senior Citizen Centers, Adult Day Care, St. Dominic's, etc.).
- 4. Inform physicians of procedures and begin laboratory testing for suspect local cases meeting CDC/WHO case definition.
- 5. Continue to coordinate with CQA to enhance surveillance at ports of entry including investigation of illness among travelers returning from affected areas and implementing isolation and quarantine measures as needed.

Vaccine Delivery

- Follow progress in development of effective vaccine for new virus.

Laboratory Plan

1. Continue laboratory testing for local cases meeting CDC/WHO case definition.
2. Review inventory of laboratory supplies and procure as needed.

Antiviral Agents

1. Inventory supply of antiviral drugs and ensure adequate supply.
2. Review and revise, as needed, priority groups and strategies for antiviral drug use.
3. Monitor current information on antiviral resistance of the pandemic strain.
4. Maintain updates of treatment guidelines as recommended by CDC.

Isolation and Quarantine

1. Prepare to activate isolation plans.
2. Prepare to activate quarantine plans.
3. Continue to coordinate with DPHSS Communications Office in educating the public on proper handwashing, cough and sneeze etiquette, and if necessary, on appropriate use of masks and other protective measures such as when in self-quarantine.
4. Coordinate with CQA to ensure isolation and quarantine procedures are in place at ports of entry.
5. Coordinate through GPD and OCD to ensure potential necessary security and enforcement.

Communications and Education

1. Frequently update the situation to the JIC with guidance and specification of actions as well as information to public.
2. Report collected data to all participating facilities and post information on the DPHSS website, and DPHSS health care listserv.
3. In coordination with the DPHSS Communications Office, the issuance of general travel advisories (i.e., posters at airport, public service announcements, and press releases) to individuals traveling to affected destinations will be initiated.

Emergency Operations

1. Continue preparedness stage.
2. Continue Plan updates.

E. PHASE 5(A). (Larger cluster(s) of human-to-human transmission but still localized to a single country/region without direct flights to Guam)

Surveillance

1. Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Continue enhanced surveillance through the daily collection and review of absenteeism data from:
 - a) Schools
 - b) Childcare Centers and Pre-Schools
 - c) Private clinics of their healthcare workers
 - d) Government of Guam departments and agencies
 - e) Facilities catering to senior population (Senior Citizen Centers, Adult Day Care, St. Dominic's, etc.).
4. Continue to inform physicians of procedures and continue laboratory testing for suspect local cases meeting CDC/WHO case definition.
5. Continue enhanced surveillance at ports of entry in coordination with CQA (same as Phase 4).

Vaccine Delivery

1. Prepare DPHSS Immunization Program for quick distribution of the vaccine, once available.
2. Determine other possible community vaccine distribution sites.

Laboratory Plan

1. Continue laboratory testing for local cases meeting CDC/WHO case definition.
2. Review inventory of laboratory supplies and procure as needed.

Antiviral Agents

1. Prepare DPHSS Central Pharmacy for rapid distribution of antiviral drugs, once available.
2. Maintain and ensure adequate supply of antiviral drugs.
3. Maintain registry of individuals in priority populations receiving antiviral drugs.
4. Monitor adverse events in persons receiving antiviral drugs.

Isolation and Quarantine

1. Continue to prepare to activate isolation plans.
2. Continue to prepare to activate quarantine plans.
3. Continue to coordinate with DPHSS Communications Office in educating the public on proper handwashing, cough and sneeze etiquette, and if necessary, on appropriate use of masks and other protective measures such as when in self-quarantine.

4. Continue to coordinate with CQA to ensure isolation and quarantine procedures are in place at ports of entry.
5. Continue to coordinate through GPD and OCD to ensure potential necessary security and enforcement.

Communications and Education

1. Coordinate communications with JIC once EOC opens.
2. Provide frequent updates of situation to JIC, as well as information to public, with guidance and specification of actions.
3. Hold daily news conferences.
4. Continue the issuance of general travel advisories (include FAQs) to individuals traveling to affected destinations.

Emergency Operations

1. Continue preparedness stage.
2. Begin identifying response personnel, equipment, and supplies.
3. In coordination with DPHSS Communications Office, develop contingency plans to provide medical care information for people sick at home.
4. In coordination with the OCD, develop contingency plans to maintain other essential community services.

- F. PHASE 5(B).** (Larger cluster(s) of human-to-human transmission but still localized to a single country/region with direct flights to Guam)

Surveillance

- Immediately enter “WHO Phase 6(A)”.

Vaccine Delivery

1. Prepare DPHSS Immunization Program for quick distribution of the vaccine, once available.
2. Determine other possible community vaccine distribution sites.

Laboratory Plan

1. Continue laboratory testing for local cases meeting CDC/WHO case definition.
2. Review inventory of laboratory supplies and procure as needed.

Antiviral Agents

1. Continue to distribute antiviral drugs to priority groups.
2. Review inventory of antiviral drug supply and procure as needed.
3. Maintain registry of individuals in priority populations receiving antiviral drugs.
4. Monitor adverse events in persons receiving antiviral drugs.

Isolation and Quarantine

1. Activate plans and support for isolation according to CDC/WHO recommendations and as necessary to limit spread of infection from ill individuals.
2. Activate plans and support for quarantine according to CDC/WHO recommendations and as necessary to limit potential transmission from exposed healthy individuals.
3. Continue to coordinate with CQA to ensure isolation and quarantine procedures are in place at ports of entry.
4. Continue to coordinate through GPD and OCD to ensure potential necessary security and enforcement.

Communications and Education

1. Continue to provide frequent updates of situation to JIC, as well as information to public, with guidance and specification of actions.
2. Hold daily news conferences.

Emergency Operations

- Alert DPHSS Director of potential event.

- G. PHASE 6(A).** (Pandemic Period. Increased and sustained human-to-human transmission in multiple countries/regions near Guam-Philippines, Hawaii, Indonesia, Japan, or Taiwan) but not Guam.

Surveillance

1. Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Office of Vital Statistics begins to report influenza deaths.
4. Continue enhanced surveillance through the daily collection and review of absenteeism data from:
 - a) Schools
 - b) Childcare Centers and Pre-Schools
 - c) Private clinics of their healthcare workers
 - d) Government of Guam departments and agencies
 - e) Facilities catering to senior population (Senior Citizen Centers, Adult Day Care, St. Dominic's, etc.)
5. Continue to inform physicians of procedures and continue laboratory testing for suspect local cases meeting CDC/WHO case definition.
6. In coordination with CQA, initiate airport surveillance for fevers, apparent illness (transported to hospital), and distribute "yellow arrival advisories" (based on SARS advisory) to passengers on flights from affected countries with direct flights to Guam.

Vaccine Delivery

1. Begin distribution of pandemic vaccine, if available, and immunization of target groups.
2. Deliver vaccine to CHCs, VFC Providers and other community sites or have them pick-up vaccine at DPHSS Immunization Program.
3. Begin active coordination through the DPHSS Immunization Program and CHCs with local partners to establish massive immunization efforts directed at high priority target groups.

Laboratory Plan

1. Continue laboratory testing for local cases meeting CDC/WHO case definition.
2. Review inventory of laboratory supplies and procure as needed.

Antiviral Agents

- Continue activities in 5(B).

Isolation and Quarantine

- Continue activities in 5(B).

Communications and Education

1. Continue to provide frequent updates of situation to JIC, as well as information to public, with guidance and specification of actions.
2. Hold daily news conferences.
3. Continue the issuance of travel advisories, and seek recommendation for the Governor's endorsement to include travel restrictions to affected destinations and the institution of "Fit for Travel", or equivalent, policy by the airlines.

Emergency Operations

1. Alert DPHSS Director of potential event.
2. Plan for activation of the EOC for those Emergency Support Functions (ESFs) needed for pandemic response.
3. Monitor actions of partners within DPHSS.
4. Prepare for activation of the Psychosocial Response and Mass Fatality Plans.

H. PHASE 6(B). (Pandemic reaches Guam)

Surveillance

1. Routine collection of morbidity data from health care providers.
2. Daily summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Office of Vital Statistics continues to report influenza deaths.
4. Continue enhanced surveillance through the daily collection and review of absenteeism data from:
 - a) Schools
 - b) Childcare Centers and Pre-Schools

- c) Private clinics of their healthcare workers
- d) Government of Guam departments and agencies
- e) Facilities catering to senior population (Senior Citizen Centers, Adult Day Care, St. Dominic's, etc.)
- 5. Investigate initial cases and outbreaks and implement interventions to decrease spread of disease.
- 6. Most lab testing discontinued when local transmission is confirmed.
- 7. Initiate "crowd avoidance" advisories and discourage gatherings with possible closure of schools, etc. Trigger points: ≥ 2 standard deviations in GMHA-ED acute respiratory disease (ARD) census, and absenteeism data.
- 8. In coordination with the DPHSS Communications Office and JIC, issuance of advisory on voluntary home isolation of sick persons and encouraging employers/supervisors to send ill employees home.
- 9. In coordination with CQA, continue intensified joint airport surveillance for fevers, apparent illness (transported to hospital), and distribution of "yellow arrival advisories".
- 10. Identify risk factors for infection and adverse health outcomes.
- 11. Assess effectiveness of public health measures and outbreak control strategies.

Vaccine Delivery

- 1. Continue to distribute (DPHSS Immunization Program) and control use of vaccines.
- 2. Modify distribution system (DPHSS Immunization Program) as needed to ensure optimal coverage.

Laboratory Plan

- 1. Local physicians notified of laboratory testing available, criteria for submitting specimens may be altered to avoid laboratory overload.
- 2. Most testing discontinued when local transmission is confirmed.

Antiviral Agents

- 1. Monitor antiviral drug distribution and adverse events.
- 2. Assess availability of antiviral drug stockpile and request for replenishment.

Isolation and Quarantine

- 1. Activate plans and support for isolation according to CDC/WHO recommendations and as necessary to limit spread of infection from ill individuals.
- 2. Activate plans and support for quarantine according to CDC/WHO recommendations and as necessary to limit potential transmission from exposed healthy individuals.
- 3. Continue to coordinate with CQA to ensure isolation and quarantine procedures are in place at ports of entry.
- 4. In coordination with the DPHSS Communications Office and JIC, issuance of advisory on voluntary home isolation of sick persons and encouraging employers/supervisors to send ill employees home.

5. Activate community-based control measures as needed.
6. Continue to coordinate through GPD and OCD to ensure potential necessary security and enforcement.

Communications and Education

1. Continue to provide frequent updates of situation to JIC, as well as information to public, with guidance and specification of actions.
2. Hold daily news conferences.
3. Continue travel advisories (including recommended travel restrictions and the institution of “Fit for Travel”, or equivalent, policy).

Emergency Operations

1. Response activities initiated.
2. Assume responsibilities at the EOC as the Operations Section Chief for direction and implementation of all response to the event.
3. Activate the Psychosocial and Mass Fatality Plans.

- I. PHASE 6(C).** (End of First Wave. Activity in initially affected regions/countries stopped; cases still occurring elsewhere and on Guam)

Surveillance

1. Continue routine and enhanced collection of morbidity data from health care providers.
2. Daily summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Office of Vital Statistics continues to report influenza deaths.
4. Review results of laboratory testing, and change criteria for submitting specimens, if advisable.
5. Continuance of “crowd avoidance” advisories.
6. Continuance of advisories for voluntary home isolation of sick persons.
7. Continue joint airport surveillance for fevers, apparent illness (transported to hospital) and distribution of “yellow arrival advisories”. Continue travel advisories.
8. Continue to assess effectiveness of public health measures and outbreak control strategies.

Vaccine Delivery

1. Continue distribution (DPHSS Immunization Program) and control use of vaccines.
2. Modify distribution system (DPHSS Immunization Program) as needed to ensure optimal coverage.
3. Assess vaccine coverage, effectiveness of targeting to priority groups, and efficiency of distribution and administration; determine number of persons who remain unprotected.
4. Monitor continued administration of vaccine to persons not previously protected.

Laboratory Plan

- Review results of laboratory testing; change criteria for submitting specimens if necessary.

Antiviral Agents

- Assess antiviral drug effectiveness and safety.

Isolation and Quarantine

1. Continue to activate plans and support for isolation according to CDC/WHO recommendations and as necessary to limit spread of infection from ill individuals.
2. Continue to activate plans and support for quarantine according to CDC/WHO recommendations and as necessary to limit potential transmission from exposed healthy individuals.
3. Continue to coordinate with CQA to ensure isolation and quarantine procedures are in place at ports of entry.
4. In coordination with DPHSS Communications Office and JIC, continuance of issuance of advisory on voluntary home isolation of sick persons and encouraging employers/supervisors to send ill employees home.
5. Continue to activate community-based control measures as needed.
6. Continue to coordinate through GPD and OCD to ensure potential necessary security and enforcement.

Communications and Education

1. Continue to provide frequent updates of situation to JIC, as well as information to the public, with guidance and specification of actions.
2. Hold daily news conferences.

Emergency Operations

1. Continue response activities.
2. Maintain EOC operations.

- J. PHASE 6(D).** (End of First Wave. Activity in initially affected regions/countries stopped; cases much decreased or absent on Guam based on local surveillance data)

Surveillance

1. Resume Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Office of Vital Statistics continues to report influenza deaths.
4. Daily collection and review of absenteeism data continues.
5. Discontinue routine laboratory testing; only test specimens from patients with appropriate travel history, new syndrome, etc.

6. Continuance of advisories for voluntary home isolation of sick persons.
7. Discontinue joint airport surveillance for fevers and apparent illness should be transported to hospital; continue to pass out “yellow arrival advisories” to passengers arriving from affected countries.
8. Continue to assess and estimate overall pandemic influenza impact including morbidity and mortality.
9. Continue to enhance surveillance to detect further pandemic waves.

Vaccine Delivery

1. Continue to distribution (DPHSS Immunization Program) and control use of vaccines.
2. Modify distribution system (DPHSS Immunization Program) as needed to ensure optimal coverage.
3. Monitor continued administration of vaccine to persons not previously protected.

Laboratory Plan

- Discontinue routine laboratory testing, only test specimens from patients with appropriate travel history, new syndrome, etc.

Antiviral Agents

1. Evaluate needs for antiviral drug use.
2. Continue to monitor adverse events and report to CDC, if any.

Isolation and Quarantine

1. Continue to activate plans and supports for isolation according to CDC/WHO recommendations and as necessary to limit spread of infection from ill individuals.
2. Continue to activate plans and supports for quarantine according to CDC/WHO recommendations and as necessary to limit potential transmission from exposed healthy individuals.
3. Continuance of advisories for voluntary home isolation of sick persons.
4. Continue to coordinate through GPD and OCD to ensure potential necessary security and enforcement.

Communications and Education

1. Continue to provide frequent updates of situation to JIC, as well as information to public, with guidance and specification of actions.
2. Modify travel advisories/restrictions based on countries of lower flu incidence.
3. Hold daily news conferences.

Emergency Operations

1. Continue response activities, but gradually return to normal operational levels.
2. Maintain EOC operations but transition Operations Section Chief responsibilities back to the OCD.

K. PHASE 6(E). (Second Wave. Second outbreak in a region, 3-9 months after first wave)

Surveillance

- Repeat Phases 4-6 as appropriate.

Vaccine Delivery

1. Continue to distribute (DPHSS Immunization Program) and control use of vaccines.
2. Modify distribution system (DPHSS Immunization Program) as needed to ensure optimal coverage.

Laboratory Plan

- Repeat Phases 4-6 as appropriate.

Antiviral Agents

1. Continue to evaluate needs for antiviral drug use.
2. Continue to monitor adverse events and report to CDC, if any.

Isolation and Quarantine

- Repeat Phases 4-6 as appropriate.

Communications and Education

1. Continue to provide frequent updates of situation to JIC, as well as information to public, with guidance and specification of actions.
2. Hold daily news conferences.

Emergency Operations

- Repeat pandemic phases 4-6 activities as appropriate.

L. Postpandemic Period. (Pandemic transmission over, likely 2-3 years after onset; immunity to new virus type is widespread in the population)

Surveillance

- Revert to interpandemic surveillance and control activities.

Vaccine Delivery

1. Assess supply status and any imminent needs.
2. Prepare report assessing vaccine delivery response.

Laboratory Plan

- Revert to interpandemic surveillance and control activities.

Antiviral Agents

1. Assess antiviral effectiveness and safety.
2. Prepare report of antiviral drug use and efficacy.

Isolation and Quarantine

- Assess and update isolation and quarantine plans, as deemed necessary.

Communications and Education

1. Continue to provide frequent updates of situation to JIC, as well as information to public, with guidance and specification of actions.
2. Hold daily news conferences.

Emergency Operations

1. Return to normal operation.
2. Transition Operations Section Chief responsibility back to the OCD.
3. Transition psychosocial response to DMHSA.
4. Transition fatality response to OCME.

X. STATUTORY AUTHORITY

Statute:	Chapter 68. Title 42
Agency:	Federal Government
Authority:	<i>provides authority to declare and respond to emergencies and provide assistance to protect public health; implemented by the Federal Emergency Management Agency</i>
Statute:	Section 361(b) of the Public Health Service Act (42 U.S.C. 264 (b))
Agency:	Federal Government
Authority:	<i>control of communicable diseases as determined by the Secretary of Health, in consultation with the Surgeon General</i>
Statute:	10 GCA, Chapter 19, <i>Emergency Health Powers Act</i> , Article 4, Section 19401
Agency:	Governor
Authority:	<i>allows Governor to declare a state of Public Health Emergency</i>
Statute:	10 GCA, Chapter 3, Article 3, <i>Disease Control</i> , and Chapter 19, <i>Emergency Health Powers Act</i> , Article 3, Section 19301
Agency:	Department of Public Health and Social Services
Authority:	<i>authorizes the department to administer and enforce laws and rules relating to control of communicable diseases</i>
Statute:	10 GCA, Chapter 19, <i>Emergency Health Powers Act</i> , Article 5

Agency:	Department of Public Health and Social Services
Authority:	<i>special powers during a State of Public Health Emergency: Management of Property</i>
Statute:	10 GCA, Chapter 19, <i>Emergency Health Powers Act</i> , Article 6
Agency:	Department of Public Health and Social Services
Authority:	<i>special powers during a State of Public Health Emergency: protection of persons, including isolation and quarantine</i>
Statute:	10 GCA, Chapter 19, <i>Emergency Health Powers Act</i> , Article 7
Agency:	Department of Public Health and Social Services
Authority:	<i>public information regarding Public Health Emergency</i>

XI. COMPONENTS

A. SURVEILLANCE

The DPHSS Director is responsible for the overall direction and control of health-related personnel and resources committed to the control of an influenza pandemic, including surveillance and related activities.

Guam Surveillance - Routine surveillance activities in Guam are also part of the national monitoring system (items 1 and 2 below). Current on-going activities include:

1. A sentinel syndromic surveillance network system that reports daily and weekly ARD and total number of patient ER visits to the GMHA.
2. Voluntary reporting through the DPHSS of ARD outbreaks in institutional settings, such as long-term care facilities, schools and prisons. As part of the regional laboratory network, DPHSS central lab has the capacity to perform rapid testing for Influenza A and B.

National Surveillance - In the US, national influenza surveillance is coordinated by the CDC, with state and county health departments assuming responsibility for virologic, mortality and morbidity components. These activities consist of:

1. WHO Collaborating Laboratory Surveillance – approximately 70 labs report the number and type of influenza viruses isolated each week, as well as submits representative and unusual viral specimens to CDC for antigenic analysis.
2. State and Territorial Epidemiologist Report – the level of influenza in their jurisdiction each week as “no activity,” “sporadic,” “regional,” or “widespread” is reported based on incoming information from the field.
3. 121 Cities Influenza and Pneumonia Mortality System – Vital Statistics Offices of 121 US cities report on a weekly basis the percentage of total deaths caused by influenza and pneumonia.
4. Sentinel Physicians ILI Surveillance System – a voluntary national network of physicians and clinics that report number of patients presenting with ILI and total number of patient visits by age group each week.

International Surveillance - These activities are coordinated at the CDC by the WHO Collaborating Center for Influenza Reference and Research. WHO's global influenza network includes approximately 110 national laboratories in over 80 countries and four international reference centers. The CDC maintains frequent communication with this network concerning the numbers and types/subtypes of influenza viruses isolated, including the extent of influenza-like disease occurring at the time of virus isolation.

Phase 1. Interpandemic Period. No indication of any new virus types.

Surveillance Activities:

1. Routine collection of morbidity data from health care providers, including military providers.
2. Routine laboratory surveillance of influenza like illness (ILI) to determine circulating virus types.
3. Weekly summary of syndromic surveillance data from the GMHA-ED Patient Log Book.
4. Routine collection of animal morbidity and mortality data by Territorial Veterinarian.

Phase 2. Interpandemic Period. New virus type detected in animals but not in humans.

Surveillance Activities:

1. Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Routine collection of animal morbidity and mortality data by Territorial Veterinarian, and laboratory testing of unusual mortalities among reservoir species.
4. Coordinate with the DPHSS Communications Office to provide education and recommendations to health care facilities, health care providers, and the general public regarding the prevention, detection, and control of influenza.
5. Routine laboratory surveillance of ILI.

Phase 3. Pandemic Alert Period. New influenza strain in a human but no (or rare) human-to-human spread.

Surveillance Activities:

1. Routine collection of morbidity data.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Routine collection of animal morbidity and mortality data by Territorial Veterinarian, and laboratory testing of unusual mortalities among reservoir species.
4. Continued coordination with the DPHSS Communications Office, to provide education and recommendations to healthcare facilities, health care providers, and the general public regarding the prevention, detection, and control of influenza.

5. Routine laboratory surveillance of ILI.

Phase 4. Small cluster(s) with limited human-to-human transmission anywhere.

Surveillance Activities:

1. Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Enhanced surveillance by assigning personnel to assist in the daily collection and review of absenteeism data from:
 - a) Schools
 - b) Childcare Centers and Pre-Schools
 - c) Private clinics of their healthcare workers
 - d) Government of Guam departments and agencies
 - e) Facilities catering to senior population (Senior Citizen Centers, Adult Day Care, St. Dominic's, etc.).
4. Routine laboratory surveillance of ILI.
5. Inform physicians of procedures and begin laboratory testing for suspect local cases meeting CDC/WHO case definition.

Phase 5(A). Larger cluster(s) of human-to-human transmission but still localized to a single country/region without direct flights to Guam.

Surveillance Activities:

1. Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Continue enhanced surveillance through the daily collection and review of absenteeism data from:
 - a) Schools
 - b) Childcare Centers and Pre-Schools
 - c) Private clinics of their healthcare workers
 - d) Government of Guam departments and agencies
 - e) Facilities catering to senior population (Senior Citizen Centers, Adult Day Care, St. Dominic's, etc.).
4. Continue to inform physicians of procedures and continue laboratory testing for suspect local cases meeting CDC/WHO case definition.
5. Intensified laboratory surveillance of ILI, particularly those with a history of travel.

Phase 5(B). Larger cluster(s) of human-to-human transmission but still localized to a single country with direct flights to Guam.

Surveillance Activity:

- Immediately enter "WHO Phase 6(A)"

Phase 6(A). Pandemic period. Increased and sustained human-to-human transmission in multiple countries/regions near Guam (Philippines, Hawaii,

Indonesia, Japan, or Taiwan) but not Guam.

Surveillance Activities:

1. Routine collection of morbidity data from health care providers.
 2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
 3. Office of Vital Statistics begins to report influenza or ILI deaths.
 4. Continue enhanced surveillance through the daily collection and review of absenteeism data from:
 - a) Schools
 - b) Childcare Centers and Pre-Schools
 - c) Private clinics of their healthcare workers
 - d) Government of Guam departments and agencies
 - e) Facilities catering to senior population (Senior Citizen Centers, Adult Day Care, St. Dominic's, etc.)
 5. Continue to inform physicians of procedures and continue laboratory testing for suspect local cases meeting CDC/WHO case definition.
 6. In coordination with CQA, initiate airport surveillance for fevers, apparent illness (transported to GMHA), and distribute "yellow arrival advisories" (based on SARS advisory) to passengers on flights from affected countries with direct flights to Guam.
 7. Using WHO/CDC definition of the pandemic illness, make it a reportable disease.
- Phase 6(B). Pandemic reaches Guam.**

Surveillance Activities:

1. Enhanced collection of morbidity data from health care providers.
2. Daily summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Office of Vital Statistics continues to report influenza deaths (useful for recording impact of pandemic).
4. Continue the daily collection and review of absenteeism data from:
 - a) Schools
 - b) Childcare Centers and Pre-Schools
 - c) Private clinics of their healthcare workers
 - d) Government of Guam departments and agencies
 - e) Facilities catering to senior population (Senior Citizen Centers, Adult Day Care, St. Dominic's, etc.)
5. Most lab testing discontinued when local transmission is confirmed (for treatment guidance only).
6. Initiate "crowd avoidance" advisories and discourage gatherings with possible closure of schools, etc. Trigger points: ≥ 2 standard deviations in GMHA-ED ARD census, and absenteeism data.
7. In coordination with CQA, continue intensified joint airport surveillance for fevers, apparent illness (transported to GMHA), and distribution of "yellow arrival advisories".
8. Continue travel advisories (including recommended travel restrictions and the institution of "Fit for Travel", or equivalent, policy).

Phase 6(C). End of First Wave. Activity in initially affected regions/countries stopped; cases still occurring elsewhere and on Guam.

Surveillance Activities:

1. Enhanced collection of morbidity data from health care providers.
2. Daily summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Office of Vital Statistics continues to report influenza deaths.
4. Review results of laboratory testing, and change criteria for submitting specimens, if advisable.
5. Continuance of “crowd avoidance” advisories.
6. Continuance of advisories for voluntary home isolation of sick persons.
7. Continue joint airport surveillance for fevers, apparent illness (transported to GMHA) and distribution of “yellow arrival advisories”. Continue travel advisories.
8. Laboratory testing of ILI for treatment guidance only.

Phase 6(D). End of First Wave. Activity in initially affected regions/countries stopped; cases much decreased or absent on Guam based on local surveillance data.

Surveillance Activities:

1. Routine collection of morbidity data from health care providers.
2. Weekly summary of syndromic surveillance data from GMHA-ED Patient Log Book.
3. Office of Vital Statistics continues to report influenza deaths.
4. Discontinue routine laboratory testing; only test specimens from patients with appropriate travel history, new syndrome, etc.
5. Discontinue “crowd avoidance” advisories, permit opening of schools, public gatherings, etc.
6. Discontinue joint airport surveillance for fevers and apparent illness should be transported to hospital; continue to pass out “yellow arrival advisories” to passengers arriving from affected countries.
7. Modify travel advisories/restrictions based on countries of lower flu incidence.

Phase 6(E). Second Wave. Second outbreak in a region, 3-9 months after first wave.

Surveillance Activity:

- Repeat Phases 4 – 6 as appropriate

Post Pandemic Period. Pandemic transmission over, likely 2-3 years after onset; immunity to new virus type is widespread in the population.

Surveillance Activity:

- Revert to interpandemic surveillance and control activities.

B. VACCINE DELIVERY

Introduction

The annual distribution and administration of vaccine for each winter's predicted strain of influenza is an "institutionalized" process involving both the public and private sectors. For this annual vaccination effort, the vaccine type is predicted by the CDC approximately 18 months before the anticipated influenza season. Two U.S. and one English manufacturer produce approximately 70 to 80 million doses over a six to eight month production period, with the supply ready for distribution during October and through the influenza immunization period of October through February.

Except for some children under 8 years of age, effective immunization is generally achieved with a single dose of vaccine. Approximately 90 percent of the vaccine is administered by the private sector and is directed toward high-risk individuals as defined by the Advisory Committee on Immunization Practice (ACIP).

The next influenza pandemic will pose a number of threats to this existing vaccine delivery and immunization process. Critical factors that will affect the current system of vaccine distribution include the following:

1. The time period for the identification, production, and distribution of vaccine to prevent influenza will be greatly shortened, placing considerable burdens on all existing processes and procedures.
2. Because time frames for planned production, distribution, and administration may be shortened, significant shortages and delays in vaccine availability will likely arise.
3. In all likelihood, the target population for vaccination coverage will be extended well beyond the typical high-risk populations, with a potential goal of vaccinating the entire population.
4. The influenza virus encountered during a pandemic will represent a new strain, with new hemagglutinin (HA) and/or neuraminidase (NA) antigens. Thus, to maximize vaccine efficacy, a second dose of vaccine given approximately 30 days after the initial administration may be necessary.

As a result of these concerns and considerations, local public health providers must develop a strategic plan for the management of vaccine delivery and administration during a pandemic. That plan must ensure that the distribution and allocation of available vaccine is completed in an organized and coordinated manner in order to maximize the public's health and safety.

The resources of local and the federal governments are utilized in sequential order to ensure a rapid and efficient response. Each level of government, upon requesting assistance from the next level of government, must ensure that local requirements have exceeded local resources before requesting assistance from the next higher level.

Assumptions

When considering the challenges that must be addressed to ensure a smooth and efficient distribution of available vaccine, Guam has accepted CDC guidance and has based its plan for making vaccine available on the following assumptions:

1. Supply

Based on guidelines issued by the CDC, it is understood that in the event of a pandemic, the total vaccine supply will be under the control of the federal government. This suggests that Guam will be assigned an "allotment" of vaccine and that all distribution efforts will be based on that allocation.

2. Distribution Activity

Actual distribution activities cannot begin until the CDC, in cooperation with manufacturers, can offer an expected date for delivery of vaccine.

3. Shortages

The vaccine allotment may not be adequate to meet Guam's entire need for vaccine. That is, vaccine shortages are expected. These shortages may be so extensive that the vaccine supply would not be adequate to protect all individuals even identified as having a critical role in managing the crisis.

4. Costs

Guam will need to absorb the "up-front" costs associated with the purchase, delivery, and administration of vaccine. The CDC anticipates that national resources may be able to offset costs, although the exact level and nature of such resources is not yet determined. Federal resource assistance may include such items as federal contracts for the purchase of vaccine, grants, or reimbursement activities to subsidize the costs associated with vaccine distribution. However, at a minimum, the territory should expect to absorb the costs associated with the redirection of personnel and should expect to use other financial resources to meet immunization objectives.

5. Liability

Any activity related to liability issues and concerns that may be associated with instances of adverse reactions to vaccine administration will be the responsibility of the federal government. For inclusion in this federal liability coverage, the medical provider must ensure there is adequate and accurate documentation regarding the vaccine administration process and be able to identify vaccine recipients.

6. Centralized Control

Activity to properly manage the distribution and allocation of available vaccine will begin as soon as is reasonably possible. However, excessively short implementation periods, limited supply, or the emergence of a highly incapacitated infrastructure may require Guam's executive leadership to issue a state of emergency. An Executive Order from the Governor will be needed for the deployment and use of personnel, supplies, equipment, materials, and facilities: this intervention would facilitate access to and use of expanded resources to meet vaccination objectives.

Interpandemic Infrastructure

As a base for disaster planning associated with vaccine delivery issues, Guam intends to rely to a large extent on the strength of its current distribution system, which is based in the DPHSS Immunization Program. That infrastructure is currently used to efficiently distribute childhood vaccines. This distribution program has the systems,

policies, and procedures, and these processes can be adapted to assist the territory in its pandemic vaccine distribution goals and objectives. Specifically, the current distribution system includes:

1. DPHSS Immunization Program for management of an island wide distribution system.
2. Adequate coolers and back-up power for proper storage of vaccine.
3. Adequate supplies for repackaging vaccine as necessary.
4. Established protocols and lines of communication.
5. An existing communications infrastructure, which includes phone and fax accessibility for the community.
6. An existing computer system for tracking inventory receipt and distribution.
7. Trained professional and support staff, who are capable of preparing vaccine orders.
8. Experience with providing rapid, accurate service with the ability to complete vaccine orders within the same day.

Pandemic Vaccine Supply and Distribution

1. Supply Needs versus Allocation

Guam had 154,805 residents in the year 2000. Guam's estimated population in 2005 is 168,564. If faced with a novel influenza virus, current estimates suggest that Guam could need over 110,000 doses of vaccine for the civilian population (including tourists) and 30,000 for the military population, with adequate lead-time, to fully immunize its population. This number may vary by season due to tourists and other visitors. However, due to anticipated shortages and delays in acquiring vaccine, the actual distribution will, in most likelihood, be substantially less than the amount needed for full population immunization.

2. Ordering and Distribution

Assuming that the need will exceed vaccine availability, Guam will submit its order to the CDC for the maximum allocation of vaccine. The CDC will assume responsibility for ensuring that the manufacturer ships the vaccine to DPHSS Immunization Program. The DPHSS Immunization Program will be responsible for ordering the vaccines and distributing them to other sites.

The DPHSS (Immunization Program, Central Pharmacy and Laboratory, CHCs and BFHNS) estimate they would be able to store 104,000 (10 dose vial) doses of influenza if other vaccines and biologicals currently in storage were temporarily relocated.

DPHSS Activities

The local vaccine storage site will be based at the DPHSS central facility in Mangilao. The DPHSS Immunization Program has the experience and resources to properly store and secure vaccine as well as track its receipt and redistribution (Appendix J). DPHSS will be required to:

1. Educate the local community in advance of a pandemic.
2. Identify the maximum amount of vaccine that can be accepted under emergency conditions for short-term storage.

3. Augment standard procedures to assure the biological safety and physical security of the vaccine within the health department.
4. Identify the community partners who will work with the health department to administer vaccine to targeted populations.
5. Adhere to procedures to accurately document the receipt and re-distribution of vaccine. This documentation should, at a minimum, indicate the amount and date the vaccine is received, as well as the amount, date, and method of redistribution to the identified community partner.
6. Modify as necessary the system for notifying community partners. Notice will include timing for the local availability of vaccine for delivery.
7. Assure that the redistribution of vaccine will occur prior to receiving the next capacity shipment so that no vaccine is lost because of storage shortages.
8. The DPHSS Immunization Program will continue shipments of vaccine to designated distribution sites. Shipments may occur weekly to monthly depending on vaccine supply and usage. If additional staff is needed to manage excessively large shipments or to continue vaccine management and shipping activity for extended hours or over non-traditional workdays, staff from DPHSS will be detailed. These staff, regardless of primary duties and authority, will be responsive to Immunization Program staff responsible for vaccine distribution and management. Other DPHSS staff participating in the Guam Strategic National Stockpile Program will be activated to assist with operations as well.

a) Potential Vaccine Distribution Sites (Appendix K)

b) Potential Partners for Vaccine Administration Only

Depending upon the extent of the event and the need for vaccinators, volunteers will be called up in a tiered manner, first calling upon licensed health care professionals, and then going down the list, as need dictates (Appendix L).

The recruitment of community partners will depend on the resources available to the community. In addition, the actual coordination with community partners may be further refined based on the populations that are targeted for actual disease management during a pandemic.

In working with community partners that will administer vaccine during a pandemic, DPHSS must ensure that these partners understand their roles and the expectations associated with this partnership. Specifically, the community partner must be prepared to accept and store their allotment of vaccine and must ensure that vaccine administration is properly documented for accountability purposes, and in the event that reimbursement becomes available. Finally, the personnel resources devoted by community partners should be considered a public health contribution to the community, rather than a cost-reimbursable or profit-making activity.

During an influenza pandemic, clinics and organizations that believe they are not receiving their fair share of vaccine will be directed to contact the DPHSS Bureau of Communicable Disease Control's Immunization Program. This

office will assume responsibility for managing calls and requests from the community to consider amendments to the allocation and distribution sites.

c) Potential Mass Vaccination Clinic Sites

DPHSS is responsible for planning and implementing Mass Vaccination Clinic Sites to administer vaccine to large numbers of people in a short period of time (Appendix M, N and O). The following facilities are potential sites for the Mass Vaccination Clinics:

- i. Northern Region
 1. Yigo Gymnasium
 2. Dededo Sports Complex
- ii. Central Region
 1. University of Guam Field House
- iii. Southern Region
 1. Inarajan Middle School Gymnasium/Cafeteria
 2. Southern High School Gymnasium/Cafeteria

d) Priority Groups for Vaccination during the Pandemic

i. Establishing Target Recipient Groups

In view of the likely vaccine shortage, the vaccine will be prioritized based on national recommendations and refined to meet the specific needs of Guam (Appendix P).

ii. General Considerations

Both the public and private sector will be mobilized to administer whatever vaccine is available. The actual organization of the vaccination program, in both the public and private sectors, will have to be customized for the community and target group and will depend on the extent and availability of the available infrastructure and resources. Success of the pandemic vaccination program will be determined in large part by public confidence in the benefits of influenza vaccination and the strength of the plan.

C. LABORATORY PLAN

Phase 1 and 2: Interpandemic Phase Actions.

Laboratory Activities:

1. Maintain inventory of laboratory supplies
2. Maintenance of laboratory equipment.
3. Establish guidelines for collection and transport of human specimens for the laboratory diagnosis of pandemic influenza infection.
4. Establish guidelines to notify physicians of laboratory testing and criteria for submitting specimens.
5. a) Purchase at least 4 kits (25 tests per kit) of influenza A & B.
b) Maintain 1 kit at all times.
6. Establish a list of reference laboratories for the confirmation of H5N1 strain.

Alexander Klimov, Ph.D
Chief, Strain Surveillance Section
Influenza Branch, Mailstop G-16
DVRD, NCID, CDC
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 639-3591
(404) 639-0080 - Fax

Phase 3: Pandemic Alert Period. New influenza strain in a human, but no (or rare) human-to-human spread.

Laboratory Activities:

1. Local physicians notified of laboratory testing available and criteria for submitting specimens.
2. Laboratory testing for influenza A and B of human patients with symptoms of the flu and history of contact to infected animals.
3. If positive for influenza A or B specimen will be sent to CDC for pandemic influenza testing.

Phase 4: Small cluster(s) with limited human-to-human transmission anywhere.

Laboratory Activities:

1. Continue laboratory testing for local cases meeting CDC/WHO case definition.
2. Review inventory of laboratory supplies and procure as needed.

Phase 5: Larger cluster of human-to-human transmission, but still localized to single country/region without direct flights to Guam.

Laboratory Activities:

1. Continue laboratory testing for local cases meeting CDC/WHO case definition.
2. Review inventory of laboratory supplies and procure as needed.

Phase 6(A): Pandemic period. Increased and sustained human-to-human transmission in multiple countries/regions near Guam (Philippines, China, Indonesia, Japan, Taiwan, Hawaii), but not Guam.

Laboratory Activities:

1. Continue laboratory testing for local cases meeting CDC/WHO case definition.
2. Review inventory of laboratory supplies and procure as needed.

Phase 6(B): Pandemic reaches Guam.

Laboratory Activity:

- Local physicians notified of laboratory testing available, criteria for submitting specimens may be altered to avoid laboratory overload, most testing discontinued when local transmission is confirmed.

Phase 6(C): End of First Wave. Activity in initially affected regions/countries stopped; cases still occurring elsewhere and on Guam.

Laboratory Activity:

- Review results of laboratory testing; change criteria for submitting specimens if necessary.

Phase 6(D): End of First Wave. Activity in initially affected regions/countries stopped; cases much decreased or absent on Guam based on local surveillance data.

Laboratory Activity:

- Discontinue routine laboratory testing, only test specimens from patients with appropriate travel history, new syndrome, etc.

Phase 6(E): Second Wave. Second outbreak in a region, 3-9 months after initial wave.

Laboratory Activity:

- Repeat Phases 4-6 as appropriate.

Post Pandemic Period: Pandemic transmission over, likely 2-3 years after onset; immunity to new virus type is widespread in the population.

Laboratory Activity:

- Revert to interpandemic surveillance and control activities.

D. ANTIVIRAL AGENTS

Introduction

In recent years, new antiviral agents to prevent or treat influenza infections have been developed. Two classes of drugs are available (the M2 inhibitors such as amantadine and rimantadine and the neuraminidase inhibitors such as oseltamivir and zanamivir). These drugs have been licensed for the prevention and treatment of human seasonal influenza in some countries.

However, initial analysis of viruses isolated from the recent human cases of A/H5N1 indicates that many of these viruses currently are resistant to the M2 inhibitors. In addition, only the neuraminidase inhibitors have been shown, in animal laboratory tests, to be effective against influenza virus A/H5N1. At this time, there is extremely little real world clinical experience with use or effectiveness of antiviral drugs against H5N1 viral infections in humans. Among the neuraminidase inhibitors, the only drug

easily deliverable (orally in capsules) is oseltamivir, known in its only commercial form as *Tamiflu*®.

Other antivirals, such as amantadine, have not shown effectiveness against A/H5N1 in laboratory settings, but could potentially have some effectiveness against another new emerging strain.

Prophylaxis

Antiviral drugs used for prophylaxis are given to people who are not infected and who are not ill. The purpose of prophylaxis is to try and prevent the development of severe pandemic disease in people who are potentially exposed to pandemic influenza.

Tamiflu® can be offered to selected staff who are needed by an organization to maintain its essential functions. The current prophylactic regimen is **one tablet of 75mg per day**. The upper limits for safe use of *Tamiflu*® as prophylaxis is unknown. However, it is assumed that based on past pandemics and epidemics that in local areas, the duration of elevated risk of exposure to the pandemic virus in an area would be 6 weeks. Use of antiviral agents for prophylaxis is extremely resource consuming. Therefore, pre-exposure prophylaxis should be limited to maintenance of essential functions of an organization. Since pandemic influenza is an infection transmitted primarily by respiratory droplets, during a pandemic, the risk of infection will be relatively similar for most people except persons such as medical workers, who will be at highest risk because of their frequent contact with many ill persons.

Tamiflu® is licensed for up to six weeks of continuous use for prophylaxis. As an alternative to daily prophylaxis, antiviral agents could be reserved for treatment of persons if fever or other symptoms of infection develop. This approach could stretch the supply of available antiviral agents, but also is more complicated logistically to implement and might be less effective theoretically in preserving maintenance of essential functions. Nonetheless because supplies of antivirals during a pandemic situation are expected to be very limited, in many situations this use of *Tamiflu*® may be the most feasible option.

Treatment

1. Of all persons: In symptomatic patients suspected of having pandemic influenza, *Tamiflu*® can be administered as treatment. Current recommendations for treatment, based on treatment against seasonal influenza, is **two 75mg capsules a day** (total of 150mg per day) for 5 days. There are no data for use for children below the age of 1 year. Oral suspension for children could be administered up to 40kg by and which adult dosage can be used. **For maximum effect, the drug should be started within 48 hours of onset of symptoms.** During a pandemic situation the possibility to test an individual patient for influenza infection will be extremely limited and therefore decisions about whether to treat or not will depend upon clinical findings. Moreover, current recommendations on the amount and duration of treatment may change as more information becomes available about the effectiveness of dosages of antiviral agents against pandemic influenza.

2. Post-exposure treatment: Theoretically if the local supply is considered adequate, then Tamiflu® could be provided to a person who does not have symptoms but who has had close and unprotected contact with another person who is suspected or confirmed to have pandemic influenza. In this situation, it will not be clear if the exposed person is infected. However, giving that person an antiviral agent theoretically could potentially protect the person from infection or reduce the severity and duration of the disease if the person has become infected. The drug would be administered in treatment doses as stated above. The effectiveness or efficiency of this approach in preventing illness is theoretical, however, and has not been demonstrated. Moreover, for most people it will not be known if they were “exposed” to pandemic influenza and **during a widespread pandemic, it will not be feasible to give post-exposure treatment to most non-ill contacts. In most situations, it is expected that most Tamiflu® will be used for treatment of persons with febrile or respiratory illnesses rather than prophylaxis.**

Assumptions

A sufficient quantity of these agents would have to be available to the DPHSS Central Pharmacy in order for any planned effectual use of these medications to take place.

Infrastructure and Distribution

A similar method to that described in the vaccine delivery part of this plan would be used to distribute antiviral medications. Key to any distribution plan in determining where the priorities are for places to distribute the medications would be specifics as to the exact ways the antivirals are recommended for use.

While the primary focus of the plan is on the distribution of vaccine for the prevention of a novel influenza virus, the CDC anticipates that a limited amount of antivirals will be available for the treatment of the disease. Their estimates suggest that nationally, adequate antiviral stock will be available to treat from 500,000 to 3 million persons per month. In addition to the anticipated limited supply, the administration of antivirals as either a prophylaxis or treatment regimen is rigorous, requiring approximately 60 doses per month to prevent illness and approximately 10 doses for therapeutic intervention. Therefore, the DPHSS Central Pharmacy will control distribution and use of any antivirals. The DPHSS and the PIC involved in implementing this plan identify those individuals and groups of individuals who shall be eligible to receive these agents. In general, use of antivirals shall be reserved for the highest priority groups with consideration given to maintaining the integrity of the healthcare community and the leadership and persons responsible for the safety and security of the communities most affected by the novel virus.

General Issues

Other considerations for antivirals include use in areas where there is a relative vaccine shortage and sufficient supplies of antiviral agents are available to ameliorate this until adequate vaccine supplies could become available. Antivirals could also serve to treat health care workers and other critical classes of individuals between vaccine doses. Again, these uses are predicated on adequate supply of antivirals.

Because no assumption can be made of adequate resources in this regard, there is no provision for use of antivirals in a prophylactic way because of the increased consumption of supplies compared to treatment. This will remain so unless more information concerning cost effectiveness shows an alteration in this balance or unless supplies become so very adequate that this higher rate of usage can be entertained with some prospect of efficacy. Even in the scenario of adequate supplies and the ability to provide these agents widely, there is the specter of emergence of viral resistance and the transmission of resistant strains. It cannot be overemphasized that antivirals, no matter how well supplied and distributed, can never be assumed to be a substitute for proper vaccine protection.

E. ISOLATION AND QUARANTINE

Introduction

The containment measures of isolation and quarantine aim to reduce the risk of transmission of pandemic influenza virus by decreasing the probability of contact between infected and uninfected individuals and decreasing the probability that contact will result in infection. These measures can be applied at the individual or community level and can be directed towards persons who are ill and persons who are well. Individual measures include isolation of ill patients (those with symptoms), quarantine and symptom monitoring of well persons who have had contact with ill persons, hand and respiratory hygiene, and use of personal protective equipment such as masks and gloves. Community measures include social distancing such as restricting mass gatherings, closing schools, and limiting domestic and international travel.

Definitions

1. Isolation is the separation of ill persons with contagious disease from those who are healthy and the restriction of their movement or activities to stop the spread of that illness.
 - a) Isolation typically applies to an individual.
 - b) People in isolation may be cared for in hospitals, in their homes, or in designated isolation facility.
2. Quarantine is the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent and therefore may become infectious.
 - a) Applied to an individual or groups in the community and may be implemented in individual homes or designated quarantine facility.
 - b) Its main purpose is to stop the spread of infectious disease.
 - c) Involves identifying what constitutes an exposure and who is considered a *close contact* to determine when a person is to be quarantined.

3. Community-Based Control Measures aim to decrease the risk of disease transmission by limiting social interactions such as cancellation of public events, limiting public transportation, and restriction of movements of segments of the community; and preventing inadvertent exposures in public or common daily experiences such as fever monitoring before entering place of congregation such as schools, use of masks, or community-wide quarantine.

May be used to delay spread of disease and allow more time for development and production of vaccines and antiviral drugs.

Assumptions and Planning Principles

1. At the initial detection of the pandemic virus, vaccine will be unavailable for an undetermined and prolonged length of time.
2. At the same time, there may be a very limited supply of available antiviral drugs, thus, public health measures of isolation, quarantine, and general public health containment may be necessary to slow the spread of pandemic influenza virus.
3. Quarantine involves isolation as well.
4. Several difficulties may be encountered in controlling exposure to pandemic influenza including our current mobile society, short incubation period of the virus, and the period of communicability that begins prior to onset of symptoms.
5. The Government of Guam has the primary responsibility for the implementation of isolation and quarantine measures within the island while Federal law has authority to prevent interstate and international travel and importation.
6. Isolation and quarantine, whether for an individual, a group, or a community, is best implemented on a voluntary basis.
7. During a pandemic, DPHSS in conjunction with CDC will most likely recommend voluntary home quarantine when possible, wherein exposed persons check themselves for fever and report early symptoms to public health staff. This will likely occur when a large portion of the population becomes ill and a shortage of personnel to monitor and enforce mandatory containment measures occurs.
8. Compliance with self-quarantine and home quarantine recommendations provided by DPHSS and the CDC is greater when those in quarantine will be more accessible to receive necessary supplies and healthcare, not discriminatory, and are clear and reasonable.
9. Personal hygiene measures such as handwashing and recommendations for use of PPE such as masks will likely also be included in recommendations to the community to help limit transmission.
10. The legal authority and duty to enforce isolation and quarantine orders is vested to the Director of DPHSS as contained in 10GCA Chapter 3, Article 3, § 3310 and Public Law 26-173 known as the "Island of Guam Emergency Health Powers Act".
11. DPHSS and law enforcement responders involved in enforcement of quarantine orders will be provided appropriate PPE and related training by their respective agencies as recommended by the CDC and WHO.
12. By law, all isolation and quarantine orders must include the length of time for the isolation and quarantine periods; and specify places or areas to or in which they are restricted in their movements.
13. DPHSS Director is responsible for determining and justifying the isolation and quarantine time periods.

Self-Quarantine and General Public Health Containment Measures

A critical aspect to a successful implementation of self-quarantine and public health containment measures is full public support and understanding through focusing on the accuracy and timeliness of communication and collaboration with the general public in the community.

Underlying Principles

1. Ensure consistency in implementation to gain public support and confidence in public health officials and to increase the credibility of the use of quarantine and public health containment measures. It must be facilitated by the proper use of an ICS structure that is compliant with the National Information Systems (NIMS).
2. Ensure a continuous public education and communication at all stages of the pandemic response to help raise public support when initiating measures such as self-quarantine and containment in community activities and movement.

Isolation – Concept of Operations

The primary purpose for isolation is to separate an ill and contagious person from the healthy and well population in the community. Because of this, it is much easier to understand, accept, and implement it than quarantine. Isolation facilities include homes, hospitals, and/or alternate sites in the community such as skilled nursing facility, hotels, or tents.

Authority

1. Pursuant to the provisions of 10GCA Chapter 3, Article 3, §3310, DPHSS Director has authority to impose isolation of any person who has or is reasonably suspected of having any communicable disease or any disease dangerous to the public health.
2. DPHSS Director will have primary authority for implementation of Guam Pandemic Influenza Plan, including recommendations and request for isolation and quarantine, with guidance from the Epidemiologist and the Medical Advisor.
3. As the pandemic threat escalates and in the event that it becomes a civil defense emergency requiring resources outside of the control of DPHSS Director, the Governor, OCD, and GHS will become involved.

Notification and Communication

1. Notification and communication of isolation (and quarantine) requirements will follow existing protocols.
2. DPHSS will reach clinicians through the Office of Epidemiology & Research email system and broadcast fax used for health notifications.
3. Multiple media sources, such as television, radio, newspapers, and DPHSS website, will be used to send announcements to the public.

Enforcement

1. Based on the current available data, the recommended duration of quarantine for influenza is generally ten (10) days from the time of exposure (this will be adjusted based on available information during a pandemic).

2. DPHSS-BCDC or emergency response staff conducts at least two randomly timed phone calls to the quarantined person on a daily basis to monitor for development of symptoms such as fever, respiratory symptoms, etc.
3. If phone calls fail to reach the quarantined person, a DPHSS response team staff trained in the use of appropriate PPE and related equipment, makes an on-site visit to the quarantined individual to ensure compliance or to confirm non-compliance.
4. If the on-site visit confirms non-compliance by the absence of the quarantined person, pursuant to 10GCA, law enforcement has the authority to locate and confine individuals in violation of the quarantine order, using reasonable force.
5. Ensure collection of accurate data for each quarantined person, including demographics, as well as the following:
 - a) relationship to the case-patient
 - b) nature and time of exposure
 - c) whether contact is vaccinated, on antiviral prophylaxis, or using PPE
 - d) any underlying medical conditions
 - e) number of days in quarantine
 - f) symptom log
 - g) compliance with quarantine

Levels of Isolation

1. The first patients presenting in Guam with the novel influenza virus will be most likely isolated in isolation rooms at GMH or Naval Hospital.
2. When hospital isolation beds have reached capacity and influenza cases continue to increase, the next level of isolation may be in mobile acute care modules established near the hospitals and staffed by hospital personnel to provide surge capacity (or as indicated in the GMHA Pandemic Plan).
3. The third level of isolation will take place in cohort facilities, such as skilled nursing facility that will provide living quarters for a group of people who are all ill with the novel influenza virus.
4. As the number of influenza cases increases and infection becomes widespread, DPHSS will more likely recommend to the public to isolate themselves and remain at home after becoming ill, thus, they will be less likely to be exposed to other infections and be less likely to infect others. Voluntary home isolation is ideal for infected persons who are not sick enough to be hospitalized but still have access to sufficient care and basic needs at home.

Isolation Facility Requirements

1. GMHA has isolation beds / rooms that conform to guidelines from the CDC and the Healthcare Infection Control Practices Advisory Committee.
2. Facilities with negative pressure capacity are desirable if the novel virus possesses characteristics that require airborne precautions.
3. A community-based facility for isolation will be required when home, hospital, or health care facility are not sufficient to accommodate persons requiring isolation.
 - a) Such facility will be useful during large outbreaks in the community.
 - b) Potential sites for isolation must be identified and evaluated during pre-pandemic preparedness planning stages.
 - c) Existing structures for community isolation facilities may include schools,

- community health centers, senior citizen centers, apartments, dormitories, and hotels. Temporary structures for community isolation facilities include trailers, barracks, or tents.
- d) The following features should be considered when selecting a site and facility:
- i. Size of facility and rooms.
 - ii. Ability to provide strict standard and droplet isolation precautions.
 - iii. Bathroom with commode and sink, including showers.
 - iv. Provision of infection control facilities for hospital or clinical staff, such as gowning/de-gowning areas, changing rooms, shower facilities, and widely available handwashing basins or waterless hand sanitizers.
 - v. Easy & controlled access to facility, including handicap accessibility.
 - vi. Basic security.
 - vii. Food and laundry service.
 - viii. Functioning telephone to allow patients contact with family and friends.
 - ix. Waste and sewage disposal system.
 - x. Procedures to monitor health of staff.
- e) For home-isolation, these additional recommendations should be made to both ill persons and their family members:
- i. Separate the ill person who should stay at home while he is most likely infectious to others, usually for five days after onset of his symptoms.
 - ii. Restrict visitors to the home.
 - iii. The patient should follow cough etiquette such as covering the mouth and nose when coughing or sneezing; disposing used tissues immediately after use; and washing hands after using tissues.
 - iv. Household members should limit contact with the patient and designating one person as primary care provider, preferably someone who does not have any underlying condition which may predispose that person to an increased risk of getting a severe influenza disease.
 - v. All household members should carefully wash hands or use alcohol-based rub after any contact with the patient, his linens, any tissues, or towels and handkerchiefs.
 - vi. Ill patients and caregiver should wear masks during interactions to decrease the spread of infection. In unavoidable circumstances, any person entering home of suspected influenza patients should wear mask within three feet from the ill patient and should wash hands after each contact and before leaving the home.
 - vii. Soiled dishes and eating utensils should be washed in a dishwasher or by hand with warm water and soap. Separation of eating utensils for use by patient with pandemic influenza should be considered.
 - viii. Laundry can be washed in a standard washing machine with warm water and detergent. When handling soiled laundry, care should be used to avoid contamination; avoid “hugging” the laundry and wash hands with soap and water or alcohol-based rub afterwards.
 - ix. Household members should monitor themselves for development of influenza symptoms and to contact a telephone hotline or medical care provider if symptoms occur.

Quarantine is the separation and restriction of movement or activities of persons who are not ill but who are suspected to have been exposed to infection to prevent or reduce influenza transmission through monitoring their health and providing medical care and infection control precautions as soon as symptoms are detected. It is a more complex measure than isolation as it involves some serious issues concerning public health, public health law, and public policy. It is resource and labor intensive, taxing the reserves of virtually every area within the government such as health care, public health, social service, and law enforcement. Quarantine should not be used as a means to immediately stop the spread of disease, but rather as one of many tools to reduce the likelihood that new cases will arise from individuals who are not aware that they may be infected. When quarantine is required, public health officials should inform the public of the threat to their health, communicate the known risks, provide full information for the need for public action, and describe how the government will support individuals whose movement is restricted. It should be emphasized to the general public that quarantine is only temporarily restricting personal movement and is a collective action implemented for the common good.

Authority: Same as that provided for Isolation needs described in page 41.

DPHSS Due Process Plan

P.L. 26-173 §19605 specifies the procedures for isolation and quarantine. DPHSS legal counsel at the AG's office will finalize templates for written directives or quarantine orders. Draft samples are ongoing.

Enforcement – Refer to pages 41-42.

Key Requirements for Quarantine

Regardless of location or type of quarantine, every effort must be made to provide those in quarantine with the following minimum set of basic capabilities:

1. Quarantined individuals must have access to public health and healthcare personnel whether through telephone hotlines, two-way radio, email, or personal care. The form of interaction must be consistent with the level of healthcare required.
2. They must have access to public information and educational resources to assist them in making informed decisions and take educated actions to protect their own health and the health of their families. This may also be in the form of emails, websites set up specifically to meet this need, hotlines, two-way radio, public access TV, or mailings.
3. Communication with relatives and friends must be made available through telephone, email, two-way radio, or video conferencing capability, if in-person visits are not advised.
4. Individuals in quarantine must be monitored for symptoms, whether by a public health or response professional, family members, or by themselves. Monitoring must be efficient and effective enough to identify the key symptoms immediately.
5. Quarantine enforcement guidelines must be established, disseminated, and maintained.
6. Upon identification, authorities must provide transportation of those who show symptoms to isolation facilities. Such transportation capabilities are important to

ensure the greatest medical care of the symptomatic individuals and are critical for minimizing potential exposure of non-symptomatic individuals in quarantine.

Types of Quarantine

DPHSS may choose from any of the following types of quarantine to implement based on the nature and scale of the pandemic, characteristics of the public at risk, susceptibility of the population, geographic distribution of the influenza-infected persons, availability of resources, and legal authorities in place.

1. **Voluntary home quarantine** will be the primary strategy wherein the exposed or potentially exposed persons remain at home during the incubation period, possibly maximum of ten (10) days with pandemic influenza.
2. **Facility quarantine or alternative quarantine sites** will be used for those contacts who may be unwilling or unable to maintain home quarantine, e.g. senior citizen centers, schools, gymnasiums, motels, or hotels. The movement of exposed or potentially exposed persons would be restricted to the facility for the duration of the quarantine. Advantages of facility quarantine include consolidation and centralization of efforts, and provide options for those who may not want home quarantine and wish to minimize risk to their household members. However, the prospect of being placed in close proximity to potentially infected persons or simply being away from home or family may cause psychological distress and pose a challenge to public health officials seeking to encourage voluntary compliance.
3. **Work quarantine** may also be considered as was used in Toronto, Canada during the SARS epidemic of 2003. It mainly applies to health care workers and other emergency response personnel where outbreak control requires employee to continue working but are required to use the prescribed PPE. When not working, they must remain in home or facility quarantine and authorities would need to arrange for safe transportation to limit contacts with others, enforce strict and frequent monitoring of symptoms.
4. **Community quarantine** applies when all persons in a specific area or region where a high community-wide case count has been identified or where there is a potential for widespread exposure are quarantined. It is implemented by arranging a perimeter of a controlled access area around the region of concern, sometimes known as *cordon sanitaire*. This type of quarantine is the most difficult to implement and enforce. It may involve a legally enforceable action and restricts travel into or out of an area circumscribed by a real or virtual "sanitary barrier" or "*cordon sanitaire*" except to authorized persons, such as public health or healthcare workers.

Alternative quarantine sites will be identified based on the following considerations:

- a) Scope of pandemic
- b) Size of facility, room, and site – adequate rooms for each contact
- c) Controlled access and adequate security
- d) On-site showers
- e) Food service delivery
- f) Laundry service
- g) Telephone service to allow patients contact with family and friends

- h) Waste disposal procedures
- i) Staff to monitor contacts at least daily for fever and respiratory symptoms
- j) Transportation for medical evaluation for persons who will develop symptoms

Quarantine sites to be considered will include primarily all schools used as typhoon shelters, senior citizen centers in each village, village gymnasium/sports complex, apartments, and hotels. Each hotel is encouraged to identify a designated area or wing in their facility to be used for quarantine of susceptible guests exposed to a suspect or ill person with pandemic influenza.

Support Services

1. During quarantine, movement to the area of quarantine will be restricted.
2. Ensure that mental health and psychological support services are provided when necessary.
3. Available law enforcement personnel to maintain security at borders and enforce restriction of movement within the quarantine areas.

Other Community-Based Containment Measures

If disease transmission in the community is significant and sustained, consider implementing community-based containment measures which are grouped into two broad categories:

1. Measures that affect groups of exposed or at-risk individuals
 - a) Group Quarantine i.e. home, facility, work, or community quarantine
 - b) Measures that apply to use of specific sites or buildings sometimes known as “focused measures to increase social distance” include cancellation of events and closure of buildings or restricting access to certain sites or buildings.

Following are examples:

 - i. Cancellation of public events like concerts, sports events, political rallies, holiday celebrations, movies, and plays, as well as smaller social activities like weddings, funerals, or religious services. The great challenge for this kind of restriction is that humans are inherently social beings. By depriving them of certain social interactions in the midst of a public health crisis in which they may feel isolated and afraid, public officials may aggravate an already stressful situation. To promote mental health, compliance with the restrictive measures, and as much “normalcy” as possible, every effort should be made to arrange for alternative means of entertainment, social, religious, or political gatherings. These might include use of radio/public TV broadcasts, video web casts, internet-based “community square” chat rooms and teleconferences to provide alternative means for groups to congregate, to experience “live” entertainment, or participate in religious services. These “quality of life” activities should be supplemented with access to mental health counselors or other support, as needed.
 - ii. Closure of recreational facilities like community swimming pools, youth clubs, gymnasium, and senior citizen centers.

2. Measures that affect communities that include both exposed and non-exposed individuals. Such measures must be considered at the following circumstances:
 - a) there is moderate to extensive transmission in the area
 - b) many cases cannot be traced to contact with an earlier case or known exposure
 - c) cases are increasing among contacts of influenza patients
 - d) there is a significant delay between the onset of symptoms and isolation of cases because of the large number of ill persons
3. As community outbreaks of pandemic influenza occur, the general public should avoid close contact with ill individuals and the following measures may decrease the overall magnitude of the outbreak:
 - a) Promotion of community-wide infection control measures such as respiratory hygiene/cough etiquette. Throughout the pandemic, Public Health will encourage all persons with signs and symptoms of a respiratory infection, regardless of presumed cause, to do the following:
 - i. Cover the nose and/or mouth when coughing or sneezing
 - ii. Use tissues to contain respiratory secretions
 - iii. Dispose of tissues in the nearest waste receptacle after use
 - iv. Perform hand hygiene after contact with respiratory secretions and contaminated objects or materials

During pandemic, persons at high-risk for complications of influenza will be advised to avoid public gatherings such as movies, religious services, or public meetings and avoid going to public areas such as supermarkets, stores, malls, or pharmacies. The use of other persons for shopping or home delivery service is encouraged. Use of surgical-type masks by healthcare workers taking care of ill patients is recommended to prevent splashes and droplets of potentially infectious material from coughs and sneezes from reaching the mucous membranes of healthcare workers' nose or mouth. The benefit of wearing masks by well individuals in public settings has not been established and is not recommended as a public health measure at this time.

Individuals may choose to wear a mask as part of their individual protection strategies that include cough etiquette, hand hygiene, and avoidance of public gatherings. Mask use is most important for individuals who are at high risk for complications of influenza and those who are unable to avoid close contact with others or those who must travel for essential reasons such as seeking medical care or attending religious services. Public education should be provided on how to use and dispose of masks appropriately. In addition, it should be emphasized that mask use is not a substitutes for social distance or other personal protection measures. Supply issues should be considered so that mask use in communities does not limit availability for healthcare settings where importance and effectiveness of this issue has been documented.

- b) Implementation of asking everyone to stay home involves the entire community in a positive way, is acceptable to most people, and is relatively easy to implement. "Stay Home Days" may be declared by the DPHSS Director, for an initial 10-day period, with final decisions on duration based

on an epidemiologic and social assessment of the situation. Such a declaration would be an official public health recommendation, but would not be legally enforceable. Local public health authorities need to consider recommendations to the public for acquisition and storage of necessary provisions including type and quantity of supplies needed during “Stay Home Days”. “Stay Home Days” can effectively reduce transmission without explicit activity restrictions such as in quarantine. Consideration will be given to personnel who maintain primary functions in the community such as law enforcement personnel, transportation workers and utility workers (electricity, water, gas, telephone, garbage disposal/sanitation). Compliance might be enhanced by “self isolation” or self-shielding behavior (i.e. many people may stay home even in the absence of an official “Stay Home Days” Declaration) as in voluntary sheltering or sometimes known as “sheltering-in-place”. It is done when individuals, acting out of self-interest, limit their own social interactions for the purpose of protecting their health.

- c) Closure of office buildings, museums, libraries, shopping malls and schools have significant impact on the community and workforce, thus careful consideration will be focused on their potential effectiveness, how they can most effectively be implemented, and how to maintain critical supplies and infrastructure while limiting community interaction.

Although data are limited, school closures may be effective in decreasing spread of influenza and reducing the overall magnitude of disease in the community. Risk of infection and illness among children is likely to be decreased which would be particularly important if the pandemic strain causes significant morbidity and mortality among children. Results of mathematical modeling also suggest a reduction of overall disease, especially when schools are closed early in the outbreak. During a Pandemic Period, parents will be encouraged to consider child care arrangements that do not result in large gatherings of children outside the school setting.

- d) Restrictions on travel have been shown to reduce geographic spread, as well as total and local incidence during a disease outbreak. Restrictions may be placed on some or all modes of transportation – air, water, and land – and may include a range of increasingly stringent limitations including issuance of travel warnings, closure of high-risk stops, limiting schedules or canceling travel routes altogether. The effectiveness of such measures will depend on many factors, most notably by total travel intensity of a community, behavior of travelers and disease pathology. Although individual car travel naturally poses lower risk for community transmission, it could potentially facilitate the spread of disease to other locations. Thus, traffic restrictions may be considered to reduce flow between villages and limiting only to passage of response and emergency vehicles and other essential transportation.
- e) Enhanced screening for sick individuals in public places may help detect and separate infected persons. Such screenings may take place passively or as a

requirement for access into public or private buildings, businesses or public events. Checkpoints or screenings may also be set up in key transportation hubs such as airports or seaports. A good example is temperature screening and visual screening of incoming or outgoing travelers.

- f) Scaling back community containment measures. The decision to discontinue community-level measures will balance the need to lift individual movement restrictions against community health and safety. Premature removal of containment strategies can increase the risk of additional transmission. Decisions will be based on evidence of improving local/regional control such as:
 - i. Consistent decrease in the number of confirmed cases
 - ii. Reduction in the number of probable and known cases
 - iii. Effective protective countermeasures are in place (e.g. high coverage with a pandemic influenza vaccine)
 - iv. General recommendations are to withdraw the most stringent or disruptive measures first.

Travel-Related Containment Measures

The 2003 SARS pandemic demonstrated how quickly human respiratory viruses can spread, especially in a world of modern air travel. Disease spread will likely be even faster during an influenza pandemic because a typical influenza virus has a shorter average incubation period and is more efficiently transmitted from person to person.

It will not be possible to identify and isolate all arriving infected or ill passengers and quarantine their fellow passengers because some persons infected with influenza will still be in the incubation period, be shedding virus asymptomatically, or have mild symptoms. Moreover, if an ill passenger is identified after leaving the airport, it might not be possible to identify all contacts within the incubation period for pandemic influenza. Nevertheless, depending on the situation, these activities might slow spread early in a pandemic, allowing additional time for implementation of other response measures such as vaccination.

The recommendations on travel-related containment strategies range from distribution of travel health alert notices, to isolation and quarantine of new arrivals, to restriction or cancellation of nonessential travel. These strategies will be implemented in coordination with CDC quarantine stations located at 18 U.S. ports of entry. The recommendations for the Interpandemic and Pandemic Alert Periods focus on preparedness planning and on management of arriving ill passengers on international flights or cruise ships. The recommendations for the Pandemic Period focus on travel-related measures to decrease spread into, out of, and within the United States.

- 1. Recommendations for the Interpandemic and Pandemic Alert periods
 - a) Prepare for implementation of travel-related containment measures. If a pandemic begins outside of Guam, early application of travel-related control measures such as identification and isolation of ill travelers and quarantine of close contacts might slow the introduction of the virus.

- i. Engaging community partners including CQA officers, first responders (GFD, GPD), TSA, CBP, GMHA and emergency medical services personnel, GIAA, Port Authority of Guam, political leaders, GVB, businesses, and other related agencies to plan for managing travel-related disease risks.
 - ii. Collaborate with partners plan for mobilizing and deploying public health staff and other emergency workers.
 - iii. Conduct walk-through exercises or drills at ports of entry
 - iv. Ensure that healthcare workers and emergency responders are trained in the use of PPE.
 - v. Develop memorandum of agreement with GMHA to isolate, evaluate, and manage suspected influenza patients and if applicable, with emergency medical services that can help perform on-site assessments of ill passengers and transport them to the hospital for evaluation.
 - b) Protocols for managing ill travelers at GIAA and the Port Authority of Guam should include provisions for the following:
 - i. Meeting flights with a reported ill passenger.
 - ii. Establishing notification procedures and communication links among organizations involved in the response.
 - iii. Reporting potential cases to CDC.
 - iv. Providing a medical assessment of the ill traveler and referral for evaluation and care.
 - v. Separating the ill traveler from other passengers during the initial medical assessment.
 - vi. Transporting the ill traveler to GMHA.
 - vii. Identifying other ill passengers and separating them from passengers who are sick.
 - viii. Transporting and quarantining contacts, if necessary.
 - ix. Enforcing isolation and quarantine, if necessary, when ill travelers and their contacts are uncooperative.
 - x. CDC is working with partners in the travel industry to ensure that airplane and cruise personnel are familiar with the following:
 1. case definitions (symptoms, travel history) for avian influenza A (H5N1) and other novel influenza strains of public health concern as they arise; additional and updated case definitions will be provided as necessary.
 2. actions to take and persons to contact at their home offices, local quarantine station, or CDC if they are concerned about a sick passenger who might have novel influenza.
2. Quarantine preparedness at GIAA and Port Authority of Guam
 - a) DPHSS and local political leaders, in consultation with the Honolulu Quarantine Station and CDC will identify quarantine facilities for housing passengers, crew, and emergency workers who may have been exposed to an ill traveler. These facilities should be equipped for:
 - i. Temporary quarantine (a few days), until the results of diagnostic tests become available.

- ii. Long-term quarantine (up to 10 days) if a diagnosis of pandemic influenza is confirmed.
3. DPHSS and community partners should plan for the provision of goods and services to persons in quarantine.
4. Legal preparedness – ensure legal authorities in place and develop protocols, if necessary, for the following:
 - a) Requirements for pre-departure screening of international and domestic travelers.
 - b) Requirements for arrival screening and/or quarantine of international and domestic travelers.
 - c) Prohibitions on travel by ill persons and their contacts.
 - d) Restrictions on use of mass transit systems.
 - e) Cancellation of nonessential travel
 - f) Enforcement of travel restrictions, in collaboration with federal &/or local law enforcement officers
5. Health Information for Travelers – CDC’s Travelers’ Health website (www.cdc.gov/travel/) will provide up-to-date travel notices for international travelers to countries affected by novel influenza viruses. This information will be provided to all representatives of airlines operating on Guam, CQA, GIAA, CBP, & TSA. Additional Travel Health Precautions or Warnings may be issued to inbound and outbound travelers if avian influenza spreads internationally and causes additional cases of human influenza.
6. Evaluation of travel-related cases of infection with novel strains of influenza. During the Pandemic Alert Period, travel-related cases of infection might be detected after entry into Guam or reported during transit by airline or cruise ship personnel prior to arrival of an ill passenger.
 - a) Managing ill passengers
 - i. Follow protocols for management of arriving ill passengers who meet the clinical and epidemiologic criteria for infection with a novel strain of influenza
 - ii. If an ill passenger with a suspected case of novel influenza is reported aboard an arriving airplane or cruise ship, quarantine officer or designated health officer should do the following:
 1. Notify all partners, including the Honolulu Quarantine Station and CDC.
 2. Request information on the ill passenger’s symptoms and travel exposure history to make an initial assessment if the illness meets the current clinical and epidemiologic criteria for avian influenza (H5N1) or is suspicious for a novel influenza strain.
 3. Designated DPHSS official, medical advisor, nurse or nurse aide shall meet the airplane or cruise ship to further evaluate the ill traveler.

4. Provide the crew with guidance on infection control procedures, if needed (e.g. separate the ill passenger as much as possible from other passengers; provide ill passenger with a mask or tissues to cover coughs and sneezes).
- b) If the designated DPHSS officials meet the airplane or cruise ship and perform an initial medical evaluation of the ill traveler, the passengers and crew should be informed of the situation and should not be allowed to disembark until evaluation is complete.
- c) If DPHSS officials determine that the ill passenger meets the clinical and epidemiologic criteria for infection with a novel influenza strain, the patient should be sent by ambulance to GMHA, using appropriate infection control procedures for transit and patient isolation.
- d) Managing travel contacts
DPHSS officials, in consultation with the Honolulu Quarantine Station and CDC, should decide how to manage travel contacts of an ill traveler on a case-by-case basis, taking into consideration the following factors:
 - i. Likelihood that the suspected case is due to a novel influenza strain (based on symptoms and travel history, if laboratory results are not available).
 - ii. Likelihood that the causative virus is transmitted from person to person with a moderate or high efficiency (as in later phases of Pandemic Alert Period).
 - iii. Feasibility of tracing and monitoring travel contacts, as well as the patient's family members, workmates, schoolmates, and healthcare providers.

Management of contacts might include passive or active monitoring without activity restrictions; quarantine at home or in a designated facility and/or; antiviral prophylaxis or treatment.

F. COMMUNICATIONS AND EDUCATION

The goal of the Communications and Education section is to ensure efficient flow of accurate and consistent information during a pandemic. It is designed to facilitate communications among local, federal and international agencies about influenza activity and circulating strains of influenza virus, and about recommendations for and availability of, vaccines and antivirals, and other recommended health measures. This plan also describes the system for providing information to the general public through the media and other information outlets.

Assumptions

1. Dissemination and sharing of timely and accurate information among DPHSS and government officials, medical care providers, the media and the general public will be one of the most important facets of the pandemic response.
2. Different types of information will have to be communicated, often to different audiences.
3. There will be widespread circulation of conflicting information, misinformation, and rumors. Communication must be coordinated among all relevant agencies to ensure consistent messages to the general public.

4. There will be a great demand for accurate and timely information regarding:
 - a) Circulation of a pandemic strain
 - b) Disease burden (incidence, prevalence, hospital admissions)
 - c) Disease complications and mortality
 - d) Disease control efforts, availability and use of vaccines, antivirals and other preventive and treatment measures
 - e) "Do's and Don'ts" for the general public
 - f) Maintenance of essential community services
5. There will be a special need for information for the general public about how and why a Priority Group List for receipt of vaccine was developed. Public education will be an important part of the immunization campaign.
6. Certain groups will be hard to reach, including people whose primary language is not English, people who are homeless, people who are hearing and visually impaired, etc.
7. Demand for information by health care providers will be so great that existing materials for educating health care providers will have to be expanded during the interpandemic period.

DPHSS Crisis and Emergency Risk Communications

During a pandemic, the DPHSS Communications Office will be responsible for informing the public through the media using the Guam Department of Public Health and Social Services Crisis and Emergency Risk Communications Manual.

The DPHSS Crisis and Emergency Risk Communications Guidelines are contained in a working document that describes the means, organization and process by which the DPHSS Communications Office will provide timely, accurate and useful information and instructions to the public before, during and after a public health threat or emergency.

These guidelines cover two areas of crisis and emergency risk communications with the DPHSS:

1. Direct communication from the DPHSS through the news media; and
2. Information dissemination to educate the public regarding exposure risks and effective public response.

One of the goals of the Guam Pandemic Influenza Plan is to educate the public, health care professionals, policy makers, partner organizations and the media about influenza viruses; their unique ability to cause sudden, pervasive illness in all age groups on a global scale; and the need for strategies by which influenza-related morbidity, mortality and social disruption might be reduced. This goal is carried out through:

1. Providing accurate, comprehensive, consistent and easily accessible information to the public, health care providers, policy makers and the media;
2. Rapidly addressing the public's questions;
3. Helping to minimize false rumors and misinformation;
4. Reassuring the public that the public health system can respond and manage

effectively

5. Coordinating communication efforts with federal, regional, and local partners.

Responsibilities for Communication During a Pandemic

During the initial phases of the pandemic, the DPHSS Communications Office will be briefing the Governor's Communications Office, and once the EOC is activated, they will be working with the JIC to effectively communicate to the public.

All media inquiries are to come to the DPHSS Communications Office. The Risk Communication Officer will identify the appropriate subject matter expert to answer questions. Chief spokespersons for the DPHSS in relation to pandemic influenza are:

1. The Director
2. The Chief Public Health Officer
3. The Epidemiologist
4. BCDC Administrator
5. DPHSS Medical Director

News release template will be prepared, whereby the latest bits of information can be filled-in and the releases can be sent out quickly. The DPHSS Communications Office will also have members readily available to work to prepare talking points for the DPHSS Director and the Governor during the pandemic.

Pandemic Phases

Phases 1 & 2 – Interpandemic Period

1. *No new influenza virus subtypes have been detected in humans. Influenza virus subtype that has caused human infection may be present in animals; if so, the risk of human infection or disease is considered to be low.*
2. *No new influenza virus subtypes have been detected in humans. However, circulating animal influenza virus subtype poses substantial risk of human disease.*

Objectives:

1. To ensure that mechanisms exist for routine emergency communications between health authorities, within and between government agencies, with other organizations likely to be involved in a pandemic response, and with the public.
2. To maintain an appropriate level of awareness among government and other essential agencies.
3. To ensure collaborative working relationships with the media regarding epidemics, including the roles, responsibilities and operating practices of public health authorities.
4. To ensure that appropriate information is shared rapidly among health authorities, other partners and the public.

5. To ensure that mechanisms exist for coordinating communications with the animal health and public health sector.

Activities:

1. Public Information Dissemination:

DPHSS Communications Office staff will:

- a) Meet with BCDC staff and the Epidemiologist to maintain a proficient level of understanding of the unfolding influenza pandemic.
- b) Assess readiness to meet communication needs in preparation for pandemic influenza.
 - i. Regular review and if necessary, updates to the Crisis and Emergency Risk Communication Plan.
 - ii. Check availability of cell phones, laptops, copiers, fax machines, phone lines, pagers, radios, staff, etc.
 - iii. Deficiencies will be given priority for correction.
- c) Identify appropriate contacts to be notified of pandemic influenza activity:
 - i. Government agencies Public Information Officer (PIO's) or other designated contacts.
 - ii. All healthcare agencies (hospital, long-term care facilities, health clinics, etc.)
 - iii. Other appropriate organizations (Red Cross, etc.)
 - iv. Media
 - v. GHS/OCD
- d) Consult with BCDC staff and the Epidemiologist to identify and maintain a list of target audiences for messages that pertain to pandemic influenza.
- e) Issue cautionary announcements and share relevant information. Such information shall include, but not be limited to, what is known about pandemic influenza, how DPHSS is monitoring influenza activity, and what steps are being or will be taken to prevent or slow the spread of the influenza and minimize its impact.
- f) Develop materials and messages for the general public, including rationale for priority groups for vaccines and antivirals, and measures to be taken until vaccine and antivirals are developed.
- g) Identify and develop relationships with public and private sector stakeholders including healthcare providers who are able to reach special populations and provide them information regarding pandemic influenza.
- h) Work with subject matter experts to develop key messages, communication products, and other resources to be used in the event of influenza pandemic.
- i) Develop public information policy and information clearance protocols specific to pandemic influenza.
- j) Assure that public information dissemination is part of any exercise or training for pandemic influenza response.

2. Communication with Healthcare Professionals:

- a) Issue Identification: Health issues and concerns that will or may need to be addressed for healthcare professionals regarding pandemic influenza will be identified by the DPHSS Communications Office staff.
- b) DPHSS Communications Office staff will consult with BCDC staff and the Epidemiologist to develop and maintain messages appropriate to specific audiences. A separate “package” of issues and messages will be developed as needed on issues particular to the group. Information may include:
 - i. Vaccine development and supply
 - ii. Isolation and quarantine recommendations
 - iii. Antiviral use
 - iv. Prevention and infection control methods
 - v. Contact investigation
- c) The Distance Learning Section will be utilized to conduct training of health care and public health personnel who would be involved in a pandemic should it occur.

Phase 3 – Pandemic Alert

Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.

Objectives:

1. To communicate openly with the public regarding possible outbreak progression and contingencies to be expected.
2. To ensure rapid sharing of appropriate information among healthcare providers, other relevant government departments, stakeholders and other partners, including what is known and what is unknown.

Activities:

1. Public Information Dissemination:

Continue activities initiated in previous phases. DPHSS Communications Office staff will:

- a) Identify spokespersons and subject matter experts; provide training in media relations, crisis and emergency risk communications, spokesperson skills.
- b) Provide regular updates and offer opportunities to address questions (e.g., in partnership with the news media, community forums, via DPHSS website, through meetings with communication partners, etc.).
- c) Educate the general public on other control measures that can be taken by individuals until such time when vaccine is available for everyone (e.g., avoiding crowds staying home when sick). Many of these measures should also be encouraged even after an individual has been vaccinated. If the vaccine will not be able to be used in certain individuals (e.g. children younger than 6 months of age, persons with absolute medical

contraindications), special emphasis will be given on how to prevent influenza in these individuals.

- d) Remain cognizant that individuals often believe events that occur after vaccinations are due to the vaccine. DPHSS Communications Office staff will include this concept in the education efforts, emphasizing the fact that events following vaccination are not necessarily caused by the vaccine.
- e) Prepare the public, through education, for the development of post-vaccination cases of respiratory illness which are likely to be viewed as vaccine failure.
- f) Distribute practical information as it becomes relevant, such as travel advisories, infection control measures, and information about potential rationing of antiviral agents and first-generation vaccines; disseminate advisories people traveling to affected areas, recommending they avoid contact with live (or dead) poultry.
- g) Reinforce and verify ways to help people protect themselves, their families and others.
- h) Formalize and communicate public information policy and information clearance protocols specific to pandemic influenza.
- i) Pre-clear as much information as possible, including key messages, talking points, backgrounders, fact sheets, FAQs, news release templates.
- j) Monitor news media reports and public inquiries to anticipate and address public information needs, including information to counter misconceptions of specific populations.
- k) Help to incorporate information regarding pandemic influenza into the DPHSS website.
- l) Identify languages used on Guam and arrange for translation services.
- m) Monitor information from CDC Communications Office to assess national response.

Note: CDC has committed to the preparation of press materials, including bulletins and newsletters; however, pursuing the preparation of similar material might be prudent and would provide material in a timelier manner at the onset of such an event.

Phase 4 & 5 – Pandemic Alert

4. Small cluster(s) with limited human-to-human transmission.

5. Larger cluster(s) but human-to-human spread is still localized to a single country/region.

Objectives:

- 1. To ensure rapid sharing of appropriate information among health authorities, other relevant government departments, stakeholders and other partners.
- 2. To prepare the public stakeholders and partners for a possible rapid progression of events and possible contingency measures, and possible disruptions to normal life.

Activities:

1. Public Information Dissemination:

Continue activities initiated in previous phases. DPHSS Communications Office staff will:

- a) Emphasize in public briefing statements and written materials how people can protect themselves, including hand washing and respiratory etiquette.
- b) Continue to monitor news media reports and public inquiries to anticipate and address public information needs.
- c) Identify special communication needs populations (defined as those people who will not or cannot receive messages via mass media), prepare and translate appropriate messages, and disseminate information through appropriate communication channels.
- d) Prepare messages for news conferences or briefings as needed to effectively communicate with the media and the public.
- e) Issue a Travel Advisory if warranted. Notify GIAA, CQA, CBP, GVB, Guam Hotel and Restaurant Association (GHRA), Chamber of Commerce and others to ensure widespread notification. Assist communication efforts with travel and tourism organizations to ensure messages on influenza precautions are understood (see Appendix F).

2. Communication with Healthcare Professionals:

- a) Communication efforts will continue as described in Phases 1 and 2. Modification will be made as appropriate.
- b) Coordinate the notification of all appropriate agencies, and healthcare professionals that the virus has been identified in human-to-human transmission. Phones, pagers, faxes, email or other redundant communication systems will be used as alternative forms of notification.
- c) DPHSS Communications Office staff will work with BCDC staff and the Epidemiologist to keep the public, healthcare providers and key stakeholders fully informed as the threat of a pandemic nears. If the Health EOC is partially activated, the Risk Communication Officer or his/her designees joins the health command staff in ICS as lead, directing communication activities.
- d) DPHSS Communications Office staff will ensure that communication messages are available for health care providers and health care facilities regarding the rationale for priority groups for vaccine and antivirals, and measures to be taken until such are available (if the current situation warrants this).
- e) Distance Learning Delivery: It is expected that the CDC will call for national satellite broadcasts dealing with the emergency. The Distance Learning Coordinator with the assistance of partners (UOG PEACESAT) will assure that appropriate communication assets are employed to receive the programming, record it and deliver it to responders across Guam.

Phase 6 – Pandemic Period

6.(a) Increase and sustained human-to-human transmission in multiple countries/regions near Guam (but not Guam).

6.(b) Pandemic reaches Guam.

Objectives:

1. To ensure public access to regularly updated official national sources and focal points for credible, consistent information related to the pandemic.
2. To maintain open and accessible channels for advice to the public on specific subjects (e.g., travel, social gatherings, etc.).
3. To achieve public acceptance and support for national responses and contingency measures.
4. To ensure rapid sharing of information regarding progress of the pandemic among health authorities, other relevant government departments, stakeholders and other partners.

Activities:

1. Public Information Dissemination:

- a) The OCD, with the DPHSS and the Governors Communications Office will set up the JIC to efficiently provide and disseminate accurate and consistent information to the general public.
- b) The JIC will begin to hold necessary news conferences each day. News conference participants may include:
 - i. Governor or Lt. Governor
 - ii. DPHSS Director
 - iii. OCD Administrator
 - iv. GHS Advisor
 - v. Other Cabinet officials, congressional delegation or legislative leadership
- c) The JIC will interface with appropriate federal agencies.
- d) DPHSS Communications Office staff will prepare to obtain and track information daily on the numbers and location of new cases, hospitals with pandemic influenza cases, etc. for the JIC.
- e) DPHSS Communications Office staff will tailor messages to special communication needs populations (defines as those people who will not or cannot receive messages via mass media), prepare and translate appropriate messages, and disseminate through appropriate communication channels for the JIC.
- f) DPHSS Communications Office staff will continue to monitor news media reports and public inquiries to anticipate and address public information needs.

2. Communication with Healthcare Professionals:

- a) Human-to-Human transmission confirmed: DPHSS Communications Office will be responsible to communicate pandemic response updates and

recommendations to targeted health professionals or agencies that serve healthcare professionals.

- b) Distance Learning Delivery: It is expected that the CDC will call for national satellite broadcasts dealing with the emergency. The Distance Learning Coordinator with the assistance of partners (UOG PEACESAT) will assure that appropriate communication assets are employed to receive the programming, record it and deliver it to responders across Guam.

Postpandemic period
Return to Interpandemic period

Activities:

1. Public Information Dissemination:

DPHSS Communications Office staff will:

- a) Assess effectiveness of public information (i.e. surveys) messages.
- b) Assess effectiveness of information provided to healthcare providers.
- c) Update the public through regular news releases and news updates as needed about the current situation.
- d) Update messages about the current pandemic influenza aftermath in coordination with the CDC information.
- e) Update fact sheets, flyers and frequently asked questions in coordination with CDC information.
- f) Update DPHSS web page as necessary.

2. Communication with Healthcare Professionals:

- a) Distance Learning Delivery: An after action analysis of the effectiveness of distance learning programming and delivery will be conducted by the DLC in order to improve delivery of services.
- b) Communication efforts will continue to inform healthcare professionals about the end of pandemic.
- c) DPHSS Communications Office staff will convene a meeting with healthcare partners to discuss communications strategy and conduct a process review. Modifications will be made as necessary.

G. EMERGENCY RESPONSE

The GHS/OCD prepares and maintains a comprehensive Guam Emergency Response Plan, which provides for an emergency management system that includes a broad range of preparedness, response, recovery and mitigation responsibilities. However, pandemic influenza is likely to pose unique challenges that may not be addressed in current emergency management plans. Due to this unique situation, emergency management plans should incorporate a pandemic influenza plan as an appendix to the existing plan.

Thus, the Emergency Response section describes the systems that will be used to ensure maintenance of essential medical and other community services in the event of a pandemic.

**During the Interpandemic and Pandemic Alert Periods
(Phase 1 through 4):**

Estimate the Need for Health Care Services:

1. Determine existing capacity.
2. Determine the reserve capacity
3. Estimate the potential impact on Guam of an Influenza Pandemic, using *Flu Aid*, *Flu Surge*, or other computer programs.
4. Determine high-risk groups.
5. Develop preventive action recommendations.
6. Develop a list of health related needs during a pandemic.
7. Develop a contingency plan to address inadequacies in the infrastructure.

DPHSS Response

1. Existing Healthcare Infrastructure

The DPHSS will update and/or inventory medical supplies, facilities and services. DPHSS will collaborate with appropriate agencies to identify and rapidly disseminate the island-wide inventory. The Chief Public Health Office will have inventory of the following services/items:

- a) Medical Personnel – including but not limited to:
 - i. Currently licensed physicians
 - ii. Physician Assistants
 - iii. Advanced Practice Nurses
 - iv. Registered Nurses, including school nurses
 - v. Licensed Practical Nurses, including school nurses
 - vi. Respiratory Therapists
 - vii. Radiology Technicians
 - viii. Certified Nurse Assistants
 - ix. Nursing and technical students
 - x. Medical Assistants
 - xi. Dentists and Dental Assistants (for identification of victims in a mass fatality situation)
- b) Number of beds (GMHA, Skilled Nursing Unit [SNU], alternative care sites)
- c) Number of ICU beds
- d) Number of isolation beds in negative air pressure rooms
- e) Number of ventilators
- f) Pharmacies, pharmacists, pharmacy technicians
 - i. Contingency supply of antibiotics
 - ii. Contingency supply of antivirals
- g) Contingency medical care facilities (i.e. group housing facilities, unused hotels)

- h) PPE
 - i) Specimen collection and transport materials
 - j) Mortuary/funeral services
 - k) Social Services/Mental Health Services/Faith Services
 - l) Sources of medical supplies (syringes, gauze, bandages)
-
- 2. In coordination with the DPHSS Communications Office, develop contingency plans to provide medical care information for people sick at home.
 - 3. A hotline will need to be established for families who will need information about how to take care of sick family members at home and guidelines regarding when to seek professional medical care.
 - 4. In coordination with the OCD, develop contingency plans to maintain other essential community services. DPHSS will develop lists of essential personnel based on national guidelines and local needs. These lists will be used to develop priority lists for vaccinations and/or antivirals if they are available. DPHSS will also maintain a list of essential community services along with contact personnel. In addition, DPHSS will prepare a list of back up personnel/replacements to these personnel in order for essential community services to continue.

DURING THE PANDEMIC PERIOD (Phase 5 through 6D)

- 1. Attend regular meetings of the PIC.
- 2. When the EOC at the OCD is activated, assume duties as Operations Section Chief to coordinate response activities (see Incident Command System organizational chart in Appendix I).

INTERWAVE AND POSTPANDEMIC PERIODS

(Phase 6D and post 6E)

- Return to normal operational levels and transition Operations Section Chief responsibility back to the OCD.

APPENDIX A LIST OF ACRONYMS

AG	Attorney General
BCDC	Bureau of Communicable Disease Control
BFHNS	Bureau of Family Health and Nursing Services
BPCS	Bureau of Primary Care Services
BPSS	Bureau of Professional Support Services
CBP	Customs and Border Protection (U.S.)
CDC	Centers for Disease Control and Prevention
CHC	Community Health Centers
CQA	Customs and Quarantine Agency
DMHSA	Department of Mental Health and Substance Abuse
DPHSS	Department of Public Health and Social Services
ED	Emergency Department
EOC	Emergency Operations Center
EFS	Emergency Support Function
FAQ	Frequently Asked Question
GCA	Guam Code Annotated
GHS	Guam Homeland Security
GHRA	Guam Hotel and Restaurant Association
GLAA	Guam International Airport Authority
GMS	Guam Medical Society
GNA	Guam Nursing Association
GPD	Guam Police Department
GPSS	Guam Public School System
GMHA	Guam Memorial Hospital Authority
GVB	Guam Visitors Bureau
ICS	Incident Command System
ILI	Influenza-like illness
JIC	Joint Information Center
NIMS	National Information Management System
NRCHC	Northern Region Community Health Center
OCD	Office of Civil Defense
PPE	Personal Protective Equipment
PIC	Pandemic Influenza Committee
RAC	Response Activity Coordinators
SARS	Severe Acute Respiratory Syndrome
SRCHC	Southern Region Community Health Center
SNS	Strategic National Stockpile
VAERS	Vaccine Adverse Events Reporting System
VFC	Vaccines for Children Program
WHO	World Health Organization

APPENDIX B

AVAILABLE PERSONNEL WITHIN DPHSS AND OTHER RESOURCES TO ASSIST IN THE PANDEMIC INFLUENZA RESPONSE

Personnel

Chief Public Health Office

- Chief Public Health Officer
- Epidemiologist
- Planner
- Bioterrorism Coordinator
- Emergency Management System Administrator
- Maternal Child Health Coordinator
- Vital Statistics staff (death certificate and burial/transport permit assistance)
- Clerical and support staff

Bureau of Communicable Disease Control

- BCDC Administrator
- CDC I, II, and IIIs
- CDC Investigators
- Health Educator III
- Community Program Aides
- Laboratory Medical Pathologist
- Laboratory Supervisor
- Laboratory staff
- X-Ray Technician
- Computer Programmer
- Support Staff

Bureau of Family Health and Nursing Services

- Nursing Administrator
- Nurse Practitioners
- Registered Nurses
- License Practical Nurse
- Nurse Aides
- Support Staff

Bureau of Primary Care Services, NRCHC and SRCHC

- Health Services Administrator
- Staff physicians
- Registered Nurses
- Licensed Practical Nurses
- Nurse Practitioner
- Nurse Midwife
- Nurse Aides
- Chief Pharmacist

- Pharmacist Technicians
- Microbiologist
- Lab Technicians
- System Analyst
- Medical Records Clerks
- Support staff

Bureau of Professional Support Services Staff

- Health Services Administrator
- Chief Pharmacist
- Pharmacy Technicians
- Medical Social Workers
- Medical Records staff
- Clerical and support staff

Other DPHSS Staff:

- Division of Environmental Health
- Facilities and Maintenance
- Health Professional Licensing Office
- Division of Senior Citizens
- Division of Public Welfare

Other Resources

American Red Cross

Citizens Corp Committee

Guam Hotel and Restaurant Association

Guam Medical Society

Guam Association of Pharmacists

Guam Nurses Association

Guam Association of Social Workers

APPENDIX C

**DRAFT SAMPLE PUBLIC HEALTH ORDER FOR MODIFICATION/USE
IF A PANDEMIC IS IMMINENT**

**TERRITORY OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES**

**ORDER FINDING IMMINENT DANGER TO THE PUBLIC HEALTH, TO AVOID THE
IMMINENT DANGER, AND TO CONTROL ADMINISTRATION OF PANDEMIC
INFLUENZA VACCINE AND CERTAIN ANTIVIRAL MEDICATIONS**

This order is made pursuant to Section 19310 of Title 10 Guam Code Annotated, Chapter 3, Article 3, Disease Control, and Chapter 19, Emergency Powers Act.

Matters of concern to the health of Guam citizens having been brought to the attention of the Director of the Department of Public Health and Social Services, and the Director having made the following determinations:

- 1) The XXX strain of influenza is spreading rapidly among humans in many parts of the world, causing the World Health Organization to declare an influenza pandemic.
- 2) Nearly all Guam's residents are expected to be vulnerable to this virus.
- 3) Disease caused by this virus can be severe, long-lasting, and may lead to death.
- 4) Large numbers of Guam residents will require medical care if this virus becomes widespread on Guam.
- 5) Supplies of pandemic influenza vaccine are sufficient to immunize only a small percentage of Guam's population.
- 6) Public and private sector supplies of the antiviral drugs amantadine, rimantadine, oseltamivir, and zanamivir, which are thought to be effective against this virus are sufficient to treat or prevent disease in only a small percentage of Guam's population.
- 7) To assure the best possible care for Guam residents in the likely event that pandemic influenza spreads on Guam, health care workers and public health personnel should be protected against this virus, so they can effectively care for Guam residents and prevent the spread of disease.
- 8) This situation constitutes an imminent danger to the health or lives of residents of the territory of Guam.

Now, Therefore, It Is Hereby Ordered That:

- A. All health care providers on Guam shall limit influenza vaccination with pandemic influenza vaccine, or administration of amantadine, rimantadine, oseltamivir, or zanamivir, to the following persons (depending on available supplies, DPHSS or health care facilities may further limit administration if necessary):
 - i. health care providers and their support staff, emergency responders, laboratory workers in hospital or clinical, or pharmacists;
 - ii. public health personnel involved with pandemic influenza response,
 - iii. spouses, domestic partners, or children of people in the above 2 categories;
 - iv. other critical personnel as determined by the Director of DPHSS, in consultation with the DPHSS Medical Director, Territorial Epidemiologist, and Immunization Program Advisor.

- v. Amantadine may continue to be given to persons in order to treat Parkinson's disease, or other diseases or conditions against which amantadine is effective.
- B. All health care providers and others that possess pandemic influenza vaccine, amantadine, rimantadine, oseltamivir, or zanamivir, shall cooperate with local health officers to assess supply of these substances and coordinate prophylaxis and treatment of persons in the above categories.
- C. Pursuant to Section 19603 of Title 10 Guam Code Annotated, Chapter 19, Emergency Powers Act, individuals who are unable or unwilling for reasons of health, religion or conscience to undergo vaccination will be isolated or quarantined.
- D. ?? Mandatory vaccination for school and work attendance??
- E. Local health officers shall provide this order to health care providers in their jurisdiction, and this order shall be prominently posted in locations where influenza prophylaxis and treatment are administered.
- F. This order shall take effect immediately.

Pursuant to Section ??? of Title 10 Guam Code Annotated, Chapter ???, Article ???, Disease Control, and Chapter ??, Emergency Powers Act, a person who violates this order is guilty of a misdemeanor punishable by imprisonment for not more than ??? months, or a fine of not more than \$???, or both.

ARTHUR U. SAN AGUSTIN, MHR
Department of Public Health and Social Services
Acting Director

Date: _____

**APPROVED AS TO LEGALITY
AND FORM:**

DOUGLAS B. MOYLAN
Attorney General of Guam

Date: _____

APPROVED:

FELIX P. CAMACHO
Governor of Guam

Date: _____

APPENDIX D
COORDINATION OF GUAM PANDEMIC INFLUENZA PREPAREDNESS WITH
OTHER GOVERNMENT, FEDERAL AND INTERNATIONAL AGENCIES

Government

Department of Administration
Department of Agriculture
Department of Mental Health and Substance Abuse
Guam Community College
Customs and Quarantine Agency
Guam Fire Department/EMTs
Guam International Airport Authority
Guam Memorial Hospital Authority
Guam Police Department
Guam Public School System
Guam Visitors Bureau
Office of Civil Defense/Homeland Security
Office of the Governor
University of Guam

Federal

U.S. Centers for Disease Control and Prevention
Department of Health and Human Services
Department of Homeland Security
Department of Defense
Federal Emergency Management Agency
Food and Drug Administration
United States Department of Agriculture
U.S. Customs and Border Protection
Honolulu Quarantine Station

International

Secretariat of the Pacific Community
World Health Organization

APPENDIX E

INFECTION CONTROL RECOMMENDATIONS

Healthcare Facilities:

1. Place suspect cases on droplet and standard precautions (see CDC Guidelines on Prevention of Nosocomial Pneumonia at http://www.cdc.gov/ncidod/hip/pneumonia/pneu_mmw.htm.)
2. All persons entering isolation rooms should wear a surgical mask and practice good hand hygiene (see CDC guidelines for hand hygiene in healthcare settings at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm>.)
3. Healthcare workers displaying influenza-like symptoms should be removed from direct patient care when possible.
4. Visitors with febrile respiratory illnesses should be restricted from visitation as much as possible.
5. Patients and staff should cover their mouths and noses with tissue when coughing or sneezing, dispose of used tissues immediately after use and wash hands after using tissues.
6. Restrict elective admissions in hospitals.
7. Isolation should be initiated at symptom onset and continue for duration of illness (usually 4 to 5 days).

At Home:

1. Persons should remain at home during their illness (usually until 4 to 5 days after symptoms appear).
2. Restrict visitors to the home as much as possible.
3. Persons entering homes of suspect influenza cases should wear a surgical mask when within 3 feet of the patient, and should wash hands after patient contact and before leaving the home.
4. Patients should cover their mouths and noses with tissue when coughing or sneezing, dispose of used tissues immediately after use and wash hands after using tissues.
5. Family members should wash hands after contact with the patient.

APPENDIX F

WHO GUIDELINES FOR THE COLLECTION OF HUMAN SPECIMENS FOR LABORATORY DIAGNOSIS OF AVIAN INFLUENZA INFECTIONS (12 January 2005)

1. General information

Respiratory virus diagnosis depends on the collection of high-quality specimens, their rapid transport to the laboratory and appropriate storage before laboratory testing. Virus is best detected in specimens containing infected cells and secretions. Specimens for the direct detection of viral antigens or nucleic acids and virus isolation in cell cultures should be taken preferably during the first 3 days after onset of clinical symptoms.

2. Type of specimens

A variety of specimens are suitable for the diagnosis of virus infections of the **upper respiratory tract**.

- Nasal swab
- Nasopharyngeal swab
- Nasopharyngeal aspirate
- Nasal wash
- Throat swab

In addition to swabs from the upper respiratory tract, invasive procedures can be performed for the diagnosis of virus infections of the lower respiratory tract where clinically indicated:

- Transtracheal aspirate
- Bronchoalveolar lavage
- Lung biopsy
- Post-mortem lung or tracheal tissue.

Specimens for the laboratory diagnosis of avian influenza A should be collected in the following order of priority.

- Nasopharyngeal aspirate
- Acute serum
- Convalescent serum.

Specimens for direct detection of viral antigens by immunofluorescence staining of infected cells should be refrigerated and processed within 1-2 hours. Specimens for use with commercial near-patient tests should be stored in accordance with the manufacturer's instructions. Specimens for virus isolation should be refrigerated immediately after collection and inoculated into susceptible cell cultures as soon as possible. If specimens cannot be processed within 48-72 hours, they should be kept frozen at or below -70°C .

Respiratory specimens should be collected and transported in virus transport media. A number of media that are satisfactory for the recovery of a wide variety of viruses are commercially available.

3. Procedures for specimen collection

a. Materials required

- Sputum/mucus trap
- Polyester fiber-tipped applicator (**NO** calcium alginate, cotton tipped or wooden stick)
- Plastic vials
- Tongue depressor
- 15-ml conical centrifuge tubes
- Specimen collection cup or Petri dishes
- Transfer pipettes

b. Virus transport Medium

(1) Virus transportation medium for use in collecting throat and nasal swabs.

- Add 10 g veal infusion broth and 2 g bovine albumin fraction V to sterile distilled water (to 400 ml).
- Add 0.8 gentamicin sulfate solution (50 mg/ml) and 3.2 ml amphotericin B (250ug/ml)
- Sterilize by filtration

(2) Nasal wash medium

- Sterile saline (0.85% NaCl)

c. Preparing to collect specimens

Clinical specimens should be collected as described below and added to transport medium. Nasal or nasopharyngeal swabs can be combined in the same vial of virus transport medium. When possible, the following information should be recorded on the Field Data Collection Form: general patient information, type of specimens, date of collection, and contact information of person completing the form, etc.

Standard precautions should always be followed, and barrier protections applied whenever samples are obtained from patients.

Nasal swab

A dry polyester swab is inserted into the nostril, parallel to the palate, and left in place for a few seconds. It is then slowly withdrawn with a rotating motion. Specimens from both nostrils are obtained with the same swab. The tip of the swab is put into a plastic vial containing 2-3 ml of virus transport medium and the applicator stick is broken off.

Nasopharyngeal swab

A flexible, fine-shafted polyester swab is inserted into the nostril and back to the nasopharynx and left in place for a few seconds. It is slowly withdrawn with a rotating motion. A second swab should be used for the second nostril. The tip of the swab is put into a vial containing 2-3 ml of virus transport medium and the shaft cut.

Nasopharyngeal aspirate

Nasopharyngeal secretions are aspirated through a catheter connected to a mucus trap and fitted to a vacuum source. The catheter is inserted into the nostril parallel to the palate. The vacuum is applied and the catheter is slowly withdrawn with a rotating motion. Mucus from the other nostril is collected with the same catheter in a similar manner. After mucus has been collected from both nostrils, the catheter is flushed with 3 ml of transport medium.

The patient sits in a comfortable position with the head slightly tilted backward and is advised to keep the pharynx closed by saying "K" while the washing fluid (usually physiological saline) is applied to the nostril. With a transfer pipette, 1-1.5 ml of washing fluid is instilled into one nostril at a time. The patient then tilts the head forward and lets the washing fluid flow into a specimen cup or a Petri dish. The process is repeated with alternate nostrils until a total of 10-15 ml of washing fluid has been used. Dilute approximately 3 ml of washing fluid 1:2 in transport medium.

Throat swab

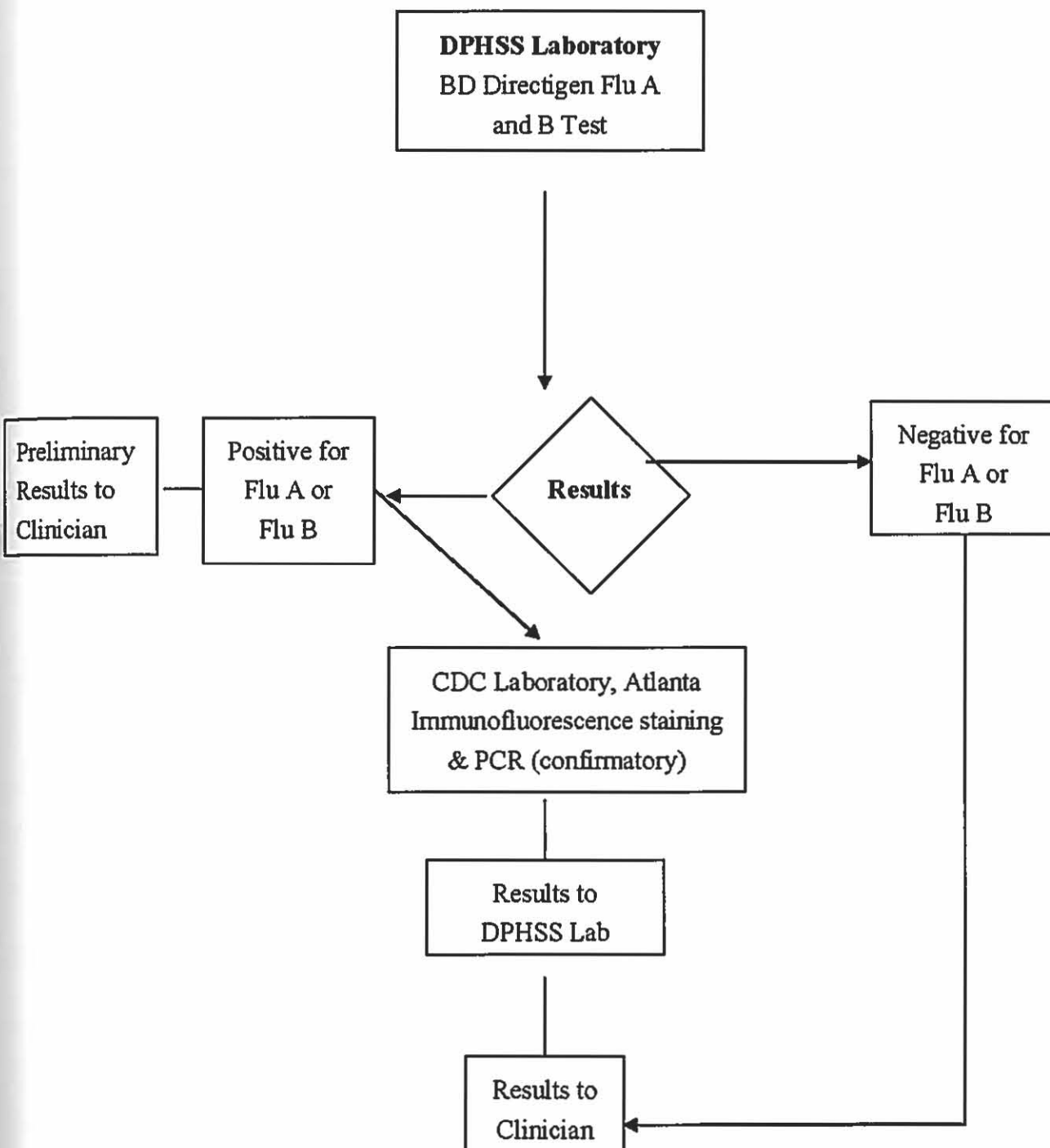
Both tonsils and the posterior pharynx are swabbed vigorously, and the swab is placed in transport medium as described above.

4. Sera collection for influenza diagnosis

An acute-phase serum specimen (3-5 ml of whole blood) should be taken soon after onset of clinical symptoms and not later than 7 days after onset. A convalescent-phase serum specimen should be collected 14 days after the onset of symptoms. Where patients are near death, a second ante-mortem specimen should be collected.

Although single serum specimens may not provide conclusive evidence in support of an individual diagnosis, when taken more than 2 weeks after the onset of symptoms they can be useful for detecting antibodies against avian influenza viruses in a neutralization test.

APPENDIX G
ALGORITHM FOR LABORATORY SCREENING AND CONFIRMATION
OF PANDEMIC INFLUENZA IN HUMANS

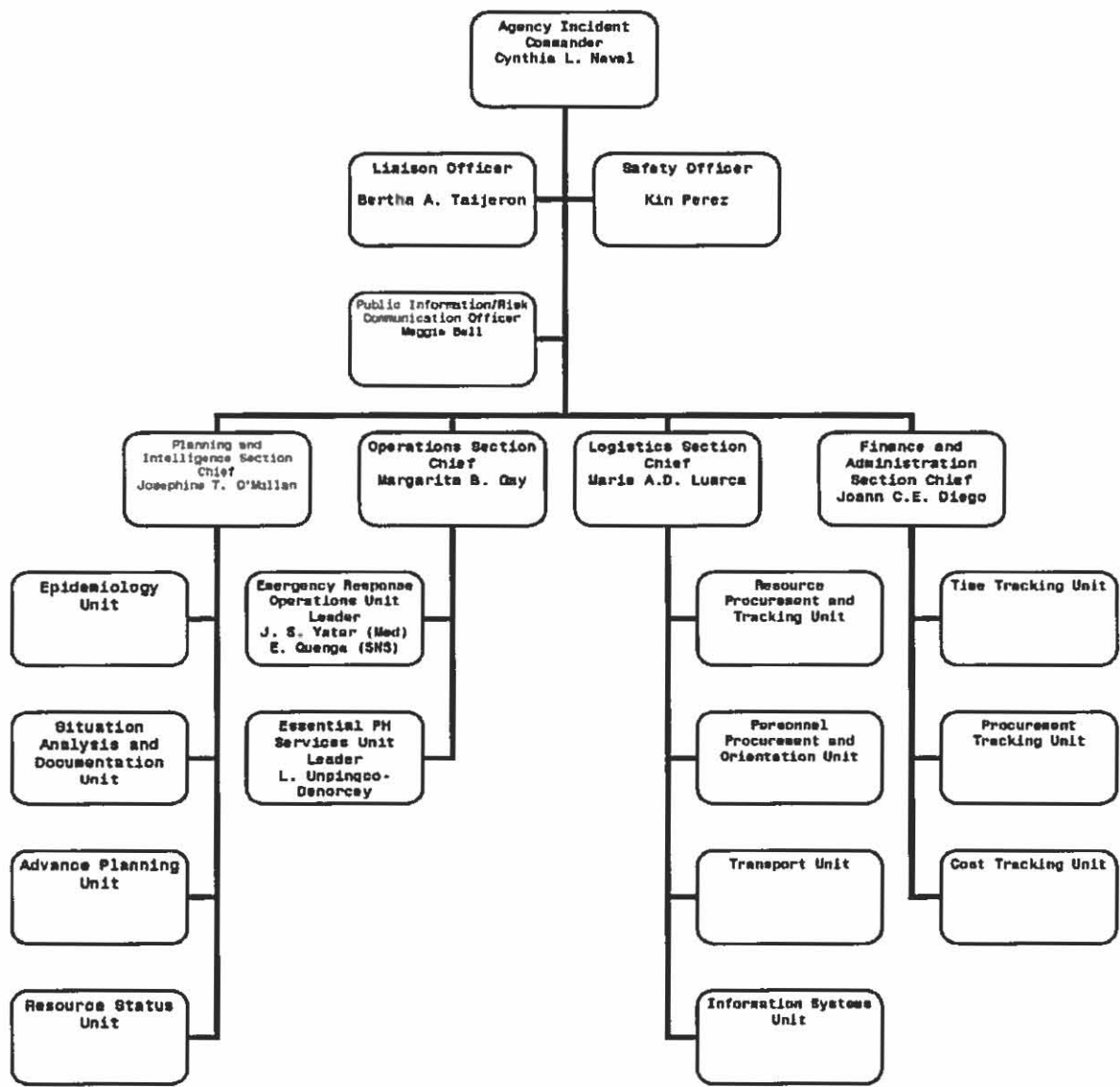


APPENDIX H
TRAVEL ADVISORY DISTRIBUTION LIST

1. Guam International Airport Authority
2. Customs & Quarantine Agency
3. Association of Terminal Operators
4. U.S. Customs and Border Protection
5. U.S. Department of Homeland Security
6. Guam Visitors Bureau
7. Guam Hotel and Restaurant Association
8. Port Authority of Guam
9. Guam Chamber of Commerce
10. Continental Airlines
11. China Airlines
12. Northwest Airlines
13. Korean Airlines
14. Philippine Airlines
15. Japan Airlines
16. Guam Fire Department/Emergency Medical Services
17. Aircraft Rescue Fire Fighting Unit
18. Office of Civil Defense/Office of Homeland Security
19. Guam Police Department
20. Guam Medical Society
21. Continental Micronesia Inc., Family Medical Clinic

APPENDIX I

Guam Department of Public Health and Social Services
ICS Organization Chart



APPENDIX J
IMMUNIZATION PROGRAM VACCINE HANDLING AND STORAGE PROTOCOL
Under Development

APPENDIX K

POTENTIAL VACCINE DISTRIBUTION SITES

Scenario I: Limited Doses of Pandemic Influenza Vaccine

- 1) Department of Public Health and Social Services- Immunization Program
- 2) Guam Memorial Hospital Authority

Scenario II: Adequate Doses of Pandemic Influenza Vaccine

- 1) Department of Public Health and Social Services
 - a) Bureau of Family Health and Nursing Services
 - Region I
 - Region II
 - Region III
 - b) Bureau of Primary Care Services
 - NRCHC
 - SRCHC
 - 2) Guam Memorial Hospital Authority
 - 3) U.S. Military Installations (If only DPHSS to receive all of vaccine allotment)
 - a) Naval Hospital
 - b) Anderson Air Force Base Medical Clinic
 - 4) Private Medical Clinics*
 - 5) FHP
 - 6) PMC Isla Health System
 - 7) SDA Clinic
 - 8) TDC
- *Criteria: Large clientele, multiple medical providers, back-up generator, and security guard
- 9) Long Term Care Facilities
 - a) GMHA- SNU
 - b) St. Dominic's Senior Care Home

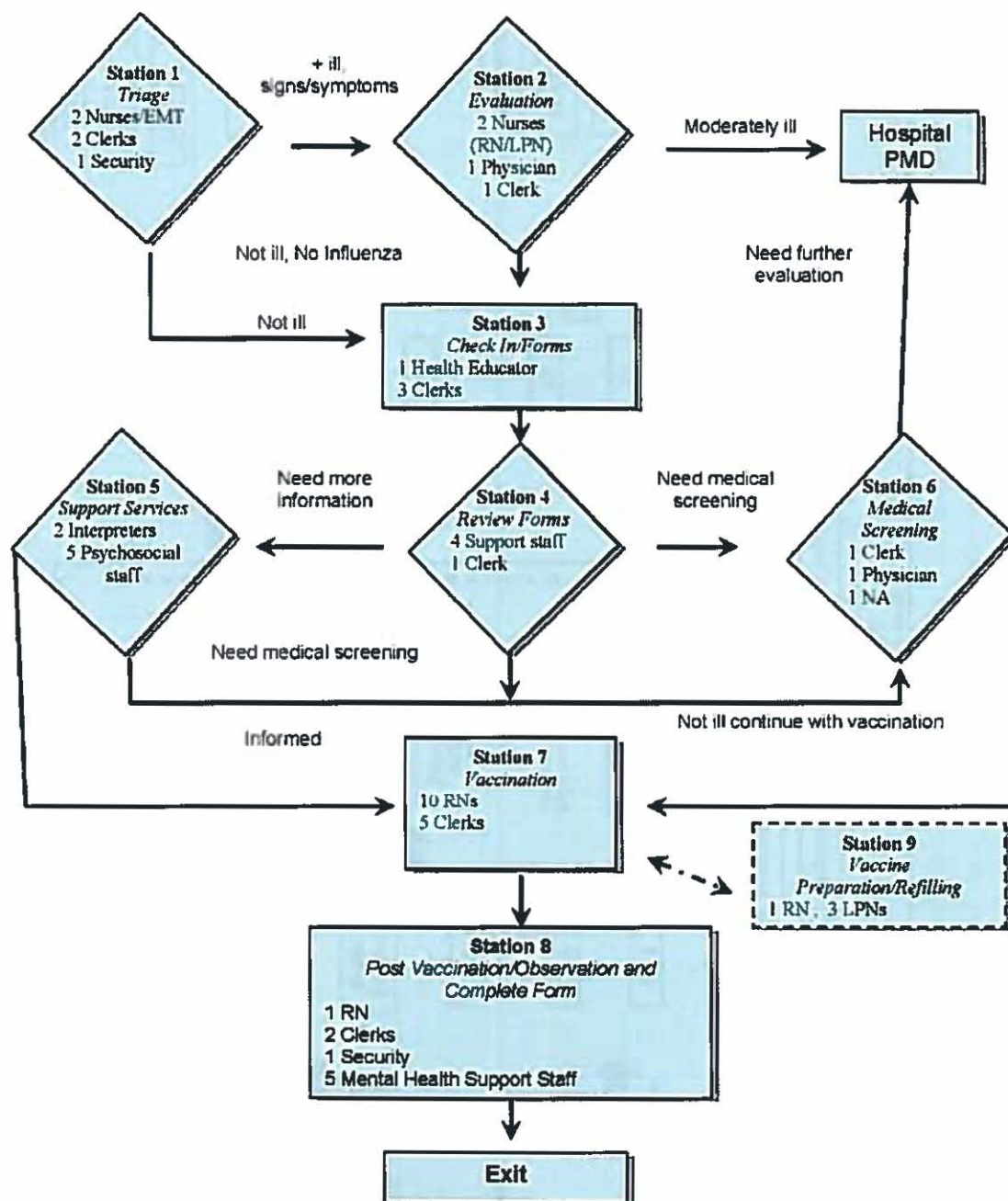
APPENDIX L

POTENTIAL PARTNERS FOR VACCINE ADMINISTRATION ONLY

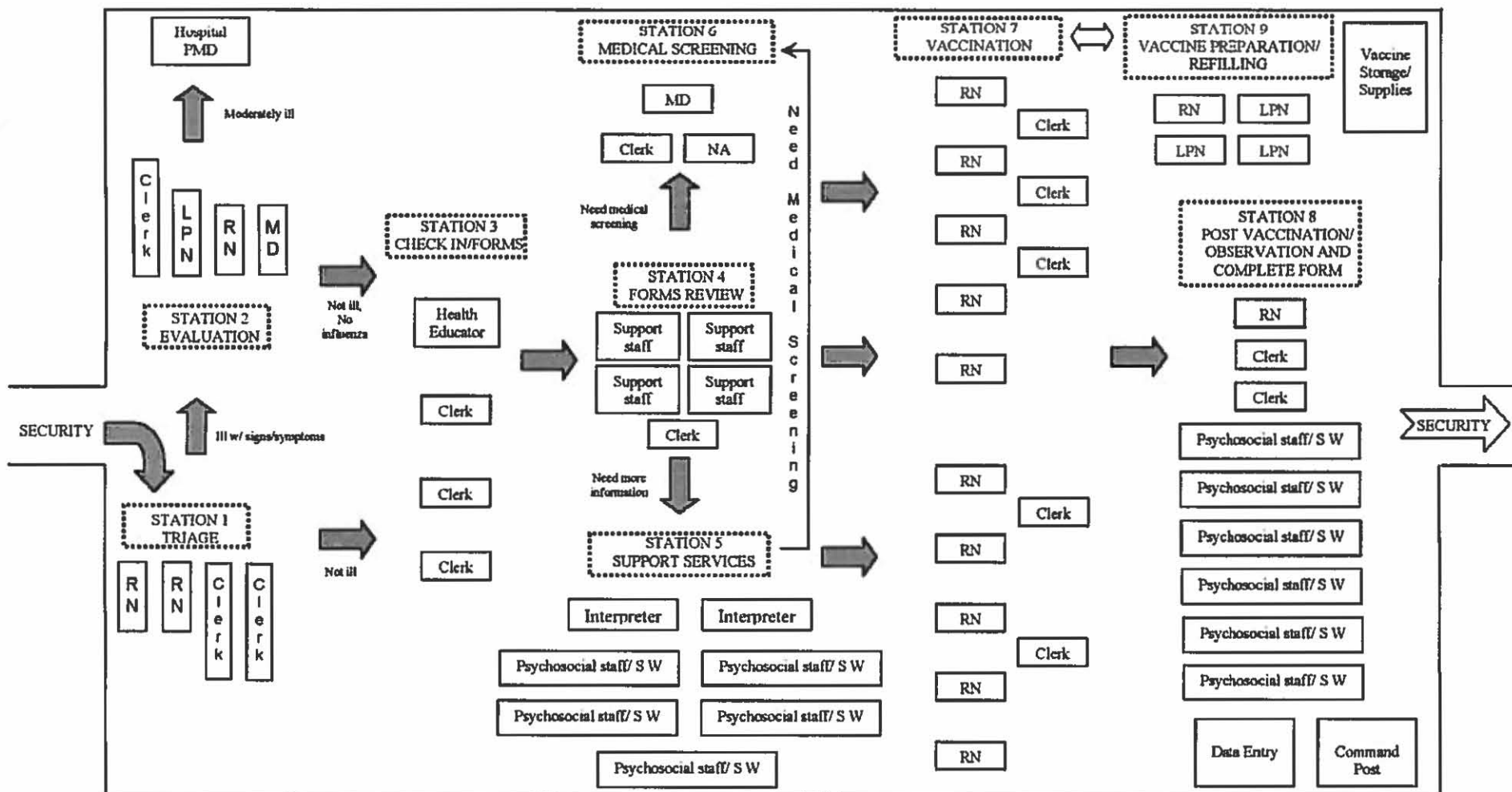
Tier	Occupation
1	Personnel who are currently licensed to administer vaccine and dispense medication (civilian and military):
	Physicians
	Registered Nurses School Health Counselors Guam Public School System Guam Community College University of Guam
	Physician Assistants
	Nurse Practitioners
	Certified Midwives
	Licensed Practical Nurses
	Dentists
2	Personnel for whom administering vaccine would constitute an expanded role:
	Veterinarians
3	Personnel who may administer injections under the supervision of a licensed physician or registered nurse:
	Emergency Medical Technician- Intermediate
	Certified Medical Assistants
	UOG Senior and Junior Nursing Students
	Military Personnel Corpsmen Immunization Technicians Allergy Technicians
4	Personnel who are not licensed or certified to administer vaccine but who have some medical training:
	Retired physicians, nurses, dentists, pharmacists, etc, with expired licenses
	Emergency Medical Technician- Basic
	Laboratory Technicians
	Phlebotomists
	Dental Hygienists
	GCC Medical Assistant Students- Second Year (successfully completed Pharmacology Course)

APPENDIX M

MASS VACCINATION CLINIC FLOW CHART



MASS VACCINATION CLINIC FLOOR PLAN



APPENDIX N
MASS VACCINATION CLINIC PROCEDURES
Under Development

APPENDIX O
SAMPLE
MEMORANDUM OF AGREEMENT FOR MASS IMMUNIZATION SITE LOCATION
BETWEEN
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
AND
DEPARTMENT OF PARKS AND RECREATION

The Department of Public Health and Social Services (DPHSS) and the Department of Parks and Recreation (DPR) enter into this Memorandum of Agreement for the purposes described below effective upon the approval of the Governor.

WITNESSETH

WHEREAS, DPR hereby acknowledges the intent for their facility, Dededo Sports Complex to serve as a local mass immunization site for the DPHSS Guam Pandemic Influenza Plan in the event that the facility is requested to address a large-scale communicable disease outbreak or bioterrorism event.

WHEREAS, DPHSS is in need of the facility and services that can be provided by DPR, and therefore desires to enter into such an arrangement with DPR; and

WHEREAS, both parties agree to the provisions contained below;

NOW, THEREFORE, the DPHSS and the DPR, in consideration of the mutual covenants hereafter set forth agree to the following:

I. DPR agrees to:

- A. After meeting our requirements to our employees, students, members, or clients, our facility will permit, to the extent of its ability and upon request of the DPHSS, the use of the physical facilities and equipment by the DPHSS within 24 hours of the request and for the time period being requested, for mass clinics for disease prevention and control activities, including but not limited to:
- Office equipment, including telephones, copy machines, computers, fax machines
 - Tables, chairs, desks, cots, wheelchairs
 - Refrigerators
- B. Designate three points of contact in case of emergency:
- An administrator who will serve as the primary point of contact. This person should have authority to open up the building.
 - A janitorial point of contact who will work with DPHSS personnel to move tables, chairs, etc.

- A security point of contact who will interact with the DPHSS and local law enforcement in making security plans.
- C. Allow our facility to be visited by members of the local health department, local law enforcement, and, if applicable, the National Guard for the development and maintenance of a mass immunization clinic.
- D. Encourage personnel to become members of the Medical Reserve Corps to ensure adequate training for personnel willing to serve as distribution clinic volunteers.

II. DPHSS agrees to:

- A. Provide a DPHSS point of contact to answer questions that noted facility might have about these arrangements.
- B. Replace or reimburse noted facility for any supplies that may be used by DPHSS in the conduction of its mass immunization clinics.
- C. Provide health and/or security professionals who would meet people at the entrance of our facility and, to the best of their ability, prevent contagious people from entering the building.
- D. Coordinate the provision of extra security personnel, and provide any post-event cleanup that is needed.
- E. Provide training for personnel who will staff the dispensing clinic.

III. It is mutually agreed that:

- A. The noted facility will maintain, and does not relinquish, their flexibility to make arrangements that will minimize the disruption that serving as a mass immunization site could entail.

IN WITNESS WHEREOF, the parties have executed this Agreement on the dates indicated by their respective names.

**DEPARTMENT OF PARKS &
RECREATION:**

TOMMY MORRISON
Director

Date: _____

**DEPARTMENT OF PUBLIC
HEALTH & SOCIAL SERVICES:**

ARTHUR U. SAN AGUSTIN, MHR
Acting Director

Date: _____

**APPROVED AS TO LEGALITY
AND FORM:**

DOUGLAS B. MOYLAN
Attorney General of Guam

Date: _____

APPROVED:

FELIX P. CAMACHO
Governor of Guam

Date: _____

APPENDIX P

PRIORITY GROUPS FOR INFLUENZA VACCINATION

The following prioritized groups are based on recommendations from the November 2005 U.S. Department of Health and Human Services Pandemic Influenza Plan, Appendix D of Part 1 – Strategic Plan. The order of these groups is based on a number of factors including the need to maintain those elements of community infrastructure that are essential to carrying out the pandemic response plan. Other factors include limiting mortality among high-risk groups (Annex 1), the reduction of morbidity in the general population, and the minimization of social disruption and economic losses.

The draft rank-order list is subject to change - potentially on short notice -depending on the epidemiological and clinical features exhibited by the actual pandemic strain (Annex 2). Early vaccination of some persons across each of the highest priority groups, rather than sequentially vaccinating groups, will be considered. Plans based on these draft recommendations should contain a great deal of flexibility in order to be responsive both to the final recommendations and changing conditions during the pandemic.

As two doses of the pandemic influenza vaccine are likely to be optimal, the decision must be made as soon as an estimate of the supply is available regarding whether to administer one dose to a greater number of residents, or to give two doses, an appropriate interval apart, to a smaller group.

Table D-1: Vaccine Priority Group Recommendations

Tier	Subtier	Population	Rationale
1	A	• Vaccine and antiviral manufacturers and others essential to manufacturing and critical support (~40,000) • Medical workers and public health workers who are involved in direct patient contact, other support services essential for direct patient care, and vaccinators (8-9 million)	• Need to assure maximum production of vaccine and antiviral drugs • Healthcare workers are required for quality medical care (studies show outcome is associated with staff-to-patient ratios). There is little surge capacity among healthcare sector personnel to meet increased demand
	B	• Persons > 65 years with 1 or more influenza high-risk conditions, not including essential hypertension (approximately 18.2 million) • Persons 6 months to 64 years with 2 or more influenza high-risk conditions, not including essential hypertension (approximately 6.9 million) • Persons 6 months or older with history of hospitalization for pneumonia or influenza or other influenza high-risk condition in the past year (740,000)	These groups are at high risk of hospitalization and death. Excludes elderly in nursing homes and those who are immunocompromised and would not likely be protected by vaccination

C	• Pregnant women (approximately 3.0 million) • Household contacts of severely immunocompromised persons who would not be vaccinated due to likely poor response to vaccine (1.95 million with transplants, AIDS, and incident cancer x 1.4 household contacts per person = 2.7 million persons) • Household contacts of children <6 month olds (5.0 million)	• In past pandemics and for annual influenza, pregnant women have been at high risk; vaccination will also protect the infant who cannot receive vaccine. • Vaccination of household contacts of immunocompromised and young infants will decrease risk of exposure and infection among those who cannot be directly protected by vaccination	
D	• Public health emergency response workers critical to pandemic response (assumed one-third of estimated public health workforce=150,000) • Key government leaders	• Critical to implement pandemic response such as providing vaccinations and managing/monitoring response activities • Preserving decision-making capacity also critical for managing and implementing a response	
2	A	• Healthy 65 years and older (17.7 million) • 6 months to 64 years with 1 high-risk condition (35.8 million) • 6-23 months old, healthy (5.6 million)	• Groups that are also at increased risk but not as high risk as population in Tier 1B
	B	• Other public health emergency responders (300,000 = remaining two-thirds of public health work force) • Public safety workers including police, fire, 911 dispatchers, and correctional facility staff (2.99 million) • Utility workers essential for maintenance of power, water, and sewage system functioning (364,000) • Transportation workers transporting fuel, water, food, and medical supplies as well as public ground public transportation (3.8 million) • Telecommunications/IT for essential network operations and maintenance (1.08 million)	• Includes critical infrastructure groups that have impact on maintaining health (e.g., public safety or transportation of medical supplies and food); implementing a pandemic response; and on maintaining societal functions
3		• Other key government health decision-makers (estimated number not yet determined) • Funeral directors/embalmers (62,000)	• Other important societal groups for a pandemic response but of lower priority
4		• Healthy persons 2-64 years not included in above categories (179.3 million)	• All persons not included in other groups based on objective to vaccinate all those who want protection

Note the following estimated numbers for certain groups in the Territory of Guam:

Group:	Estimated Size
Health Care Workers (direct patient care)	585 ^a
Essential Public Health Workers (DPHSS)	111 ^a
Adults $\geq$ 65 years of age	10,981 ^b
Pregnant women	3,427 ^c
Persons 6 mos. and older with underlying chronic disease	29,574 ^{a,d}
First Responders (Public Safety and Law Enforcement)	1,102 ^a
Essential Utility Workers	363 ^a

^a Based on data collected by the Guam DPHSS Immunization Program.

^b Guam Bureau of Statistics and Plans, Mid-Year Population By Age and Sex, December 2003.

^c Guam DPHSS, Vital Statistics 2004 birth data.

^d Based on data from 2005 HIES Health Supplement

ANNEX 1

INFLUENZA HIGH-RISK CONDITIONS

- Chronic disorders of the pulmonary system including emphysema and asthma;
- Chronic disorders of the cardiovascular systems (coronary heart disease, angina, heart attack, or other heart condition) Note: Hypertension is NOT considered a high-risk condition;
- Chronic metabolic diseases including diabetes;
- Renal dysfunction;
- Hemoglobinopathies (group of inherited disorders known by changes in the structure of the hemoglobin molecule; includes sickle cell anemia, hemoglobin C disease);
- Immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]);
- Diagnosis of cancer during the previous 12 months (excluding non-melanoma skin cancer);
- Chronic bronchitis or weak or failing kidneys;
- Condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration;
- Children and adolescents (aged 6 months-18 years) who are receiving long-term aspirin therapy and, therefore, might be at risk for experiencing Reye Syndrome after influenza infection

ANNEX 2
PANDEMIC INFLUENZA VACCINE SCENARIOS

SCENARIO I: 1-1,000 DOSES

TIER	SUBTIER
1	A

SCENARIO II: up to 7,000 DOSES

TIER	SUBTIER
1	A B

SCENARIO III: up to 10,000 DOSES

TIER	SUBTIER
1	A B C D

SCENARIO IV: up to 20,000 DOSES

TIER	SUBTIER
1	A B C D
2	B

SCENARIO V: up to 30,000 DOSES

TIER	SUBTIER
1	A B C D
2	A B

SCENARIO VI: up to 40,000 DOSES

TIER	SUBTIER
1	A
	B
	C
	D
2	A
	B
3	--

SCENARIO VII: 40,000 + DOSES

TIER	SUBTIER
1	A
	B
	C
	D
2	A
	B
3	--
4	--

**APPENDIX Q
DRAFT GUAM
MASS FATALITY MANAGEMENT PLAN
FOR PANDEMIC INFLUENZA**

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

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Section 1.0. Introduction

1.1. Guam Laws Governing Dead Bodies

The embalming, cremation, transport, burial, and record-keeping of dead bodies in Guam are governed by Title 10 GCA, Chapters 3 (and its rules and regulations), 4a, and 30:

- a. All unembalmed dead human bodies shall be buried or cremated within 24 hours after death, unless kept under adequate refrigeration.
- b. No human body shall be buried; deposited in a crypt, mausoleum or vault; cremated; or otherwise disposed of, unless a burial permit has first been issued by the Department of Public Health and Social Services (DPHSS).
- c. DPHSS shall arrange for the burial or other disposition of unclaimed dead bodies.
- d. In protecting public health, DPHSS in its discretion may order such form of burial or disposition of a dead human body as it deems necessary.
- e. No person shall transport any dead human body of any person who died from, or while having, any communicable disease specified in Subchapter D, within Guam without the approval of DPHSS. (*Note: Influenza is not included in Subchapter D.*)
- f. Establishment of all cemetery, crypt, mausoleum, vault, or crematory must be approved by DPHSS.
- g. Every person in charge of a cemetery, crypt, mausoleum, vault, or crematory shall keep complete record of all dead human bodies interred, disinterred, removed, or cremated.
- h. Only one (1) body shall be buried in each grave, unless approved by DPHSS.
- i. Graves shall not be less than 6 feet in depth below the surface and shall be not less than 1 foot in width and length than the coffin; however, when vaults are used, it shall not be less than 18 inches in depth below surface.
- j. The Governor of Guam is authorized to set aside from public lands such amount thereof as he may deem necessary for the establishment of a public cemetery.

The management of dead bodies is further governed by Title 10 GCA, Chapter 19 (Emergency Health Powers Act) during a declaration of public health emergency by the Governor. Under such state of emergency:

- a. The Governor of Guam may suspend any Government of Guam regulatory statutes, orders, and rules and regulations that would prevent, hinder, or delay necessary action to respond to the public health emergency, and seek the aid of the Federal Government in accordance with any emergency compact.
- b. The Department of Public Health and Social Services (DPHSS) shall coordinate all matters pertaining to the public health emergency response of Guam, including the safe disposal of dead bodies.
- c. DPHSS may take measures to safely dispose dead bodies, which include, but not limited to, their embalming, burial, cremation, interment, disinterment, transportation, and disposal.
- d. DPHSS, when necessary, require any business/facility that is authorized to embalm, bury, cremate, inter, disinter, transport, and dispose dead bodies to accept any dead bodies or provide the use of its business/facility if such actions are reasonable and necessary as a

condition of licensure, authorization, or ability to continue doing business on Guam. The use of business/facility by DPHSS may include the transferring of management and supervision of such business/facility to DPHSS until the end of the public health emergency.

- e. Government of Guam shall pay just compensation to the owner of any facilities or materials that are lawfully taken by DPHSS for temporary (or permanent) use during the public health emergency.

1.2. Need for Management of Mass Fatality in Guam

During a pandemic, Guam will have to be prepared to manage additional deaths due to influenza, over and above the number of fatalities from all causes currently expected during the inter-pandemic period. The total number of fatalities (including influenza and all other causes) occurring during a 6- to 8-week pandemic wave is estimated to be similar to that which typically occurs over six months in the inter-pandemic period, which is approximately 350 people in Guam.

The following assumptions are made with regard to mass fatality management for pandemic influenza:

- a. In a worst-case scenario, Guam may expect deaths of approximately 8,400 individuals (based on 5% fatality of the entire population similar to 1918 Pandemic).
- b. Most victims will have sought medical care and identified before dying in the hospital; however, many others will die in homes.
- c. More body bags will be necessary to wrap the greater number of dead bodies in and outside of the hospital.
- d. There will be an increase in the number of official pronouncement and certification of death by authorized individuals.
- e. More vehicles, stretchers, and applicable personnel will be needed to transport dead bodies from the sites of death to the morgue.
- f. Guam Memorial Hospital, Office of Chief Medical Examiner, and U.S. Naval Hospital will not have the capacity to store dead bodies of those dying in and outside the hospital.
- g. Guam mortuaries will not have the resources to conduct mass fatality operations, including administration, embalming, cremation, storage, and burial of corpses, and they will lose staff to illness, family illness, death, and refusal to work.
- h. The Office of Vital Statistics will be unable to issue/certify death certificates as quickly as they occur, requiring detailed documentation and close coordination with morgue and funeral activities.
- i. Mutual aid resources will be needed to support local hospital, medical examiner, Office of Vital Statistics, and funeral homes.
- j. Federal assistance will be sought, but Guam cannot be assured that necessary support can or will be provided in timely manner.

This plan will guide the Department of Public Health and Social Services (DPHSS) to cope with large-scale fatalities due to an influenza pandemic. The plan was developed with the review and input of the Guam Mass Fatality Subcommittee, comprised of the Office of Chief Medical

Examiner, Guam funeral directors, Office of Vital Statistics, Guam Memorial Hospital Authority, the U.S. Navy and the U.S. Air Force.

Section 2.0. Plan for Mass Fatalities

To identify planning needs for the management of mass fatalities during a pandemic, the Subcommittee examined each step in the management of a corpse under normal circumstances and then identified what the limiting factors will be when the number of dead bodies increase over a short period of time. Algorithm for the normal management of a corpse in Guam during interpandemic phase is presented in **Annex 1**, while **Annex 2** identifies the usual steps and solutions or planning requirements of a corpse.

It is not the intent of the Department of Public Health and Social Services (DPHSS) to dictate or interfere with the (normal) operation of funeral homes, cemeteries, mortuaries, hospitals, and morgues. Each service provider is expected to prepare its own internal plan to counter the expected increase in demand for their service during a pandemic. Only when such services cannot be, or will not, be provided by the service providers will DPHSS implement necessary actions in the management of mass fatalities in accordance to this plan.

2.1. General Plan

In developing this mass fatality plan, which shall be known as the “Guam Mass Fatality Management Plan” (the “Plan”), the Department of Public Health and Social Services (DPHSS) involved the representatives from the following entities:

- Medical examiner from the Office of the Chief Medical Examiner,
- Local funeral directors,
- Territorial Registrar of DPHSS’ Office of Vital Statistics
- Planner from Guam Memorial Hospital Authority
- Preventive Medicine of U.S. Naval Hospital, Guam
- Public Health Element of Andersen Air Force Base, Guam

This plan is to be reviewed and tested to determine if it is appropriate for the relatively long period of increased demand which may occur in a pandemic, as compared to the shorter response period required for most disaster plans. DPHSS and involved representatives do not recommend mass burials or mass cremations and would only be considered in the most extreme circumstances.

Since it is expected that most fatal influenza cases will seek medical services prior to death, hospitals, nursing home, and other institutions (including correctional facility) must be capable of rapidly processing corpses. These institutions must develop their own internal plans for a pandemic influenza and work with DPHSS and the Office of the Chief Medical Examiner to ensure that they have access to additional supplies (e.g., body bags) and can expedite the steps, including the completion of required documents, necessary for efficient corpse management during a pandemic.

In order to deal with the increase in fatalities, it may be necessary for funeral homes to establish their own temporary holding facility for corpses needing embalment, cremation, or burial. If funeral directors are unable or unwilling to handle the increased number of corpses, DPHSS will be responsible for initiating and implementing appropriate measures, including the institution of powers granted under the Emergency Health Powers Act.

2.2. Preparations for Funeral Directors and Crematoriums of Guam

There are six (6) funeral homes in Guam with five (5) morticians (**Annex 3**). In a pandemic, each individual funeral home could expect to handle about six months work within a 6- to 8-week period. All funeral directors are expected to develop their own internal plans for addressing the increase in number of corpses during a pandemic. Such plan should include the procurement and storage of supplies (e.g., fluids, body bags, and caskets); contingency plan for what would happen if they were incapacitated or overwhelmed; and the need for additional human resources for embalming, cremating, digging graves, etc.

Crematoriums will also need to look at the surge capacity within their facilities. Crematoriums should be able to handle at least one body every four hours, and plan to operate for 24 hours to cope with increased demand. Since cremations have fewer resource requirements than burials, this may be an expedient and efficient way of managing large numbers of corpses during a pandemic, especially when land for burials may be limited.

2.3. Office of the Chief Medical Examiner and Autopsies

The Office of the Chief Medical Examiner (OCME) is responsible for the autopsies and/or certifications of death of individuals dying at home, from foul-play, and under non-hospital care. OCME has the ability to store nine (9) bodies in its morgue facility, and acts as a repository to accept the overflow of dead bodies from Guam Memorial Hospital when it's own morgue exceeds its capacity of twelve (12). Thus, the coroner's office and the hospital combined can accommodate the temporary storage of 21 corpses. The morgue of the U.S. Naval Hospital, Guam can manage 24 dead bodies at maximum capacity.

Majority of deaths during a pandemic would not require autopsies since autopsies are not indicated for the confirmation of influenza as the cause of death. However, for the purpose of public health surveillance (e.g., confirmation of the first cases at the start of the pandemic), respiratory tract specimens or lung tissue for culture or direct antigen testing could be collected post-mortem. Serological testing is not optimal but could be performed if 8-10 mL of blood can be collected from a subclavian puncture post-mortem. Permission will be required from next-of-kin for this purpose.

DPHSS will seek the consultation of the Chief Medical Examiner for any proposed changes to the regular practices pertaining to the management of corpses as it relates to autopsy requirements during a pandemic.

If a physician requires that an autopsy be performed, normal protocols will be followed,

including permission from the next-of-kin. In cases where the death is reportable to a medical examiner, the usual protocols prevail based on Guam law.

During a pandemic and when the plan is activated and implemented, necessary public announcements will be made to educate the public on when a body will and will not be autopsied.

2.4. Plan for Temporary Morgue(s)

Additional temporary cold storage facilities will be required during a pandemic for the storage of corpses prior to their transfer to funeral homes. A temporary morgue must be maintained at 36 °F to 40 °F (2.2 - 4.4 °C). If a temporary morgue cannot reach such temperature range, 40 °F to 45 °F (4.0 - 7.2 °C) is acceptable; however, corpses may begin to decompose in a few days. If the body will not be cremated, expedited embalming process will be necessary considering that bodies will likely be stored for an extended period of time.

Arrangements will be made for temporary morgues based on availability and requirements. The resource needs (e.g., body bags and refrigeration) and supply management for temporary morgues will also be addressed. The types of temporary cold storage to be considered include refrigerated containers and vehicles, and cold storage lockers.

Without stacking the bodies, a refrigerated 40-ft container can generally hold 20-25 bodies without additional shelving. To increase storage capacity, temporary wooden shelves can be constructed of sufficient strength to double the capacity to 40-50 bodies. Shelves should be constructed in such a way that allows for safe movement and removal of bodies (i.e., storage of bodies above waist height is not recommended). To reduce any liability for business losses, containers and trucks with markings of a supermarket chain or other companies will be avoided since the use of such trucks for the storage of corpses may result in negative implications for business. Furthermore, utilization of local businesses for the storage of human remains will not be recommended and will only be considered as a last resort.

2.5. Plan for Temporary Mortuary

The mass processing of dead bodies at a centralized location by the Government of Guam (DPHSS), with the assistance of the Department of Defense (U.S. Navy/U.S. Air Force), will occur when local funeral homes are unable, or unwilling, to meet the demands of embalming, cremating, casketing, and/or burying dead bodies. Within this temporary facility, bodies will continue to be documented, embalmed (or transported to a crematorium if still possible), dressed, casketed, and arranged for their final disposition. However, certain step or steps will be modified, limited, or ceased altogether when resources and/or time become limiting. In a worse-case scenario when the temporary mortuary become overwhelmed with large number of dying people and resources are severely strained to meet the demand, bodies will be immediately bagged and/or boxed without the usual embalmment and then buried at a site and manner determined by DPHSS.

The temporary mortuary facility will provide psycho-social and possibly religious and cultural

support to the families of the deceased. These support personnel will assist the family in coping with the death of their loved ones and assist the temporary morgue in the dissemination of pertinent information. They will further assist the morticians of the facility by collecting articles of clothing the family wish to dress the deceased when a temporary mortuary becomes operational for the mass embalming of dead bodies.

2.6. Capacity and Access to Temporary Holding Facility

A temporary dry holding facility may be required for embalmed remains if burials cannot be performed within reasonable time. Such holding site may be situated in or near the designated temporary mortuary; however, it should ideally be close to the cemetery as reasonably possible. Furthermore, the temporary holding facility needs to be secured with necessary degree of security to prevent unauthorized access.

Section 3.0. Other Technical and Logistic Considerations

3.1. Death Registration

In Guam, the pronouncement of death is primarily the responsibility of a licensed medical doctor, but it may be performed by a licensed nurse practitioner for a terminally ill patient who dies under his/her care at a hospice. The certification of death on the other hand is conducted only by the Chief Medical Examiner, unless the person dies of natural cause at a hospital who has been admitted for more than 24 hours. In such case, the decedent's doctor may certify the death. During a pandemic, authorization to perform certification of death will be expanded to include authorized licensed medical physicians determined by the Chief Medical Examiner.

All deaths occurring in Guam require the filing of the original "Certificate of Death" form with the Office of Vital Statistics (Vital Statistics) to be officially acknowledged and documented. The form is commonly identified and called a death certificate. Blank death certificates are provided to Guam Memorial Hospital (GMH), U.S. Naval Hospital (USNH), and the Office of the Chief Medical Examiner (OCME) by Vital Statistics. Relevant information about the deceased is typed on the certificate by GMH, USNH, or OCME representative before it is submitted to Vital Statistics. It is on this form that pronouncement and certification of deaths are formalized through the signature(s) of applicable practitioner(s).

The original death certificate cannot be released to anyone; it is to be filed and maintained by the Office of Vital Statistics. Death certificates issued to families and/or funeral homes by Vital Statistics are valid only if the forms have been properly certified. Such certified "Certificate of Death" is printed on specialized safety paper and embossed with the seal of the Territorial Registrar.

During pandemic situation, with increased number of deaths, body collection plan will be implemented to ensure that there is no unnecessary delay in moving a body to the morgue. If the person's death does not meet any of the criteria for needing to be autopsied or further examined by the Chief Medical Examiner, then the person will be moved to a holding area soon after the

pronouncement of death. Then a designated physician will certify the death of the deceased.

Funeral directors will be prohibited from collecting a body from the community or an institution until there is a completed certificate of death filed with Vital Statistics. In the event of a pandemic with numerous deaths, it will be necessary to implement a plan that will allow the completion and issuance of death certificates in timely, efficient manner.

3.2. Infection Control

The World Health Organization's "Influenza A (H5N1): Interim Infection Control Guidelines for Health Care Facilities" indicates that embalming may be performed routinely. Thus, special infection control measures are not required for the handling of persons who died from influenza. Funeral homes are recommended to implement universal precautions for embalment of all dead bodies.

Designated personnel tasked to transport and process dead bodies, exclusive of embalmers, will be provided appropriate personal protection equipment, and personal hygiene and sanitizing supplies.

Visitations could be a concern in terms of influenza transmission amongst attendees. It is the responsibility of DPHSS to place restrictions on the type and size of public gatherings if this seems necessary to reduce the spread of disease. This may apply to funerals and religious services. If families are permitted to view the body, they should be provided disposable gloves and masks.

Families requesting cremation of their deceased relative are much less likely to request a visitation, thus reducing the risk of spreading influenza through public gatherings.

3.3. Transportation

No special vehicle, driver license, or permit is needed for transportation of a corpse in Guam, provided the deceased did not die of the plague, smallpox, cholera, yellow fever, typhus fever, typhoid fever, or anthrax. Therefore, there will be no restrictions of families transporting bodies of family members who die of influenza.

In the event the collection and transportation of a corpse cannot be performed by family members or an institution, the Department of Public Health and Social Services will utilize its own, or other Government of Guam agencies', transportation personnel and vehicles.

3.4. Supply Management

DPHSS is recommending to funeral directors that they not order excessive amounts of supplies, such as embalming fluids, body bags, etc., but that they have enough on hand in a rotating inventory to handle the first wave of the pandemic (that is enough for six months of normal operation). Fluids can be stored for years, but body bags and other supplies have a limited shelf life. Cremations generally require fewer supplies since embalming is not required. A list of

current suppliers is provided in **Annex 4**.

Families having multiple deaths are unlikely to be able to afford multiple higher-end products or arrangements. Funeral homes could quickly run out of lower-cost items (e.g., inexpensive caskets such as cloth and some wooden caskets) and should be prepared to provide alternatives. DPHSS will allow the use of durable body bags, cardboard cremation caskets, and other materials that will prevent the leakage of fluids in place of standard commercial caskets when necessary. The use of such materials and the specifications for the home construction of wooden caskets will be distributed to the public by DPHSS (**Annex 5**).

3.5. Land and Sea Burials

All burials of corpses in Guam require “Burial-Transit Permit”, aka Disposition Permit, from the Territorial Registrar (Office of Vital Statistics) of the Department of Public Health and Social Services. For burials at sea, further approval must be obtained from the Guam Environmental Protection Agency.

Guam has a total of 16 known cemeteries. Two are public cemeteries while the remaining fourteen are owned by various families, religious denominations, and commercial entities (**Annex 6**). Vicente Limtiaco Cemetery (Tiguac) in Nimitz Hill and Veteran’s Cemetery in Piti are two public cemeteries. Limtiaco Cemetery accepts the burial of any dead body for a fee, but Veteran’s Cemetery is limited to only veterans and their dependents. Both public cemeteries are under the authority of the Department of Parks and Recreation; however, the operation of the Veteran’s Cemetery is in the process of being transferred to the U.S. Veteran’s Administration. Thus, Vicente Limtiaco Cemetery is the only cemetery readily available for use by the Government of Guam for burying human remains.

Limtiaco Cemetery is approximately 30 acres in total land size; however, only a third of the area is usable for burials. About nine acres are currently occupied with ~3000 bodies and only 120 slots remain. An alternate site for burial must be quickly identified and prepared if death toll (~8000) equaling to that of the pandemic of 1918 is assumed. According to the Department of Parks and Recreation, another location in Mangilao has been identified but clearance and grading of the area have not been conducted.

Another alternative to ground burial is sea burial, which will require sea-going vessels of appropriate specifications to handle large number of bodies.

3.6. Crematoriums

The two crematoriums exist in Guam. They are located in Yona (Our Lady of Peace) and Sinajana (Ada’s Funeral Home). Each crematorium is capable of cremating one body every 4 hours for total of 6 bodies in a 24 hour period. Thus, total of 12 corpses can be cremated at the two facilities if they operate continuously. Cremation of bodies may be preferable over burials since the procedure requires fewer resources. However, when dead bodies exceed the capability of the crematoriums, land and/or sea burials will still need to be performed.

Standard cremation involves the use of corrugated cardboard casket to hold the body as it is burned in the oven. This disposable casket is used to retain leakage of bodily and embalming fluids. If necessary, the cardboard caskets may be replaced with body bags that do not contain chlorides and carbons, which pollute the air and damage the cremation chamber. The continuous operation of the furnace will require necessary maintenance, and the availability of LP gas to run the furnace. Crematorium operators must include the procurement and storage of these and other supplies and materials in their own pandemic plan.

3.7. Transshipment of Corpse Off-island

DPHSS does not anticipate restricting the transshipment of dead bodies for off-island burials, provided such bodies have been effectively embalmed. In all likelihood, such restriction or limitation may come from the airlines as availability of space and/or flights are expected to decrease with fewer visitor arrivals. Family members who wish to have their loved ones buried off-island, but unable to do so during the period of pandemic, may consider having the bodies buried in Guam but in a sound casket. These bodies may later be exhumed for transport off-island, assuming no mass burials were conducted.

3.8. Assistance from Disaster Mortuary Operational Response Team (DMORT)

When the capacity of local jurisdiction to manage mass fatalities is exceeded, U.S. Department of Health and Human Services (HHS) will coordinate with the Department of Homeland Security and the Department of Defense to assist in providing mortuary services; establishing temporary morgue facilities; and processing, preparing, and the disposition of dead bodies through the Emergency Support Function #8 (ESF #8). Under ESF #8, Disaster Mortuary Operational Response Team (DMORT) may be activated, which consists of voluntary staff of private citizens with expertise in mass fatalities that are activated in the event of disaster.

Guam will seek the assistance of HHS and the activation of DMORT when routine management of dead bodies can no longer be performed. In spite of this, DPHSS realizes that Guam cannot rely on the aid of DMORT and other off-island entities during a pandemic when the entire nation will be seeking similar assistance from HHS. An alternative to HHS/DMORT assistance is the U.S. Department of Defense. Guam has the U.S. Navy and the U.S. Air Force based on the island. Their assistance should enhance DPHSS' capability to implement this plan for the management of mass fatalities.

Section 4.0. Social/Religious Considerations

A number of religious and ethnic groups have specific directives about how bodies are managed after death, and such needs are considered as a part of the management of mass fatalities. Jews, Hindus, and Muslims, all have specific directives for the treatment of bodies and for funerals. As a result of these special requirements, the assistance of Catholic Church and other common religious groups on Guam may be sought in the implementation of this plan.

Section 5.0. Activation and Implementation

The Department of Public Health and Social Services will begin preparations for the implementation of the Plan immediately. Such preparations may include updating of information and contact numbers, establishing designated sites of operations, inventory and/or distribution of supplies, procurement of materials, identifying and training applicable personnel, and leasing of equipment. It is intent of this Plan to manage dead bodies as it is currently practiced during interpandemic phase as best as possible. As resources become limited or unavailable, the Plan will institute actions to restrict, or cease altogether, certain activities normally performed in the handling and disposition of corpses.

The actual implementation of the Plan begins when morgue space at the Guam Memorial Hospital becomes unavailable and additional morgue space is sought from the U.S. Naval Hospital, which will likely occur in Phase 6(B) of the pandemic phase. When morgue space in U.S. Naval Hospital is also exceeded, Temporary Refrigeration Morgue (TRM) will be established. The TRMs will be positioned at location near a facility where incoming bodies are identified, examined, bagged, and documented. This facility, which will be identified as the Corpse Processing Center (CPC), is to be converted to a large temporary mortuary for the mass processing of dead bodies when local funeral homes are unable, or unwilling, to meet the demands of embalming, cremating, casketing, and/or burying dead bodies.

At CPC, all procedures in the processing of dead bodies will be performed in a centralized site that will be operated by both civilian and military personnel. Bodies will continue to be documented, embalmed (or transported to a crematorium if still possible), dressed, casketed, and arranged for final disposition. CPC will modify, limit, or cease certain step or steps as resources and/or time become limiting. For example, intravenous embalment may be replaced, or performed in conjunction, with external embalment if embalming fluids become scarce or the need to quickly embalm corpses become necessary. In a worse-case scenario when CPC is overwhelmed with large number of remains that cannot be processed, bodies will be immediately bagged and/or boxed without the usual embalment and then buried at a site and manner determined by CPC.

CPC will psycho-social (and possibly religious) support to the families of the deceased at the facility. These support personnel will assist the family in coping with the death of their loved ones and assist in the dissemination of information.

5.1. PHASES 1 - 5: Preparation for the implementation of the Plan

A. Review, and revise if necessary, Memorandum of Agreement (**Annex 7**) between Government of Guam and U.S. Department of Defense that addresses the following:

1. The temporary use of USNH morgue for housing dead bodies when GMH morgue exceeds capacity.
2. The assistance and use of military facility and its resources (including personnel) for establishing a central facility for mass processing of dead bodies when additional morgue space is unavailable and island funeral homes become unable to effectively embalm/cremate, dress, casket, and/or bury dead bodies.

- B. U.S. Department of Defense identifies suitable site for the mass processing of dead bodies (Corpse Processing Center – “CPC”) when local resources are exceeded for the effective management of dead bodies. In determining such site, the following are considered:
 - 1. Size of the facility to conduct entire processing of dead bodies, which include administrative processing, embalming, dressing, casketing, and temporary storage of corpses for burials;
 - 2. Structural capability (plumbing, electrical, ventilation, and telecommunication needs; protection from weather, including typhoons; etc.)
 - 3. Location (accessibility by military personnel and civilians and their vehicles; proximity to other facilities, such as the hospital, Temporary Refrigeration Morgue, and cemetery; psychosocial effects to nearby residents; etc.)
 - 4. Security to control access and prevent unauthorized entry.
- C. DPHSS contacts applicable vendor(s) for the use of their refrigeration vehicle and/or container for the establishment of a Temporary Refrigeration Morgue (TRM) or Temporary Refrigeration Vehicle (TRV). DPHSS will confirm that the TRMs/TRVs are capable of reaching appropriate temperature to store dead bodies.
- D. TRMs/TRVs are delivered to designated location near the Corpse Processing Center (CPC).
- E. Preparation for the activation of CPC is made by identifying and listing all necessary physical necessities (equipment, furniture, communication lines, etc.), personnel (civilian and military), and supplies (embalming fluids, body bags, etc.).
- F. Flow chart of CPC operation (**Annex 8**), identifying areas for administrative processing, embalming, dressing and casketing of corpses, temporary storage, etc. is reviewed and revised, if necessary.
- G. Licensed medical doctors who can assist the Office of the Chief Medical Examiner to pronounce and certify deaths outside hospital settings are identified, and trained if necessary, by the Chief Medical Examiner.
- H. Multiple teams of two individuals from the Division of Environmental Health of DPHSS are created to operate the TRMs in scheduled shifts when the CPC become operational. The team is identified as “TRM Team”.
- I. Additional supplies and materials are ordered (body bags, gloves, toe tags, etc.).
- J. Multiple teams of two individuals from the Transportation Section of the Division of Senior Citizens of DPHSS are created to transport dead bodies to and from the CPC. The teams shall be identified as the Corpse Transportation Team (CTT). CTT personnel will identify vans and buses within their inventory that will be converted into vehicles to be used for transporting dead bodies. Each CTT will consist of a driver, an assistant, and designated bus. The designated bus may also include TRVs.

- K. Customer Service Representatives (CSRs) and other administrative personnel of DPHSS are identified to assist the Office of Vital Statistics for processing and issuing Certificates of Death and Burial-Transit Permits.
- L. TRM Teams, CTT, and CSRs are trained in their respective duties and responsibilities in preparation for their possible activation. TRM Teams and/or CTT must be instructed on completing applicable forms; operating laptop, printer, and digital camera, and fingerprinting corpses, etc.
- M. Template(s) for public service announcement of telephone hot-line for the pick up and transport of dead bodies to CPC is reviewed and revised, if necessary. See **Annex 9**.
- N. Review and revise, if necessary, forms that will be used in the operation of the Corpse Processing Center.
 - 1. Corpse Transportation Form (CT Form). See **Annex 10**.
 - 2. Corpse Processing Form (CP Form). See **Annex 11**.
 - 3. Corpse Management Log Sheet. See **Annex 12**.
 - 4. Certificate of Death. See **Annex 13**.
- O. "TRM Kits" for the Temporary Refrigeration Morgue Teams are created. The kits will include:
 - 1. Key or combination to open the designated TRM
 - 2. Corpse Processing Forms (CP Form) and Corpse Management Log Forms
 - 3. Certificates of Death
 - 4. Two sets of laptop computer with compatible digital camera, storage drive, and printer.
 - 5. Keys to TRV, if any
 - 6. Contact numbers of applicable personnel and facilities
 - 7. Communication radios, if not already provided
 - 8. Pens, pencils, permanent markers, and paper
 - 9. Personal protection equipment (masks, gloves, hand-sanitizers, and other personal protection and hygiene supplies)
 - 10. Disinfecting solution, spray, and/or wipes
- P. "CTT Kits" for Corpse Transportation Team are created. The kits will include:
 - 1. Personal protection equipment (masks, gloves, overalls, hand-sanitizers, etc.)
 - 2. Corpse Transportation Forms (CT Form)
 - 3. Corpse Processing Forms (CP Form)
 - 4. Blank photocopies of Certificates of Death
 - 5. Pens, pencils, and permanent markers
 - 6. Street maps of Guam
 - 7. Body bags
 - 8. Clipboards
 - 9. Disinfecting solution, spray, and/or wipes
 - 10. Communication radios, if not already provided
- Q. The Office of Vital Statistics ensures sufficient quantities of Death Certificates are in stock in

preparation for the pandemic.

- R. Individuals assigned to perform internal and/or external embalming of dead bodies identified to supplement current, active certified morticians.
- S. Individuals for digging graves at cemeteries, along with heavy equipment necessary to accomplish the task, are identified in the event the cemetery operators unable to perform such activity.

5.2. PHASE 6: Implementation of the Plan

A. Morgue capacity is exceeded

When morgue space at Guam Memorial Hospital Authority (GMH) approaches maximum capacity and need for additional space is expected, the hospital shall notify the Department of Public Health and Social Services (DPHSS) of the situation. Morgue space at the Office of Chief Medical Examiner (OCME) will not be used to house deceased patients of GMH. It is to be used for only storing bodies requiring autopsy; however, this facility may be temporarily used to assist GMH when absolutely necessary and the operation of OCME will not be compromised.

1. DPHSS contacts U.S. Naval Hospital (USNH) and requests for utilization of their hospital's morgue space.
2. Corpse Transportation Team (CTT) is activated and issued the CTT Kit, and instructed to report to GMH.
3. TRM Team is placed on alert in preparation for the possible activation of the temporary refrigeration morgues (TRM) at the Corpse Processing Center (CPC).
4. Once the use of USNH morgue is approved, CTT transports all dead bodies of GMH (including those in the hospital morgue) to USNH morgue. GMH morgue will only act as interim holding site of dead bodies while awaiting transport to USNH or OCME.
5. In coordination with the Department of Defense, the TRM and/or the temporary refrigeration vehicles (TRVs) at CPC are activated when USNH morgue approaches 50% capacity. TRM Team on stand-by is issued TRM Kit and instructed to turn on the refrigeration system of the TRM in preparation of its use. Keys to TRV, if available, are transferred to CTT by the TRM Team.
6. A medical examiner is assigned to the CPC when the facility is activated to conduct formal pronouncement of death of deceased who are delivered to the site by family members or CTT. The medical examiner is also required to identify suspicious deaths. Any deceased individuals delivered to TRM that may have died under unusual circumstance that require further review or autopsy are delivered to the morgue of the Office of the Chief Medical Examiner by CTT.

7. TRM Team notifies designated representatives of GMH and USNH when the temporary refrigeration facilities are operational at CPC and available to accept remains. All dead bodies of GMH and USNH (and OCME) are delivered to CPC. CTT will continue to transport the deceased to CPC. CTT will also assist USNH in transferring their dead to CPC, including those stored in their morgue. USNH morgue will only act as interim holding site of dead bodies while awaiting transport to CPC or OCME.
8. Directors of island funeral homes are notified when USNH morgue is utilized and when CPC becomes operational. They are provided instructions for retrieving bodies from the USNH morgue or CPC for funeral services.
9. Federal assistance is sought from U.S. Department of Human and Health Services for the activation of DMORT to Guam.

B. TRM Operation

Temporary Refrigeration Morgues are manned and operated by TRM Teams at the Corpse Processing Center (CPC). TRM Teams are to document the receipt and release of all dead bodies at the temporary facility through the utilization of Certificate of Death, Corpse Processing Form (CP Form), Corpse Transportation Form (CT Form) and/or the Corpse Management Log Form.

Three separate areas will be established in the CPC (**Annex 8**): (1) Intake Room, (2) Examination Room, and (3) Psycho-Social Room. The Intake Room is to be occupied by TRM Teams to interview family members and/or process documents. The bodies will be examined in the Examination Room by the medical examiner. Psycho-Social Room will be used by designated social workers to console and assist family members.

With the exception of death certificates already prepared by Guam Memorial Hospital (GMH), U.S. Naval Hospital (USNH), and the Office of Chief Medical Examiner (OCME) for those who died at the hospital or autopsied at the coroner's office, all Certificates of Death of decedents that are delivered to CPC will be prepared and printed at the temporary facility by TRM Team using their assigned laptop and printer. Handwritten Certificate of Death prepared by the Corpse Transportation Team (CTT) at the private resident where the dead body is collected is considered "provisional" since the information must be transferred onto a laptop computer for printing at CPC by the TRM Team.

Information necessary to complete the Certificate of Death is obtained from the "provisional" death certificate prepared by CTT Team, or from family member who delivers the deceased to the facility. Once the certificate is printed, it is transferred to the medical examiner to officially pronounce and certify the death of the deceased. The medical examiner will annul the printed certificate, by writing the word "VOID" in large letters across the form, if suspicious death is suspected. The certificate is returned to TRM Team (whether signed or voided) for transmittance to the Office of Vital Statistics.

CP Form is used to collect general information of the deceased and includes Identification Placard, Toe Tag, and Fingerprint Card that can be detached from the form along perforated lines. The form, with the exception of the detachable attachments, comes in triplicate. The original is retained by TRM Team with copies going to the Office of Vital Statistics and family of the deceased. Each CP Form and its attachments are serialized. Identification Placard, Toe Tag, and Fingerprinting Card are used to document the identity of deceased through photograph and physical examination.

CT Form is used by the Corpse Transportation Team to document the pick up and delivery of dead bodies. Corpse Management Log Form is used to centralize the information of all dead bodies received and released by TRM Team.

Algorithm for the processing of dead bodies delivered to CPC is presented in **Annex 14**, and further detailed below:

1. Dead Body delivered to CPC by family
 - a. Intake Room
 - (1) Photo identification cards of the deceased and family member are examined to confirm identities.
 - (2) Name of deceased is written on the Identification Placard, Toe Tag, and Fingerprint Card on the Corpse Processing Form (CP Form). They are detached from the CP Form and provided to the medical examiner.
 - (3) CP Form and Certificate of Death are completed with the assistance of family member. A copy of the CP Form is detached from the original and provided to family member.
 - (4) Certificate of Death is printed and forwarded to the medical examiner for signature. After signed, or voided, the certificate is stapled to the second copy of CP Form and filed.
 - (5) The original copy of CP Form is stapled to the Fingerprint Card and filed.
 - (6) Information of the deceased are recorded in the Corpse Management Log Form.
 - b. Examination Room
 - (1) Body is placed on gurney with assistance of available CTT and wheeled into the Examination Room.
 - (2) Toe tag is received from TRM Team and placed on any of the digits of the right foot. If right foot is not available, then it is placed on the left foot. Fingers are to be used if toes are unavailable.
 - (3) Serialized Identification Placard is received from TRM Team and placed on the chest of the deceased. A single photograph of the head and placard is taken. The medical examiner ensures the serial number of the placard is visible in the photograph.
 - (4) The body is examined, fingerprinted, and bagged with the assistance of TRM Team or CTT. Corresponding serial number is written clearly and in large print on the outside of the body bag with date at the foot of the bag. The Identification Placard is placed inside the body bag.
 - (5) Fingerprint Card is given to TRM Team.
 - (6) Body is wheeled out by CTT to the TRM for storage.

2. Dead Body delivered by CTT that did not originate from hospital or coroner
 - a. Intake Room
 - (1) Corpse Processing Form (CP Form) is received from CTT. Identification Placard and Fingerprint Card are detached from the CP Form and provided to the medical examiner.
 - (2) Corpse Transportation Form (CT Form) is received from CTT for filing.
 - (3) "Provisional" Certificate of Death received from CTT is formalized by transferring information into computer and printing an official Certificate of Death. The certificate is forwarded to the medical examiner for signature.
 - (4) Fingerprint Card from medical examiner is stapled together with the original copy of CP Form and CT Form and filed.
 - (5) The signed, or voided, Certificate of Death received from the medical examiner is stapled to the copy of the CP Form and filed.
 - (6) Information of the deceased is recorded in the Corpse Management Log Form.
 - b. Examination Room
 - (1) Body is placed on gurney with assistance of available TRM Team and wheeled into the Examination Room.
 - (2) The number and name on the Identification Placard received from TRF Team is compared to the Toe Tag on the body for confirmation of identity.
 - (3) The Identification Placard is received from TRM Team and placed on the chest of the deceased. A single photograph of the head is taken, which will also show the serial number on the placard.
 - (4) The body is examined to rule out foul-play and then fingerprinted.
 - (5) Body is then bagged with the assistance of TRM Team or CTT. Corresponding serial number on the placard is written on the outside of the body bag at the foot of the deceased. The date of the action is also printed on the bag. The Identification Placard is placed inside the body bag.
 - (6) Fingerprint Card is given to TRM Team.
 - (7) Body is wheeled out by CTT or TRM Team to the TRM for storage.
3. Dead Body delivered by CTT from hospital or coroner
 - a. Intake Room
 - (1) Corpse Transportation Form (CT Form) and Corpse Processing Form (CP Form) are received from CTT for filing.
 - (2) Certificate of Death received from CTT is forwarded to the medical examiner for pronouncement of death, if not done so already by the attending physician.
 - (4) Signed Certificate of Death is stapled to the copy of CP Form and filed.
 - (5) Original CP Form and CT Form are stapled and filed.
 - (6) Information of the deceased is recorded in the Corpse Management Log Form.
 - b. Examination Room
 - (1) Body is placed on gurney with assistance of available TRM Team and wheeled into the Examination room.
 - (2) Identification Placard inside the body bag is compared to the death certificate for confirmation of identity.

(3) Body is examined by the medical examiner, if necessary, and wheeled out to the TRM for storage by CTT.

4. All documents are filed separately and secured for safe-keeping.
5. Digital camera used to photograph bodies of deceased is given to TRM Team when its memory card is full. The camera is returned to the medical examiner after the TRF Team downloads the images into the hard drive of the laptop. TRF Team creates backup file of the photographs by copying images into the flash drive(s). Files are labeled and organized by the dates when the photographs were taken.
6. Certificates of Death and corresponding copies of CP Forms are picked up by the Office of Vital Statistics for the processing and issuance of certified death certificates and disposition permits to families.

C. Influenza deaths occurring outside GMH and USNH

Individuals who die from influenza, or other natural causes, outside GMH or USNH may be delivered directly to applicable morgue site. Such transportation may be conducted by family members of the deceased, or CTT may be contacted to pick up and transport the dead. *(This will not be applicable to suspicious death or foul-play, which will require the action and involvement of the Guam Police Department and the Office of the Chief Medical Examiner.)*

1. DPHSS is to establish telephone hot-line for the public to call if they wish to have their dead family member(s) picked up by CTT for transport to the hospital or CPC. Hot-line number is disseminated to the public through public announcements. The hot-line and other public announcements will provide instructions on when, where, and how the dead bodies are to be delivered if performed by family members (**Annex 15**).
2. CTT personnel picking up dead bodies are to complete Corpse Transportation Form (CT Form), "provisional" death certificate, and the Corpse Processing Form (CP Form) through the assistance of family member and photo identification card of the deceased.
3. CTT detaches the Toe Tag and Identification Placard from CP Form when the form is completed. The Toe Tag is attached to the toe of the deceased and then the body is bagged. The placard is inserted inside the body bag. The serial number of CP Form and date are written on the outside of the body bag at the foot of the deceased.
4. A copy of the completed CP Form is provided to family of the deceased.
5. Suspicious death is reported to the Guam Police Department by CTT and the body is not collected.

D. Vital Statistics Operation

The Office of Vital Statistics (Vital Statistics) will continue to operate from DPHSS central

facility in Mangilao. The office will operate 24/7 when necessary, as determined by the Territorial Registrar.

1. Funeral homes are not permitted to pick up the Certificates of Death at GMH, USNH, OCME, or CPC when the Plan is implemented. Instead, Vital Statistics will be responsible for picking up the certificates at CPC. The frequency of visit by Vital Statistics to pick up these documents will be based on need, as determined by the Territorial Registrar in coordination with the TRM Team.
2. The Territorial Registrar of Vital Statistics is to request for the activation of support staff to assist in the processing of Certificates of Death and Burial-Transit Permits when the need arises. Upon notification, designated personnel from DPHSS are to report to the Territorial Registrar to assist Vital Statistics. Work schedule for all personnel assigned to Vital Statistics is created by the Territorial Registrar.
3. Vital Statistics is tasked to contact applicable funeral home(s) selected by the family, as indicated in Corpse Processing Form (CP Form), when the death certificate is processed. Burial-Transit Permit (**Annex 16**) is also prepared and released to the funeral home if the location of the burial/cremation is confirmed. Vital Statistics will contact the alternate funeral home if the selected primary provider is unable, or unwilling, to service the dead body. For whatever reason, if the alternate funeral home indicated in the CP Form is also unavailable to accept the body, Vital Statistics is to contact other mortuary providers.
4. Family of a deceased person that cannot, or will not, seek the service of a funeral home will be required to release the corpse to DPHSS for proper disposition. DPHSS will determine such disposition and prepare the Burial-Transit Permit.
5. Vital Statistics is to immediately notify DPHSS when funeral homes are collectively unable to accept decedents in timely manner because of overwhelming number of deaths and dwindling resources.

E. Corpse Processing Center Operation for Mass Embalming and Casketing of Dead Bodies

The Corpse Processing Center (CPC) is prepared and activated for mass embalming and casketing when DPHSS receives notification from the Office of Vital Statistics that funeral homes have reached full capacity and incapable of serving dead bodies in timely manner.

1. DPHSS notifies U.S. Department of Defense of the need to convert CPC for mass embalming and casketing of dead bodies and the facility is arranged in accordance to floor plan of **Annex 17**.
2. Emergency morticians are contacted by DPHSS and instructed to report to CPC.
3. DPHSS issues public announcements (**Annex 18**) informing the public and funeral homes of the following:
 - (a) Activation of the CPC for mass embalming and casketing of deceased;

- (b) Instructions on the delivery of deceased to CPC by family members; and
 - (c) Instructions to families on completing Corpse Processing Form in reference to naming the funeral homes of their choice and the consequences of those bodies which are not accepted by any funeral homes.
4. The operation of CPC will occur in various steps, with each step consisting of specific task in the processing of a dead body.
- (a) Intake Room
 - Operated by the TRF Team
 - Documents are processed and issued
 - (b) Examination Room
 - Operated by the Medical Examiner
 - Bodies are examined, photographed, tagged, and bagged
 - (c) Embalming Room
 - Operated by morticians
 - Bodies are embalmed intravenously and/or externally
 - (d) Dressing and Casketing Room
 - Operated by morticians or designated personnel
 - Bodies are dressed in clothes provided by family
 - (e) Temporary Holding Room
 - Operated by CTT
 - Utilized for the temporary storage of embalmed bodies awaiting transport to final disposition site
5. Bodies are processed in the order they are received in a “First-in, First out” (FIFO) method. However, the medical examiner may prioritize the embalming of a particular body because of its advanced stage of decomposition.
6. CTT transports the embalmed bodies to the cemetery after receiving the Burial-Transit Permit from the Office of Vital Statistics. Corpse Transportation Form is used by CTT for recording deliveries to cemeteries. The form is submitted to the TRM Team upon returning to CPC.

F. Funeral Home Operation

Funeral homes will not be permitted to pick up the Certificates of Death from the hospital, Temporary Refrigeration Morgue (TRM), or the Corpse Processing Center (CPC) for hand delivery to the Office of Vital Statistics (Vital Statistics) once the Plan is activated. Vital Statistics will instead retrieve the death certificates and contact the funeral homes when these certificates are processed and ready for release to the funeral homes. It is the responsibility of a funeral home to notify and educate individuals (or family member) with whom they have existing funeral contracts regarding the Corpse Processing Form to ensure the families indicate the appropriate name in the form.

1. A funeral home is to retrieve the Certificate of Death when contacted by Vital Statistics. If site of burial or cremation is already determined, the information is to be provided to

Vital Statistics.

2. A funeral home that accepts a body that was not accepted by primary and alternate providers listed in Corpse Processing Form must contact the family of the deceased and notify them of the change.
3. If the family of the deceased so wishes, funeral homes are required to casket a body in a wooden casket that meets the specifications outlined in **Annex 5**.
4. A funeral home that is no longer capable of continuing operation, or meet public demand, will notify DPHSS of the situation.

G. Cemetery Operation

Public cemetery is to be utilized for the burying of all deceased individuals that are not buried elsewhere. DPHSS will activate individuals identified as emergency grave diggers in the event the Department of Parks and Recreation is unable to provide personnel to perform such function.

When burial spaces become limited at the public cemetery, multiple family members may be buried in a single grave, provided the uppermost body is at least three feet below the surface. Minimum distance between each grave may be shortened if necessary to maximize burial space.

Mass burial will be implemented only when absolutely necessary.

APPENDIX R

CORPSE TRANSPORTATION TEAM (CTT)

Transportation Segment

Purpose: To provide a fleet of vehicles and volunteers to ensure transportation of infected human remains from home, surveillance area, or other identified location to a hospital or mortuary then to a designated burial site.

Identified Vehicle Fleet:

- Number of Division of Senior Citizens (DSC) transportation vehicles available for this activity: 16
- Total corpse transportation capacity: 150

The following table is a breakdown of DSC vehicles identified:

Vehicle No.	Manufacture/ Model	Model Year	Parking Location	Lifter Capacity	Vehicle Condition	Corpse Capacity	Operator License
32	Ford E350 Bus	1999	Central-DPHSS	Yes (Y)	Good (G)	12	Chauffeurs (C)
35	Ford E350 Bus	2000	Central-DPHSS	Y	G	12	C
21	Ford E350 Van	2001	Dededo F.S.	Y	G	3	C
16	Ford E350 Van	2002	Inarajan Satellite	Y	G	3	C
20	Ford E350 Van	2002	Central-DPHSS	Y	G	12	C
15	Ford E350 Van	2004	Ordot Satellite	Y	G	12	C
37	Ford E350 Van	2003	Central-DPHSS	Y	G	12	C
1	Ford E350 Van	2004	Central-DSC	No (N)	G	6	C
3	Ford E350 Van	2004	Inarajan Satellite	N	G	6	C
19	Ford E350 Van	2003	Agat Satellite	N	G	6	C
8	Ford E350 Van	2003	Ordot Satellite	N	G	6	C
22	Ford E450 Bus	2002	Dededo F.S.	Y	G	12	C
23	Ford E450 Bus	2002	Astumbo F.S.	Y	G	12	C
18	Ford E450 Bus	2003	Dededo F.S.	Y	G	12	C
25	Ford E450 Bus	2003	Agat Satellite	Y	G	12	C
36	Ford E450 Bus	2003	Ordot Satellite	Y	G	12	C

Type of Vehicle License Required:

- Chauffeurs License (A – Operator’s License/ B – Chauffeurs License) – May operate under 15 pax capacity. Written test required; cost \$15.00
- G – License – May operate under 15 pax capacity with lifter. No written test required; cost \$5.00
- D – License – May operate over 15 pax capacity. Written and Road Test is required; no fee required but permission from agency/organization is needed for Road Test.

Conduct Screening of Volunteer Transporters:

- Identify Department staff to provide transportation.
- Survey the 23 Division of Senior Citizens Transportation Drivers to volunteer; 3 of the drivers have 25 lb lifting restrictions.
- Survey Department staff with a Chauffeurs License.
- Survey existing Department staff for volunteer efforts and conduct training to obtain chauffeur’s license (DSC and Department of Motor Vehicles); cross-train Department staff for transportation back-up.

Other Coordination Activity Required:

- Coordinate vehicle refueling stations, transportation support (DPW/GMTA/Commercial Rental), payment methods, emergency service for vehicle maintenance (DPW/Private Vendors).
- Identify other government vehicles and personnel to assist with Corpse Transportation.
- Identify Corpse Management Team (communication and coordination activities/define roles and responsibilities of team members involved/develop back-up coverage/counseling and other training needed for response team).

APPENDIX S
LICENSED HEALTH PROFESSIONALS ON GUAM

HEALH PROFESSION	NUMBER LICENSED
Physicians (M.D.)	165
Registered Nurse	474
Practical Nurse (LPN's)	105
Advanced Nurse Practitioner	13
Certified Midwives	3
Physician Assistant	13
Dentist	51
Veterinary	9
Podiatry	2
Pharmacist	37
Medical Assistant	52
GCC Students(Currently Enrolled in LPN Program)	20
U.O.G. Students(Nursing Students)	400
Individual, Marriage & Family Therapy	52
Clinical Psychologist	6

APPENDIX T

DRAFT PSYCHOSOCIAL RESPONSE PLAN

PURPOSE

The purpose of this appendix to the Guam Pandemic Influenza Response Plan is to address how the Department of Public Health and Social Services (DPHSS) will respond to situations as they relate to pandemic influenza.

DPHSS is responsible for periodically reviewing and updating this plan to ensure that information contained within the document is consistent with current knowledge and changing infrastructure. While this plan serves as a guide specifically for influenza intervention activities during a pandemic, the judgment of public health leadership based on knowledge of the specific virus may alter the strategies that have been outlined.

Priorities of DPHSS during pandemic influenza will be to assure the continuation and delivery of essential services while providing assistance to meet the emergency needs of the population.

SCOPE OF OPERATIONS

This applies to all victims of the disaster as well as personnel assigned to emergency oriented missions within the Territory of Guam. DPHSS will operate within the established incident command structure.

SITUATION AND ASSUMPTIONS

1. An influenza pandemic in Guam will present a massive test of the emergency preparedness system. Advance planning for the island's emergency response could save lives and prevent substantial economic loss.
2. A pandemic will pose significant threats to human infrastructure responsible for critical community services due to widespread absenteeism.
3. Guam's healthcare and mental healthcare systems will be strained to the breaking point by staff attrition and increased demand for services. Healthcare workers and other first responders may be at higher risk of exposure and illness than the general population further straining the healthcare system.
4. Widespread illness in the community could increase the likelihood of sudden and potentially significant shortages of personnel in other sectors who provide critical public safety services.
5. An effective response to an influenza pandemic will require the coordinated efforts of a wide variety of organizations, private as well as public.

6. Disasters, by their inherent conditions, produce the need for behavioral health response. Responding to the psychological and emotional impact of disasters for all people involved is an integral part of a comprehensive and effective disaster response and recovery strategy. Hence, a behavioral health response should be made available to individuals at various venues such as home, school, shelter, hospital, and isolation/quarantine areas.
7. Individuals psychologically impacted often include those involved in treating the physical casualties. In fact, disaster responders, including medical personnel, are a high-risk group for developing trauma-related disorders. Certain members of the workforce (e.g. healthcare workers) may be at increased risk of infection or stress related illness. Those workers at increased risk of infection are an especially vulnerable group due to a real or perceived increased risk of becoming infected themselves, and/or transmitting infection to their friends and families. In addition to assuring access to personal protective equipment, vaccination and prophylactic treatments for first responders and frontline health care workers, health care organizations need to direct attention to mitigating the stress-related psychological effects of disaster response on these individuals. Hence, there is a particular need for sensitivity to personal concerns and obligations when workers, for instance, may be separated from their families and loved ones for long hours and even days.
8. An influenza pandemic may pose substantial short-term and long-term physical, personal, social, and emotional challenges to individuals and/or the community at large.
9. In an influenza pandemic, there may be short and/or long term effects on the mental health of individuals due to direct experience with sick and dying loved ones, and on the population as a whole. The particular mental health needs of other populations such as; tourists from Japan, China and Korea, residents from other cultures such as the FSM, homeless people, and persons who are homebound due to other illness also need to be considered. Along with additional pandemic-related mental health needs of the community, providing care for those with pre-existing mental illness will need to continue.

CONCEPT OF OPERATIONS

DPHSS will organize the psychosocial support response into a comprehensive network to include social workers and counselors from the various divisions within the department as well as from the various government agencies to mitigate the psychosocial impact of any mass casualty incident and in coordination with other private organizations such as the Guam Association of Individual and Marriage Therapists (GAIMFT), the Guam National Association of Social Workers (GNASW), American Red Cross, interfaith agencies, Social Work and Psychology Departments of the University of Guam, and private partners. Provision of local behavioral response will be administered as available resources permit.

Because some or all of the state-level resources may quickly be exhausted, DPHSS may need to request assistance from Federal Emergency Management Agency (FEMA), the National Disaster Medical System (NDMS). NDMS consists of the Disaster Medical Assistance Team, the Disaster Mortuary Operation Response Team, Medical Support Unit, Mental Health and Stress Management teams, and the Veterinary Medical Assistance Team. To this end, DPHSS will:

1. Conduct an island-wide resource inventory to determine the availability of staff at the debriefing centers, corpses processing centers, senior citizens centers, community shelters and other potential sites needing psychosocial support care. (*ON- GOING*)
2. Assess related mental health needs of community, victims, families, behavioral health consumers, emergency workers and their families. (*BEING PLANNED*)
3. Provide oversight and coordination of State response by promoting psychological first aid and resilience for victims and their families as well as coordinating with Incident Command Center to ensure Critical Incident Stress Management is available for first responders and healthcare workers. (*BEING PLANNED*)
4. Provide staff and community partners with literature and educational materials for community-wide distribution, on the human response to disaster, stress reduction and self-help information, and support Public Health community education efforts. (*ON-GOING AND UNDER DEVELOPMENT*)
5. Coordinate with the designated Public Information Officer in providing accurate information to the public the will address the fear and other psychological reactions to an influenza pandemic via media (TV, radio, newspaper). (*BEING PLANNED*)
6. Provide assistance to the existing Crisis Hot Line that will: (*BEING PLANNED*)
 - Provide information and education via phone line for the community
 - Assure mental health consumers' concerns are addressed
 - Provide information in other languages.
7. Institutionalize psychosocial support services in order to help workers manage emotional stress during the response to an influenza pandemic and to resolve related personal, professional and family issues. (*ON GOING*)
8. Train first responders on how to: (*ON-GOING*)
 - Help victims of a disaster emergency deal with the psychological trauma directly associated with an emergency or disaster
 - Provide immediate support
 - Make appropriate referrals for continuing services.
(Refer to US DHHS Pandemic Influenza Plan, *Supplement 11: Workforce Support* for more information on psychosocial considerations and information needs for healthcare workers).
9. Create a plan for continuity of operations in case of increased workload or staff losses during a pandemic. (*BEING PLANNED*)
10. Provide training to psychosocial support staff and volunteers on a yearly basis. (*ON-GOING*)

RESPONSE PHASES

It is expected that an influenza pandemic will occur in the phases listed below. In actual practice, the distinction between the various phases of pandemic influenza may be blurred or occur in a matter of hours, underscoring the need for flexibility. DPHSS response is detailed in each phase.

Interpandemic Phases 1 and 2

- Identify private and public sector responding partners in the planning process and develop a Resource Directory for psychosocial support staff.
- Foster coordination and participation among private and public sector partners in the planning process.
- Work within agencies to develop contingency plans for large scale public health disasters like an influenza pandemic.
- Provide education and planning guidance to responding partners and community on preparing for and responding to an influenza pandemic.
- Identify major gaps in current ability to effectively respond to an influenza pandemic. Explore possible avenues for addressing and resolving gaps.
- Review existing pamphlets on stress reduction for suitability for use during Pandemic Flu and for distribution to the community.
- Hold quarterly meetings with the psychosocial support planning committee.

Pandemic Alert Phase 3

- Designate an official contact person to receive updates.
- Develop and update training syllabus for psychosocial support staff.

Pandemic Alert Phase 4

- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate
- Review and update pandemic influenza response and contingency plans for the psychosocial support.
- Activate psychosocial support staff at pre-designated sites.

Pandemic Alert Phase 5

- Coordinate with the designated Public Information Officer in notifying the public and community partners of the potential for an influenza pandemic in Guam to ensure adequacy of behavioral health response.
- Continue to review pandemic influenza response and contingency plans for large scale public health disasters
- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate

Pandemic Phase 6

- Ensure designated agency contact available to receive updates from DPHSS
- Coordinate use of available resources during pandemic, including private, public and volunteer resources.
- Assess effectiveness of local response and available local capacity.
- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate

Second or Subsequent Waves

- Continue all activities listed under Pandemic phase.
- Review, evaluate and modify as needs, the local pandemic response
- Monitor resources and staffing needs.

Postpandemic Period

- Assess state and local capacity to resume normal behavioral health functions.
- Assess fiscal impact of pandemic response.
- Modify the pandemic influenza response and contingency plans based on lessons learned.

Modified on:
April 17, 2006