

All Hazards Response and Recovery Plan

PANDEMIC INFLUENZA RESPONSE AND RECOVERY ANNEX

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MDH All Hazards Response and Recovery Plan

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Preface

The original version of The Minnesota Department of Health (MDH) Pandemic Influenza Base Plan was developed in 1999 and has been revised as necessary based on federal guidance, partner plans, and exercises. This version includes revisions guided by lessons learned from the 2009-2010 H1N1 pandemic response.

Response staff responsibility

Response staff should become familiar with the plan to ensure effective and efficient implementation. Divisions and programs are responsible for developing and maintaining their applicable sections.

Revision

The plan is continually evaluated, updated, and refined to meet the department's changing needs. The Infectious Disease Epidemiology, Prevention and Control (IDEPC) Division and the Emergency Preparedness and Response (EPR) Section coordinate plan revisions.

Partner Involvement

Implementation of this plan requires extensive communication, coordination and collaboration among all involved in pandemic preparedness, response, and recovery. The size and scope of the pandemic will determine the level of coordination and support required from federal, tribal, state, and local partners.

Leadership

All division directors agree to ensure effective incident management by designating lead and back-up response staff, and by using the National Incident Management System (NIMS) framework.

Data Practices

The MDH Commissioner has determined that the department's emergency plans, including the Pandemic Plan, are public information with some exceptions. Please see the MDH All-Hazards Response and Recovery Base Plan section, *Determination of Data Privacy*, for additional information.

Activation

Plan activation depends on the unique characteristics of the pandemic virus and pandemic epidemiology. The authority to activate the plan rests with the following individuals at the Minnesota Department of Health:

1. Commissioner of Health
2. Director of Emergency Preparedness and Response (DEPR)
3. Director of Infectious Disease Epidemiology, Prevention and Control (IDEPC) or designee

I. Plan Purpose

The MDH Pandemic Influenza Base Plan provides a management framework for the MDH pandemic influenza response. The plan describes MDH response actions and also addresses some partner roles and responsibilities.

Organization of the Plan

The All-Hazards Response and Recovery Base Plan provides an overview of MDH response organization and policies used in response to any emergency. The plan cites the legal authority, general concept of operations, and roles and responsibilities for MDH staff in emergency planning and operations. As an Annex to the All-Hazards Response and Recovery Plan, the Pandemic Base Plan describes the concept of operations and assigns roles and responsibilities that are specific to a pandemic response.

While many of the response actions MDH uses during a pandemic require special coordination structures or actions, some authorities and command and control decisions are addressed in the All-Hazards Response and Recovery Base Plan. These authorities and considerations are referenced throughout this document as appropriate.

Scope

The Pandemic Influenza Response and Recovery Annex:

- Provides MDH pandemic influenza planning guidance
- Describes the essential MDH functions during an influenza pandemic response
- Delineates MDH, local public health, and other partner responsibilities during a pandemic influenza response

**Note: The [MDH All Hazards Response and Recovery Plan](https://www.health.state.mn.us/communities/ep/plans/allhazardsbase.pdf) is referenced in this plan and can be found on the MDH website at: <https://www.health.state.mn.us/communities/ep/plans/allhazardsbase.pdf>*

Situation Overview

Seasonal Influenza Background

Seasonal influenza viruses cause significant morbidity and mortality annually, and are particularly susceptible to changes in genetic make-up. Because a novel influenza virus can occur at any time, a robust surveillance system must be in place both domestically and internationally.

The MDH, working in conjunction with the Centers for Disease Control and Prevention (CDC) and healthcare partners, continually collect suspect influenza viral samples for testing and serotyping to:

- Determine when and where influenza activity is occurring
- Characterize circulating influenza viruses
- Detect changes in influenza viruses
- Measure influenza-associated morbidity and mortality

Pandemic Influenza Background

Experts consider pandemic influenza to be a relatively high probability event - even inevitable. States could have very little lead time between the identification of a novel influenza virus that results in human-to-human transmission and the time that widespread outbreaks occur. Outbreaks are expected to occur simultaneously throughout much of the nation and the world, thus preventing relocation of human and material resources. These characteristics will force every community to rely primarily on its own resources, and will reinforce the need for clear delineation of roles and responsibilities in order to lead a coordinated, successful response.

While the impact of the next pandemic is unknown, a moderate to severe pandemic would have devastating effects. Effective preventive and therapeutic measures – including vaccines and antiviral agents – likely will be in short supply. Health care workers and first responders will be at high risk, further impeding the care of ill persons. Widespread illness in the community will decrease capabilities of essential community services personnel.

Pandemic influenza historically occurs in waves which may prolong the response. A pandemic response is a complex health issue to communicate to the public and will involve coordinated communication at all levels of government and the private sector. The only certainty in a pandemic response is how uncertain the initial months will be.

II. Assumptions and Considerations

The plan includes the assumption that there will be sufficient resources to respond. However, the Department recognizes that the extent of the pandemic may overwhelm response capacity, making scaling back or re-prioritizing services necessary.

Pandemic Impact Assumptions

1. Efficient and sustained person-to-person transmission of a novel influenza virus signals an imminent pandemic.
2. When the influenza pandemic first reaches the state of increased and sustained transmission in the general population, there will be no vaccine against the specific strain of influenza for four to six months.
3. Susceptibility to the pandemic influenza virus may be universal.
4. The incubation period for influenza is approximately two days.
5. Persons who become ill may shed virus and can transmit infection for up to one day before the onset of illness. Viral shedding and the risk of transmission will be greatest during the first two days of illness. Children usually shed the greatest amount of virus and therefore are likely to pose the greatest risk for transmission.
6. On average, infected persons will transmit infection to two other people.
7. The clinical disease attack rate likely will be 30 percent or higher in the overall population. Illness rates will be highest among school-aged children (about 40 percent) and decline with age. Among working adults, an average of 20 percent will become ill during a community outbreak.
8. Some persons will become infected but not develop clinically significant symptoms. Minimally symptomatic individuals can transmit infection and develop immunity to subsequent infection.
9. Of those who become ill with influenza, approximately 50 percent will seek outpatient medical care; however, if antiviral drugs are effective and available, the proportion may be higher.
10. The number of hospitalizations and deaths will depend on the virulence of the pandemic virus. Estimates differ about 10-fold between more and less severe scenarios (see Tables 1 and 2).
11. Risk groups for severe and fatal infection cannot be predicted with certainty but are likely to include infants, the elderly, pregnant women, and persons with chronic medical conditions.
12. During a severe outbreak of pandemic influenza, up to 30 percent of the workforce will be too sick to come to work at any given time. During the peak weeks, rates of absenteeism may be driven to 40 percent.

13. Rates of absenteeism will depend on the severity of the pandemic.
14. Certain public health measures (e.g. closing schools, quarantining household contacts of infected individuals, “snow days”) are likely to increase rates of absenteeism.
15. In an affected community, a pandemic outbreak will last about six to eight weeks.
16. Multiple waves of illness could occur with each wave lasting two to three months. Historically, the largest waves have occurred in the fall and winter, but the seasonality of a pandemic cannot be predicted with certainty.
17. Extrapolations from past pandemics were used to make the assumptions summarized in Tables 1 and 2.

Table 1: United States: Number of Episodes of Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic Influenza Scenarios^{1,2,3}

Characteristic	Moderate (1957/68-like)	Severe (1918-like)
Illness	90 million (30% of population)	90 million (30% of population)
Outpatient medical care	45 million (50% of ill)	45 million (50% of ill)
Hospitalization	865,000 (1% of ill)	9,900,000 (11% of ill)
ICU care	128,750 (15% of hospitalized)	1,485,000 (15% of hospitalized)
Mechanical ventilation	64,875 (50% of ICU)	745,500 (50% of ICU)
Deaths	209,000 (0.23 % of ill)	1,903,000 (2.1% of ill)

Source: United States Department of Health and Human Services Pandemic Influenza Plan

Table 2: Minnesota: Number of Episodes of Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic Influenza Scenarios^{1, 2, 3}

Characteristic	Moderate (1957/68-like)	Severe (1918-like)
Illness	1,544,000 (30% of population)	1,544,000 (30% of population)
Outpatient medical care	772,000 (50% of ill)	772,000 (50% of ill)
Hospitalization	15,000 (1% of ill)	172,000 (11% of ill)
ICU care	2,250 (15% of hospitalized)	25,700 (15% of hospitalized)
Mechanical ventilation	1,120 (50% of ICU)	12,900 (50% of ICU)
Deaths	3,600 (0.23 % of ill)	32,900 (2.1% of ill)

¹ These data are derived from the November 2005 HHS Pandemic Influenza Plan. Estimates were based on extrapolation from past pandemics in the United States. These estimates do not include the potential impact of interventions not available during the 20th century pandemics. Using demographic data from the Minnesota State Demographic Center, categorical data were scaled to the HHS data to provide regional and state data.

² Column totals do not necessarily equal the sum for the total population because numbers have been rounded.

³ A pandemic outbreak may last about 6 to 8 weeks. The above data reflect the number of persons affected during this time frame.

2009 Pandemic Estimates

CDC impact estimates for the 2009 H1N1 (pHN1) pandemic were calculated by extrapolating from the Emerging Infections Program (EIP) laboratory-confirmed hospitalizations data. United States, 2009 H1N1 associated data from April 12th, 2009 to April 10th, 2010 show:

- 60.8 million cases (range: 43.3 – 89.3 million)
- 274,304 hospitalizations (range: 195,086 – 402,719)
- 12,469 deaths (range: 8,868 – 18,306)

Eighty-seven percent of deaths were in persons *under* 65 years of age. Children had 4-7 times the risk of hospitalization and working adults had 8-12 times the risk of hospitalization as compared to seasonal influenza hospitalization data from 1976-2001. (Sundar S. Shrestha, David L. Swerdlow, Rebekah H. Borse, *Estimating the Burden of 2009 Pandemic Influenza A (H1N1) in the United States (April 2009–April 2010)* Clin Infect Dis. (2011) 52 (suppl 1): S75-S82).

Ethical Considerations

The Minnesota Department of Health has supported the development of a Crisis Standards of Care Framework to address ethical decision during a Crisis Standards of Care situation such as an influenza pandemic. The goal of this framework is twofold:

1. To outline the Minnesota Department of Health response during a Crisis Standards of Care situation and
2. To provide planning guidance to health care and public health organizations to successfully manage the transition from conventional to contingency to crisis care and a shift in care from individual patients to the good of the community.

Additional information about the [Minnesota Crisis Standards of Care Framework](https://www.health.state.mn.us/communities/ep/surge/crisis/index.html) can be found at: <https://www.health.state.mn.us/communities/ep/surge/crisis/index.html>

A summary of the ethical commitments, objectives, and strategies is shown below,

Ethical Frameworks At-a-Glance

Ethical commitments for pandemic planning and response

Pursue Minnesotans' common good in ways that:

- Are accountable, transparent and worthy of trust
- Promote solidarity and mutual responsibility
- Respond to needs fairly, effectively and efficiently

Ethical objectives for rationing resources in a severe pandemic

Steward scarce resources to promote Minnesotans' common good by balancing three equally important and overlapping ethical objectives.

- Protect the population's health by:
 - Reducing mortality and serious morbidity from influenza and its complications;
 - Reducing mortality and serious morbidity from disruption to basic health care, public health, public safety and other critical infrastructures.
- Protect public safety and civil order by:
 - Reducing disruption to basic health care, public health, public safety and other critical infrastructures;
 - Promoting public understanding about and confidence in resource distribution.
- Strive for fairness and protect against systematic unfairness by:
 - Reducing significant group differences in mortality and serious morbidity;
 - Making reasonable efforts to remove barriers to access;
 - Making reasonable efforts to reciprocate to groups accepting high risk in the service of others;
 - Rejecting strategies that are discriminatory or exacerbate health disparities;
- Using fair random processes for those similarly prioritized.

General strategies

- Consider and adjust strategies as part of a comprehensive pandemic response plan.
- Revise strategies in light of new information about a specific pandemic.
- Extend supplies and conserve resources before rationing; ration only as a last resort.
- Scale rationing strategies to different levels of scarcity.
- Do not ration based on:
 - Race, gender, religion or citizenship;
 - First-come, first-served;
 - Predictions that some people's lives can be extended more than others (except for people who are imminently and irreversibly dying);
 - Judgments that some people have greater quality of life than others; or
 - Judgments that some people have greater social value than others.

- Generally, de-prioritize people who are unlikely to benefit from the resource.
- Generally, prioritize key workers on a separate track in parallel with a track for the general public, recognizing that in limited circumstances a two-track approach might not be justified.
- Ration different resources based on varying combinations of the following considerations (rather than resort to random processes from the start).
 - For the general public:
 - Risk of flu-related mortality and serious morbidity;
 - Good or acceptable response to resource;
 - Risk of exposure to flu;
 - Risk of transmitting flu.
 - When appropriate to prioritize key workers separately from the general public, consider:
 - Risk of occupational exposure to flu;
 - Risk of flu-related mortality and serious morbidity;
 - Irreplaceability in the critical infrastructure workforce;
 - Risk of transmitting flu;
 - Good or acceptable response to resource.
- When the supply is inadequate to serve all similarly prioritized people then use a fair random process. Note: Under limited circumstances and if feasible, before resorting to randomization among the general public in any given tier, consider prioritizing children. Then depending on the resource and its supply consider prioritizing younger adults before older (either after children or simultaneously with them, as the supply allows).

III. Concept of Operations

Conceptual Frameworks

CDC's central conceptual pandemic response framework, the Pandemic Intervals Framework (PIF), was introduced in 2008 and updated during the 2009 pandemic. The PIF added further detail to the WHO pandemic phases and United States government pandemic stages used to delineate outbreak progression. The Intervals framework also includes Triggers and Actions for each Interval.

CDC's current pandemic planning recommendations published in the September 26, 2014 MMWR [Updated Preparedness and Response Framework for Influenza Pandemics](#) once again update the Intervals as well as the Pandemic Severity Index (PSI) – now the Pandemic Severity Assessment Framework (PSAF).

Three concepts are included in the updated guidance document:

1. **Pandemic Intervals** – The Pandemic Intervals provide a detailed framework for pandemic response. Six intervals delineate the pandemic progression, and specific federal and state indicators (formerly “triggers”), and actions are provided for each interval. The updated intervals framework employs lessons learned from past influenza pandemics including the 2009 H1N1 pandemic.
2. **Influenza Risk Assessment Tool (IRAT)** – The IRAT was introduced in the 2014 CDC guidance. The IRAT uses a scoring system to evaluate two things: 1) emergence – the risk of the virus acquiring the ability to spread efficiently in humans and 2) impact – the potential severity of human disease caused by the virus (e.g., deaths and hospitalizations) as well as the burden on society (e.g., missed workdays, strain on hospital capacity and resources, and interruption of basic public services).
 - a. [CDC has provided an IRAT frequently asked questions document at http://www.cdc.gov/flu/pandemic-resources/tools/risk-assessment.htm](http://www.cdc.gov/flu/pandemic-resources/tools/risk-assessment.htm)
3. **Pandemic Severity Assessment Framework (PSAF)** – The PSAF replaces the Pandemic Severity Index (PSI) and focuses on epidemiologic parameters of transmissibility in addition to severity. The PSAF was created from an analysis of 2009 pandemic data. Because of limited data in the beginning of the pandemic, severity did not provide adequate information to respond appropriately. The transmissibility data will enhance the severity data and further inform response actions.

Goals and Objectives

Cumulative CDC planning guidance has given rise to the following MDH pandemic influenza planning goals and objectives. (For detailed information on federal planning guidance from 2008, see [Federal Guidance to Assist States in Improving State-Level Pandemic Influenza Operating Plans](#)).

1. **Surveillance:** Maintain situational awareness through epidemiologic and laboratory surveillance (Two strategies: *Public Health Laboratory Surveillance and Testing and Disease Surveillance, Investigation and Control*).
2. **Clinical Management:** Partner with health care to ensure adequate medical care for all Minnesotans with influenza (Three strategies: *Clinical Management and Care Guidance and Infection Prevention and Control Guidance and Health Care Surge*).
3. **Vaccination:** Provide vaccine to identified populations in accordance with public health guidelines and procedures (One strategy: *Vaccine Distribution and Use*).
4. **Asset Management:** Manage Minnesota’s strategic national stockpile (SNS) and other influenza-response assets including antiviral medication (One strategy: *Asset Management*).
5. **Community Mitigation:** Implement interventions based on federal guidance and identified decision points (One strategy: *Community Mitigation Interventions*).
6. **Communication:** Provide communication and guidance for MDH staff, MDH partners, and the public throughout the pandemic (One strategy: *Public Information and Warning*).
7. **Care of Deceased:** Manage death related resources (One strategy: *Care of the Deceased*).

Response Strategies

Within the Pandemic Influenza Response and Recovery Annex are a series of Annex Chapters Several MDH All Hazard Response and Recovery Plan Annexes as well as Pandemic Influenza Response and Recovery Annex Chapters describe key response strategies for addressing pandemic influenza response goals and objectives. These additional document are held on an internal agency repository available to all MDH response staff.

Key response strategies include:

Disease Surveillance, Investigation and Control: IDEPC will lead epidemiological surveillance and investigations to identify and characterize the nature of the health threat in Minnesota. Data are collected from hospitals, sentinel clinics, schools, long-term care facilities, and medical examiner offices. Analysis of these data will inform recommendations and actions.

8. **Public Health Laboratory:** The MDH Public Health Laboratory (PHL) will use the State of Minnesota Laboratory System (MLS) to enhance laboratory surveillance. The MLS is a voluntary network established by the MDH-PHL to facilitate inter-laboratory communication and collaboration. Its members include public health and private clinical laboratories, as well as veterinary and agriculture laboratories, serving Minnesota residents. The MDH PHL will manage staff to provide emergency 24-hour laboratory capabilities.
9. **Community Mitigation Interventions (CMI):** IDEPC will coordinate with CDC and state partners to determine appropriate CMI. Factors to assess include access to health care,

tolerance for interventions, demographic make-up, as well as fiscal, logistical, and political considerations. IDEPC staff will use conceptual frameworks developed by CDC including the Pandemic Intervals, IRAT, and the PSAF.

10. **Infection Prevention and Control:** IDEPC will use CDC guidance to develop and provide infection prevention recommendations including the appropriate implementation and cessation of actions such as the use of personal protective equipment (PPE).
11. **Clinical Management and Care:** IDEPC will use CDC guidance to develop and provide clinicians with current clinical and epidemiological criteria, case definitions, and recommendations for case management.
12. **Asset Management:** EPR will manage the Strategic National Stockpile (SNS) (e.g. PPE, ventilators, antivirals). The Department will work closely with other state agencies, local officials, health care providers and pharmacies to implement the receipt, storage, and staging of available resources to areas in need of support.
13. **Vaccine Distribution and Use:** IDEPC will lead the allocation and distribution of vaccine. While vaccine may not be available for months, federal and state groups will work to establish guidelines for the use of vaccine. During this time, the department will work closely with local health departments and health care facilities to ensure that vaccine is allocated and distributed fairly. Supply and demand, ethical considerations, available distribution, and tracking mechanisms will be considered.
14. **Health Care Surge:** EPR will provide guidance and coordination of resources to support health care facilities including the implementation of health care surge plans.
15. **Public Information and Warning:** The MDH Communications Office will assume primary responsibility for the completeness and accuracy of health-related messages. MDH will ensure consistency in messaging by coordinating and supporting public communication activities of local health departments, health care providers, and other partners. If the SEOC is activated, the MDH Communications Office will support the state public information officer (PIO) as the lead PIO.
16. **Care of the Deceased:** When called upon by the Governor, the Department's Health Regulation (HR) Division will direct the Disaster Mortuary Emergency Response Team (D-MERT) to provide support for mortuary or death-related resources.

IV. Direction, Coordination, and Support

Lead Division, Section, Unit or Office

Per the Governor's Executive Order 19-22, [Assigning Emergency Responsibilities to State Agencies](#), the Minnesota Department of Public Safety, Division of Homeland Security and Emergency Management (HSEM), is the coordinating agency during a statewide emergency including an influenza pandemic. In this role, HSEM leads a statewide response.

In a pandemic response, MDH is the lead technical agency. MDH staff are responsible for determining response priorities and staffing appropriate roles in the planning cell at the State Emergency Operations Center (SEOC), including providing the Deputy State Incident Manager. For additional information on the roles and responsibilities of MDH and Partnering Agencies see [Appendix A](#).

Internal Support Division(s), Section(s), Unit(s) or Office(s)

The department maintains the following applicable resources during a pandemic:

- Infectious Disease Epidemiology Prevention and Control: Epidemiologists, physicians, veterinarians, infection preventionists, Advanced Practice Registered Nurses (APRNs) and disease investigators.
- Public Health Laboratory: Microbiologists, laboratory technicians and other laboratory staff, laboratory testing facilities for infectious diseases.
- Disaster Mortuary Emergency Response Team (D-MERT): Mortuary or death-related resources (when called upon by the Governor).
- Health Regulation: Registered Nurses (RNs).
- Behavioral Health: Minnesota Responds database includes the Minnesota Behavioral Health Medical Reserve Corps (MRC). The Department also coordinates regional behavioral health stakeholder groups. If requested by local or state authorities, MDH can provide technical assistance and coordinate short-term behavioral health services to impacted individuals, communities, and responders.

Multijurisdictional Coordination

During a pandemic, all levels of government may respond. Considerations for a multijurisdictional response must include:

Federal Government

The National Response Framework (NRF), in response to Homeland Security Presidential Directive – 5, establishes the basis for federal assistance to states. [See http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf](http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf).

Homeland Security and Emergency Management (HSEM)

HSEM is responsible for coordinating state emergency preparedness, response, recovery, and mitigation. Emergency responsibilities are assigned to HSEM in Minnesota Statutes, Chapter 12, and [Governor's Executive Order Assigning Emergency Responsibilities to State Agencies](#).

State Agencies

State agencies will carry out emergency assignments as assigned in the [Governor's Executive Order Assigning Emergency Responsibilities to State Agencies](#).

Local Government

In accordance with National Incident Management System (NIMS) processes, resource and policy issues are addressed at the local level (e.g., tribal governments, counties, cities, and townships). It is the role of local government to provide initial emergency response and coordination for citizens when a pandemic occurs.

State Response

The *Governor's Executive Order Assigning Emergency Responsibilities to State Agencies* charges HSEM to "... activate the state EOC when any major emergency or disaster occurs that poses a significant threat to public safety and/or health." The SEOC establishes levels of activation and will help decision makers determine the most appropriate level of activation for their agency. Because a pandemic threat is likely to require response from multiple state agencies, a unified command structure may be established. Support agencies facilitate response per the latest [Governor's Executive Order Assigning Emergency Responsibilities to State Agencies](#).

To coordinate operations at the Minnesota Department of Health (MDH), agency leadership will activate the Department Operations Center (DOC) by following procedures outlined in the *All-Hazards Response and Recovery Base Plan*. Regional Multi-Agency Coordination (MAC) and Local Operations Centers (EOCs) also may be activated to support local public health response

Service Continuation

A reduction of workforce makes ensuring continuation of priority services a critical component of the Department's pandemic response. The department will activate the *Continuity of Operations Support Annex* as needed.

Demobilization:

The Pandemic Influenza Response and Recovery Annex follows the demobilization procedures outlined in the *All-Hazards Response and Recovery Base Plan*.

V. Administration Finance and Logistics

Emergency Authorizations

According to guidance on Emergency Authorizations from the Department of Administration Materials Management Division (MMD), when the MDH commissioner or authorized designee determines an emergency exists as defined in [Minnesota Statutes §16C.10, Subd. 2 \(see detail at: <https://www.revisor.mn.gov/statutes/?id=16C.10>\)](https://www.revisor.mn.gov/statutes/?id=16C.10) MDH should take whatever action it deems necessary to protect the public health, safety and welfare, including securing consultants or obtaining needed commodities. No prior approval by MMD is required. Contract documents and related paperwork should be forwarded to MMD within 15 working days as stated in the Emergency Authorizations. If the MDH commissioner or authorized designee has determined that the procurement must be made pursuant to emergency authority, a single source request form is not required, and any work conducted or goods obtained prior to the creation and issuance of a contracting document does not constitute a 16C/A violation. For details, see [Minnesota Statute 16C/A at: <https://www.revisor.mn.gov/statutes/?id=16A.15>](https://www.revisor.mn.gov/statutes/?id=16A.15)

Augmenting Staff and Reassigning Employees

State agencies may be asked to re-allocate personnel from within the agency to meet pandemic response needs. If this cannot be done, a request to fulfill priority one and two services can be made to Minnesota Management and Budget (MMB). State agency requests for logistical items (computers, cars, etc.) are directed to the State Emergency Operations Center (SEOC) within the Division of Homeland Security and Emergency Management (HSEM). MDH may need to reassign staff and resources to support time critical and priority public health services during a pandemic. Staff will not be reassigned without appropriate training, including safety training.

Telecommuting

At the department's discretion, some employees may work from home or from other remote areas. Telecommuting is a valid continuity strategy used to provide time-sensitive or other priority services if that work cannot be provided from an MDH facility. Effectiveness of these policies will be evaluated during a response.

Volunteers

Workers' compensation protections are in place for Medical Reserve Corps (MRC) and other government volunteers engaged in emergency management activities, including provisions of health care.

VI. Authorities and References

Federal Authority

Federal Public Health Emergency Declaration: When the Health and Human Services (HHS) Secretary declares a public health emergency, HHS may waive certain Medicare, Medicaid and Children’s Health Insurance Program (CHIP) requirements and temporarily lift sanctions under the Health Insurance Portability and Accountability Act (HIPAA) and Emergency Medical Treatment and Labor Act (EMTALA). An Emergency Use Authorization may also be allowed. *See:*

[http://uscode.house.gov/view.xhtml?req=\(title:42%20section:247d-6%20edition:prelim\)](http://uscode.house.gov/view.xhtml?req=(title:42%20section:247d-6%20edition:prelim))

Emergency Use Authorization (EUA): During an emergency as determined by the Departments of Homeland Security, Defense, or Health and Human Services (HHS), the HHS Secretary may issue an emergency use authorization, allowing certain drugs, medical devices, biological products or diagnostic tests to be used outside label or prior licensing requirements. *See 21 U.S.C. § 360bbb-3 at:*

<http://www.gpo.gov/fdsys/pkg/USCODE-2010-title21/pdf/USCODE-2010-title21-chap9-subchapV-partE-sec360bbb-3.pdf>

Stafford Act: Robert T. Stafford Disaster Relief and Emergency Assistance Act was signed into law in 1988. The Act amended the Disaster Relief Act of 1974 and constitutes the authority for most federal disaster response activities. *The Act was amended in April 2014 and can be found at:*

https://www.fema.gov/media-library-data/1582133514823-be4368438bd042e3b60f5cec6b377d17/Stafford_June_2019_508.pdf

Public Readiness and Emergency Preparedness Act (PREP): Where the Health and Human Services Secretary declares a public health emergency and authorizes administration of “covered countermeasures” (i.e., drugs, biologics and medical devices), everyone in the chain of providing countermeasures (from manufacturer to clinic worker) receives protection from tort liability, except in cases of willful misconduct. Persons injured by countermeasures are eligible for federal administrative compensation. *See 42 U.S.C. § 247d-62 – 247d-6e at:*

<http://policy.defense.gov/portals/11/Documents/hdasa/references/42%20USC%20247d-6.pdf>

Pandemic and All-Hazards Preparedness Act (PAHPA): Signed into law in 2006 and reauthorized in 2013, PAHPA provides authority for a number of programs, including the requirement for states to develop pandemic and All-Hazards plans. *See Public Law No. 113-5 at:*

<http://www.gpo.gov/fdsys/pkg/PLAW-113publ5/pdf/PLAW-113publ5.pdf>

Emergency Management Assistance Compact (EMAC): Administered by the National Emergency Management Association (NEMA) is a model compact for disaster response, designed and maintained to ensure mutual aid can be both effective and efficient. *See Public Law No. 104-321 at:*

<http://www.gpo.gov/fdsys/pkg/PLAW-104publ321/pdf/PLAW-104publ321.pdf>

State Authority

Chapter 12 of the Minnesota Statutes grants the Governor and HSEM overall responsibility to prepare for and respond to emergencies and disasters. Chapter 12 directs the Governor and HSEM to develop and maintain a comprehensive state emergency operations plan (MEOP).

Furthermore, Minnesota Statutes grant the Commissioner of Health authoritative powers relevant to an influenza pandemic are set forth in Chapters 144, 145, 145A, and 157 of Minnesota Statutes.

Appendix A: Roles and Responsibilities of Partnering Agencies

Outlined below are responsibilities of MDH and its partners during a pandemic influenza response.

Pandemic Plan Chapter	1	2	3	4	5	6	7	8	9	10
Responsible Organizations	Public Health Laboratory	Disease Surveillance	Community Mitigation	Infection Prevention Guidance	Clinical Care Guidance	Asset Management (Antivirals)	Vaccine Distribution and Use	Health Care Surge	Care of the Deceased	Public Information and Warning
Department of Health (MDH)										
Health Regulation									C	
Communications Office										P
Infectious Disease Epidemiology, Prevention and Control		P	P	S	P		p			
Emergency Preparedness						P	C	C		
Public Health Laboratory	P									
State Agencies										
Public Safety	C	C	C	C	C	C	C	C	C	C
Local Agencies										
Local Health Departments		C	S	S	S	C	C	C		
Public Safety and EMS			S							
Regions								C		
Hospitals		C		C	C	C		P		
Tribal Government					S	C	C	C		
Federal Government										
Centers for Disease Control and Prevention	S			P		P	P	S		
Third Party Partners										
Minnesota Laboratory System (MLS)	C									
Medical Reserve Corps.								S		
P: Primary responsibility. Department or jurisdiction is in charge of and responsible for specified function. C: Coordination responsibility. Several departments or jurisdictions have partial responsibility for a particular function, but no one agency has obvious primary responsibility. This may occur where non-governmental agencies are involved. S: Support responsibility. Department or jurisdiction will assist the department or jurisdiction having primary or coordination responsibility for a specified function.										

