Integrating Primary Care Providers into Community Pandemic Influenza Planning:

A Stakeholder Meeting

Meeting Proceedings

InterContinental Buckhead Atlanta

Atlanta, Georgia

Department of Health and Human Services
Centers for Disease Control and Prevention

August 24–26, 2009

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Division of Healthcare Quality Promotion

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The Oak Ridge Institute for Science and Education (ORISE) is a United States (U.S.) Department of Energy (DOE) institute focusing on scientific initiatives to research health risks from occupational hazards, assess environmental cleanup, respond to radiation medical emergencies, support national security and emergency preparedness, and educate the next generation of scientists.

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Introduction

With the emergence of the H1N1 novel influenza virus, the importance of the primary care provider (PCP) office's role in the community healthcare system has become increasingly evident. Often serving as the entrance into the healthcare system, PCPs are likely to play a large role in alleviating surge on the hospital emergency department (ED). However, there seems to be miscommunication between PCPs and public health, hospitals, and emergency management with regards to community pan flu planning. Furthermore, many PCP offices lack their own internal pandemic plans.

For the purposes herein, the term "primary care provider" is used to describe those healthcare professionals who provide routine care to their patients. This is a broad category, and includes general practice, osteopathy, family medicine, internal medicine, pediatrics, obstetrics, and geriatrics. Put in perspective, the PCP is who patients call when they need care, whether they have flu, chicken pox, or need a "checkup."

In February of 2008, the Centers for Disease Control and Prevention's (CDC's) Division of Healthcare Quality Promotion (DHQP), in partnership with the Oak Ridge Institute for Science and Education (ORISE), began researching existing planning efforts being undertaken by PCP offices. Initial research indicated a lack of information geared towards both preparing the PCP office for an influenza pandemic and including the PCP office in community planning efforts. Based on anecdotal evidence that providers lack sufficient time to devote to planning, it was hypothesized that office managers might be an untapped avenue for the planning process. DHQP and ORISE contacted several office manager associations, including the Professional Association of Healthcare Office Management (PAHCOM) and the Medical Group Management Association (MGMA), to validate this hypothesis. Both groups reported that, yes, often it is the office managers, rather than the providers, who are responsible for planning within the PCP office.

On September 19, 2008, DHQP and ORISE hosted an hour-long session at the 20th Annual PAHCOM Conference. After a brief presentation tagged "Pan Flu 101," participants were asked to provide feedback regarding the state of planning in their offices. Notably, 91% of the session participants stated their office had not begun developing a written pan flu plan, and 64% said their office had yet to begin coordinating planning efforts with local and state public health and emergency management agencies.

Additionally, telephone conversations with MGMA further revealed the apparent gap between PCP offices and other community partners. Results of a survey conducted by MGMA found that while most offices have emergency preparedness plans, 62% have not had drills within their offices, 71% have not participated in drills with a local hospital, and 84% have not participated in drills with governmental agencies in the last 12 months; and 68% do not know how to coordinate actions with federal agencies.

Based on these results and the observations from the PAHCOM conference, it was determined that a stakeholder meeting was needed to develop tools to assist PCP offices with creating a pan flu plan and integrating it into the broader community plan.

On August 24–26, 2009, a group of subject matter experts convened in Atlanta, Georgia, to begin work on developing tools for PCP offices. Participants included PCPs, office managers, hospitals, local and state public health departments, local and state emergency management agencies, professional associations, and federal stakeholders.

During the three-day (half day, full day, half day) meeting, 76 participants heard presentations describing some of the challenges facing PCP offices in planning for an influenza pandemic, and one community's approach to integrating PCP offices into their planning efforts. They also engaged in facilitated activities aimed at developing a template for PCP offices to use to create an internal office pan flu plan, and identified strategies for integrating the office plan with public health and emergency management plans in their community. On the final day of the meeting, participants outlined key components of a proposed planning tool, the Pan Flu Organizer (PFO).

Summary of Meeting Proceedings

Day One, August 24, 2009

The first day of the meeting was a half day, and consisted of four presentations designed to set the tone for the rest of the meeting. Following a brief description of the work in which DHQP and ORISE have been engaged and participant introductions, the goals of the stakeholder meeting were outlined. Those goals were as follows.

- Develop a pan flu plan template for PCP offices
- Identify coordination issues affecting PCP offices and their ability to manage patient surge during an influenza pandemic
- Identify coordination strategies for integrating PCP offices into community healthcare system surge response

Recognizing that many PCP offices have yet to begin planning for an influenza pandemic, the meeting was designed to work through the process of integrating PCP offices into community planning. Starting with past experience ("where they had been"), to the current situation ("where they are now"), and finally, to future challenges ("where they are going"), participants were encouraged to share their experiences as their community began the task of incorporating PCP offices into community planning.

To reinforce this continuum of integration from developing an internal office plan to coordinating with community partners, participants heard four distinct presentations. Aimed at setting the tone of the meeting, these presentations described the role of PCP offices in the 1918 Influenza Pandemic, the experiences of one PCP in the spring when H1N1 influenza first emerged, legal and ethical issues facing PCP offices, and one community's successful attempt at integrating PCP offices into their community pan flu plan. The four presentations are summarized below.

An Historical Perspective

Jacob Lauer, a third year medical student from the University of Kansas, opened the presentations with a historical review of the 1918 Influenza Pandemic. He described the role of the PCP in 1918, and detailed the extent to which the medical system was overwhelmed. Based on historical research, Lauer cited lack of coordination among the government, private agencies, and the public sector as a key challenge for PCPs, both in 1918 and presently.

A Provider's Perspective

Asha Devereaux, MD, MPH, a private practitioner from Coronado, California, gave a presentation detailing a PCP's perspective of the initial H1N1 influenza outbreak in the spring of 2009. She echoed the need for coordination between public health departments and PCP offices, and offered practical suggestions for ways to increase communication between the two. Devereaux stressed the importance of the "public-private partnership," encouraging public health to reach out to PCP offices.

Legal and Ethical Issues for Primary Care Offices

Elisabeth Belmont, JD, an attorney with MaineHealth in Portland, Maine, focused on legal and ethical issues facing PCP offices during a pandemic. She organized her presentation into six categories.

1. Protection of Employees and Maintaining Operations
2. Temporary Licensing and Credentialing of Healthcare Workers
3. Liability and Altered Standards of Care
4. State Regulatory Issues
5. Integration of Public and Private Response Activities
6. Ethical Considerations

In addition to discussing ramifications associated with each category, Belmont explained the legal processes surrounding the issues, and encouraged PCP offices to engage their partners in legal discussions to mitigate some of the concerns expected during the fall 2009 flu season.

A Community's Effort

Jon Surbeck and Deb Blandin-Surbeck, from the Weld County Department of Health and Environment in Greely, Colorado, were the final presenters. Their presentation detailed a full-scale exercise Weld County conducted in 2007, which focused on providing care at a PCP office during an influenza pandemic. The exercise was conducted in real-time, during office hours, and services were not disrupted. In addition to describing the exercise, the presentation also included lessons learned and recommendations for developing relationships within the community.

Day Two, August 25, 2009

The second day of the meeting was a full day and began in the plenary room with participants seated at assigned round tables of six to eight people. The assignments were made in an effort to maintain equal representation of sectors during activities. Each table included representation from PCP offices, hospitals, public health, and emergency management. Participants kept these table assignments throughout the meeting; however, many stated on the post-meeting evaluations that they would have preferred to change table assignments each day in order to meet more of their peers.

Day two began with Daniel Jernigan, MD, MPH, from CDC's Influenza Division, giving a brief presentation updating participants on the current H1N1 influenza situation and projections for the fall flu season.

Session I: Role-play #1—Early Pandemic (1st Wave)

Following Dr. Jernigan's presentation, facilitators at each round table led participants through a discussion designed to elicit feedback about planning and responses when a pandemic is still in the early stages. Participants described their organization's responses during the initial H1N1 influenza outbreak in their community by answering the following questions.

1. What were the first two weeks of the H1N1 influenza outbreak like for your agency? Your community?

2. What was the rest of the spring like for your agency? Your community?

3. Were there any "lessons learned" or "best practices"?

4. What challenges do you expect for the fall?

5. What are you doing to prepare for the fall?

Many of the participants experienced an increase in ill patients during the initial H1N1 influenza outbreak in their community. Despite limited supplies, most said their community's healthcare system was able to manage the surge. In addition, participants stated that they were kept busy with requests for information from patients; common questions encountered dealt with H1N1 influenza symptoms and treatment.

In terms of preparing for the challenges expected in the fall, one concern was the start of the school year. Some participants worried that with school physicals and administering school vaccines, PCPs would be overwhelmed. Other participants stated they were developing public service announcements (PSAs) and information to distribute in their community, encouraging people to stay home when ill. The information gathered during this session served to familiarize participants with the experiences of their counterparts, and assisted in the development of the office plan template.

Prior to beginning Session II, participants were asked to identify unique ideas that came out of their discussions. Most of these ideas centered on communication. Participants felt that information sharing between agencies needed to be consistent, clear, and clinically relevant. Several participants suggested conducting daily information briefs, using e-mail and fax to communicate between agencies, and involving both the media and elected officials in the communication process. A complete list of the ideas identified can be found in Appendix A.

Session II: Develop Office Plan Template

After discussing their experiences with H1N1 influenza in the spring, participants began the process of creating a pan flu plan template for PCP offices to use. Participants were provided with a draft office plan template and asked to further expand upon the details, strategies, and action items to be included in the template. The draft template was comprised of six sections.

1. Pre-Planning
2. Clinic Operations
3. Staffing
4. Clinic Environmental Operations
5. Supplies and Equipment
6. Special Considerations

Each of the 12 round tables was assigned two sections of the draft office plan template to expand; therefore, each section was expanded by two tables. Using a "fishbone diagram," participants brainstormed topic areas related to their assigned sections. Once each table determined these topic areas, they discussed the specific tasks and action items related to each. Facilitators encouraged participants to generate deeper levels of planning, using layers of branches to indicate related tasks. Examples of the completed diagrams are located in Appendix B.

CDC Presentations: Vaccine and Antiviral Guidance Updates

Following Session II and a short break, Suchita Lorick, DO, MPH, from CDC's Immunization Services Division, gave participants an overview of CDC's vaccine guidance for H1N1 influenza. In addition, Lisa Rotz, MD, from CDC's Division of Bioterrorism Preparedness and Response, presented CDC's preliminary antiviral guidance for H1N1 influenza. Participants then had the opportunity to ask questions related to the CDC guidance. This question and answer period extended into the working lunch.

Session III: Role-play #2—Peak Pandemic (2nd Wave)

Following lunch, participants moved to their assigned breakout rooms. Each room was designed to represent a community, and participants were grouped so that each room had similar sector representation. This session was designed to elicit feedback about planning and responses when the pandemic is nearing or has reached its peak. Participants brainstormed ways in which community partners can work together to manage a surge in ill patients.

A scenario was presented in which the pandemic had worsened in the community. In the scenario the PCP office experienced a surge in patients due to an outbreak of Hepatitis A, in addition to patients seeking H1N1 influenza testing, vaccination, or care for influenza-like illnesses (ILI).

Each sector (PCPs and office managers, hospitals, public health, and emergency management) was given time to identify external coordination issues related to the scenario that would affect PCP offices. Once identified, participants selected three to five priority coordination issues and began developing strategies for them. These issues and strategies will be incorporated into both the office plan template and the PFO.

Session IV: Role-play #3—Late Pandemic (3rd Wave to Recovery)

Following a short break, participants returned to the breakout rooms for Session IV. The objectives of this session were to identify issues and strategies related to planning and response when the pandemic is slowing and recovery is beginning. Participants brainstormed ways to manage ill patients while looking forward to recovery.

The scenario from Session III progressed into Session IV. Several weeks later, the PCP office began to see a decrease in the number of H1N1 influenza cases, and preventative measures such as vaccination and social distancing reduced the likelihood of future waves of illness due to the virus. However, seasonal flu activity was anticipated to pick up and the PCP office's supplies were exhausted. In addition, the PCP office was faced with rescheduling routine appointments postponed during the H1N1 influenza peak. The community was beginning to return to normal.

Each participant identified issues related to the scenario that they anticipated facing when the pandemic begins to slow. Through a facilitated activity, participants then expanded upon the issues identified by their peers, before beginning to develop strategies for three to five priority issues. These issues and strategies will be incorporated into both the office plan template and the PFO. Many of the issues in Sessions III and IV were identical; a full list of these issues and their corresponding strategies is located in Appendix C.

One key issue identified in all three breakout rooms was staff fatigue. Many participants expressed concern that the prolonged duration of a pandemic would result in high levels of staff burnout, in turn leading to increased absenteeism and the possibility of office closure. Several strategies for addressing mental health concerns were suggested, including partnering with other healthcare providers to share staff; implementing a staff appreciation program; altering work schedules and leave policies; and the use of employee assistance programs to provide psychological support.

Another issue common to each room dealt with a lack of supplies and/or resources. In addition to allocation concerns, participants raised issues related to vendors and financing. Some of the strategies identified included developing or revising "use and reuse" policies; identifying vendors (both primary and secondary) and renegotiating prices and payment schedules; partnering with other community providers to share supplies and/or patient load; and communicating with public health regarding supply levels and asking for assistance.

While several participants were concerned about communication between PCPs, public health, hospitals, and emergency management, many determined that relationship building was the central strategy to employ. Participants suggested that public health establish two-way methods of communication with PCPs in order to become more involved in the community's healthcare team.

Other issues identified included an increase in walk-in patients, patient triage, surveillance, communication with patients, communication with partners, the "worried well," and business continuity. These issues and their corresponding strategies can be found in Appendix C.

CDC Presentation: Clinician Outreach and Communication Activity

Day Two closed with a presentation by Dahna Batts, MD, Clinician Communication Team Lead from CDC's Emergency Communication System. She described the Clinician Outreach and Communication Activity (COCA) at CDC. At the end of her presentation, Dr. Batts provided instructions to PCPs for signing up to receive alerts.

Day Three, August 26, 2009

The final day of the meeting, another half day, focused on identifying components to include in the Pan Flu Organizer (PFO). To begin the process, participants spent time in the plenary session compiling the original "fishbone diagrams" from Day Two, Session II and discussing the office plan template. After all diagrams had been completed, participants returned to the breakout rooms to outline the PFO.

Session V: Develop Pan Flu Organizer outline

Facilitators provided participants with an initial outline of the proposed contents of the PFO. Participants were asked to add to the outline, paying special attention to ways in which PCP offices could coordinate with their community partners. The completed PFO outline can be found in Appendix D.

Participants returned to the plenary room before the meeting adjourned, and were asked to serve as reviewers for the tools and documents to be developed as a result of the meeting. Two review groups were formed; one to review the Primary Care Office Plan Template, and one to review the Pan Flu Organizer.

A tentative timeline of three weeks was set to develop both an abbreviated Office Plan Template and the PFO framework. A timeline for the long-term deliverables, the full Office Plan Template and completed PFO, was not set.

A "hot wash" was conducted to gather participants' opinions on what worked well; what could have been improved; and what training or information related to the topic they felt they still needed (see Appendix F for responses). In addition, participants completed post-meeting assessments and meeting evaluation forms to elicit feedback on whether the objectives were met and what modifications could be made for future stakeholder meetings. The meeting concluded with closing remarks from Captain Deborah Levy of CDC–DHQP.

Conclusion

As PCP offices around the country are experiencing increases in the number of ill patients seeking care, the need for coordinated community-level planning becomes ever clearer. In many communities PCPs serve as the first line of care, keeping people out of hospital EDs. However, in lacking communication and coordination with their community partners, many of these PCPs struggle to manage the surge in ill patients.

The *Integrating Primary Care Providers into Community Pandemic Influenza Planning* Stakeholder Meeting sought to bring together representatives from various backgrounds and experiences. More than 49 agencies in 35 communities were represented at the meeting. With such a diverse group of participants, it was possible to capture a broad variety of issues, strategies, and personal experiences. This depth and breadth of knowledge will serve to create well-rounded tools for PCP offices to use when planning for a pandemic.

Overwhelmingly, participants stated that networking and building relationships with their peers was as beneficial as the issues and strategies raised. The meeting reinforced the need for PCP offices and public health, hospitals, and emergency management to work together towards an integrated community pan flu plan, and demonstrated that such an effort could be accomplished. With the information garnered from the meeting, comprehensive tools aimed at assisting the PCP will be developed and may serve to bridge the disconnect between PCPs and their community partners in planning efforts.

The current H1N1 influenza pandemic underscores the relevance of this meeting and the interaction between PCPs, public health, hospitals, and emergency management that took place. It is anticipated that by promoting better integration of PCP offices into community pan flu plans, surge on the healthcare system, particularly hospital EDs, will be decreased both in the current pandemic and in future pandemic situations.

Presentation slides available upon request.

Descriptions of Proposed Tools

Pan Flu Plan Template for Primary Care Provider Offices

The office plan template is intended to assist PCPs and office managers with preparing their offices for an influenza pandemic. It provides key considerations for PCP offices, and is divided into six sections addressing issues related to pre-planning, patient care, staffing, environmental operations, supplies, and other considerations such as legal or recordkeeping issues. Offices are encouraged to utilize this template as a guide to preparing a plan for handling an increase in patients due to an influenza pandemic, and beginning to integrate the plan into their community's plan.

Pan Flu Organizer

The Pan Flu Organizer (PFO) is intended to be a tool for PCPs and office managers to use to develop a pan flu plan for their office, and then integrate their plan into the broader community plan. Likewise, it is also intended to help familiarize community partners, such as public health and emergency management, on the planning, preparations, and challenges facing PCP offices during a pandemic. Using a tab-divided system, the PFO will consist of the Office Plan Template, a planning calendar, resources, and sections focused on coordinating with public health, hospitals, emergency management, and other healthcare providers in the community. Recognizing the demands on providers' time, the PFO will be written in concise segments, and will be adaptable to any office.

In addition to the Office Plan Template, a major component of the PFO is the planning calendar. Based on the Office Plan Template, and using a 12-month timeline, the calendar will outline steps offices can take to create a plan that is integrated into the broader community plan. Providers and office managers may choose to accelerate the process, working through the items in six to nine months. Items in the planning calendar will be brief; more detailed strategies and considerations will be contained within the subsequent sections of the PFO.

It is important to note that Section 2, Office Plan Template, and Section 3, Planning Calendar, are intended to provide greater detail on the planning process for PCP offices. The remaining sections are intended to serve as resource sections, detailing in-depth strategies, key considerations, and resources relative to each topic. An outline describing the components of the PFO can be found in Appendix D.

Summary of Evaluation Results

Evaluation of the *Integrating Primary Care Providers into Community Pandemic Influenza Planning* Stakeholder Meeting consisted of three independent components.

1. A pre- and post-meeting assessment to measure changes in knowledge regarding preparedness for pan flu and the integration of PCP offices into community pan flu planning.

2. An end-of-meeting evaluation Form to establish whether participants felt the goal and objectives of the meeting were met.

3. An overall participant feedback Form to determine perceived effectiveness of the meeting's design and logistics.

Pre- and Post-Workshop Assessment

Participants were instructed to complete an identical survey instrument on the first and last day of the meeting to assess their understanding of planning for and integrating PCP offices into community planning to reduce surge on the healthcare system during an influenza pandemic. Participants ranked eight statements on a five-level Likert scale that represented their level of understanding or ability, with **1** indicating **Not At All, 2** indicating **Not Much, 3** indicating **Somewhat, 4** indicating **Very Much,** and **5** indicating **Completely.**

Response Rate

Seventy-six participants (54 subject matter experts and 22 federal representatives) attended the stakeholder meeting. Table 1 illustrates the response rates on the assessment survey conducted both on the first and last day of the meeting.

Table 1: Pre- and Post-Meeting Assessment Response Rates

	Distributed (n)	Completed (n)	Response Rate
Pre-Meeting	76	62	82%
Post-Meeting	76	53	70%

Results

Table 2 summarizes the gathered data from the pre- and post-meeting assessment surveys. Only responses that could be matched into a corresponding pre- and post-assessment pair were used for statistical analysis. Overall, there was an increase in each of the mean post-meeting scores, indicating a positive change in participants' perception of their knowledge regarding planning for and integrating PCP offices into community planning to reduce surge on the healthcare system during an influenza pandemic.

Table 2: Pre- and Post-Meeting Assessment Mean Change

	Pre-Meeting n = 52		Post-Meeting n = 52		Degree Mean Change
Question	**Mean**	**SD**	**Mean**	**SD**	**+/-**
1. I am able to describe how my agency will respond during a moderate to severe influenza pandemic (clinical attack rate of 25% or higher).	3.92	1.01	4.48	0.85	+0.56
2. I realize what type of situation would serve as a trigger for initiating an influenza pandemic response in my agency.	3.85	1.00	4.56	0.67	+0.71
3. I believe that coordination between public health and primary care is critical to successful patient surge management in provider offices during an influenza pandemic.	4.85	0.41	4.92	0.33	+0.07
4. I believe that coordination between emergency management and primary care is critical to successful patient surge management in provider offices during an influenza pandemic.	4.71	0.50	4.81	0.49	+0.10
5. I believe it is necessary to develop an integrated pandemic influenza plan for providing healthcare in my community.	4.79	0.46	4.81	0.44	+0.02
6. I understand the primary care provider's role in community-wide planning for an influenza pandemic.	3.88	0.98	4.44	0.67	+0.56
7. I understand the roles and responsibilities of **my** agency in my community's integrated response to an influenza pandemic.	4.23	1.00	4.56	0.83	+0.33
8. I understand the roles and responsibilities of **other** agencies in my community's integrated response to an influenza pandemic.	3.48	1.00	4.33	0.86	+0.85

The increases in mean average that are greater than or equal to 0.50 points on the Likert scale demonstrate the greatest change in perception of participants' knowledge and confidence. The changes greater than or equal to 0.50 points were reflected in the following four statements.

1. I am able to describe how my agency will respond during a moderate to severe influenza pandemic (clinical attack rate of 25% or higher).

2. I realize what type of situation would serve as a trigger for initiating a pandemic influenza response in my agency.

3. I understand the primary care provider's role in community-wide planning for an influenza pandemic.

4. I understand the roles and responsibilities of **other** agencies in my community's integrated response to an influenza pandemic.

It is interesting to note that the largest changes in knowledge perception occurred in statements that are related to roles and responsibilities. Many of the participants commented that they learned most from the PCPs. This observation reinforces the importance of community integration, and highlights the miscommunication that often occurs between PCPs and public health, hospitals, and emergency management. In addition, the fact that these statements represented the largest changes in knowledge indicates that relationship building between partners is a key strategy for coordinating a community response to patient surge.

The standard deviation consistently decreased from the pre- to post-assessment, indicating that for all eight questions in the survey tool, individual scores shifted closer to the mean during the meeting. Greater group consensus can be inferred regarding the degree of understanding among participants of integrating PCP offices into community pan flu planning. Since a primary goal of the meeting was to identify coordination issues and strategies affecting PCP offices, and how to integrate those offices into a community plan, a shift towards consensus across diverse healthcare sectors can be viewed as a success.

Assessment of Meeting Goal and Objectives

Before leaving the meeting, participants were asked to complete an evaluation form designed to determine their perceptions of whether the five objectives of the meeting were met. The survey form asked participants to mark "yes" or "no" to indicate whether they felt that each goal or objective was met and then to describe "why" or "why not."

Objective 1: I have increased my knowledge of the primary care provider's role in planning for an influenza pandemic in a community.

In responding to this objective, two participants answered, "no"; one chose not to respond; and 53 indicated that, "yes," their knowledge of the PCP's role in planning for an influenza pandemic in the community had increased.

The two participants who felt their knowledge did not increase made these statements.

- *What I DID learn was that most of primary care has no idea of their role within the bigger public health and emergency management system*
- *I was already well aware as well as actively involved in planning and education*

Overall most experienced an increase in knowledge of the PCP's role, as indicated in the following comments.

- *The mix of participants was valuable; I heard more definitively about how they perceive their roles*
- *Wow, great insight!*
- *Although I gained some insight of the PCP's role, it would have been beneficial to have a moderated session where PCPs described their practices and how they would be impacted by surge*
- *I had not realized their role and willingness to be engaged*
- *I didn't realize the scope and diversity of PCP; I was made aware of the 80% who are small clinics—very surprising*
- *I learned about some of the obstacles they face; the meeting reinforced the importance of supporting their efforts, especially the needs of smaller provider groups with staffing and resource issues*
- *I had thought it was not necessarily our major responsibility; now I am aware of deficiencies in planners' knowledge regarding primary care roles*
- *It was very interesting to learn expectations and disconnects; I see such a huge gap—so much work remains to be done*

Objective 2: I have outlined a pandemic influenza plan for primary care offices.

Forty-two of the participants agreed that, "yes," they had outlined a pandemic influenza plan for PCP offices; seven responded, "no"; three were unsure; and four did not respond.

The seven participants who felt they did not outline a pandemic influenza plan gave the following reasons.

- *The plan seemed unorganized—needs to be consistent with other plans*
- *The outline is not more than what is already available out there*
- *We already had one; fishbone exercise was uneven as some issues/areas were at the 10,000-foot level, and others were in the weeds*
- *We did not get into details of practical next steps*

Many participants, including those who were unsure, indicated the objective had not been fully met as evidenced by the following comments.

- *Not sure—the basic conversation was good*
- *We made great progress—still work to be done*
- *Partially—looking forward to the product*

When providing comments on why they felt they had achieved this learning objective, participants wrote the following comments.

- *It's probably not the "perfect" product, but one that will be good, functional, and can always be modified/improved*
- *I am looking forward to seeing outcomes*
- *It has to be a generic plan that can be adapted based on locality*
- *An educational campaign on emergency preparedness is needed for private physicians*

Objective 3: I have identified strategies to further integrate the primary care office into the community plan.

Forty-eight participants agreed they had met the third objective, three felt they had not, three were unsure, and two chose not to respond.

In responding to why they felt the objective had been not been met, the dissenting participants made the following comments.

- *I already knew this*
- *I identified the need but not "how" (in progress)*
- *We actually could not substantially address this issue*

The participants who were undecided as to whether the learning objective had been met made the following statements as to why or why not.

- *Lots of work to do still*
- *Somewhat*

The participants who felt the objective had been met added the following statements.

- *PCPs need to improve relationships with local public health departments; we still need discussions on how public health can reach out to PCPs; we sometimes relied too much on primary care voices versus discussing how to integrate into the broader health system*
- *Definitely—I have a better understanding of how PCPs need to connect with public health*
- *I am now more knowledgeable about how to access/integrate and how the system works at the local level, and will contact public health and emergency management*
- *This needs to be maintained and streamlined, especially for the small clinics*
- *The meeting reinforced my belief in the importance of the PCP in a pan flu response*
- *Integrating primary care is a tough sell that requires marketing*

Objective 4: I have outlined the components for a planning calendar and organizer (Pan Flu Organizer).

Forty-seven participants agreed they had met the objective above, six felt they had not, one was unsure, and two chose not to respond.

In responding to why they felt the objective had been not been met, the six dissenting participants made the following comments.

- *No discussion of time frame*
- *Calendar components not as clearly articulated*
- *Plan template was clear, organizer is not*
- *Breakout session was too unfocused, more of a brainstorm*
- *I do not agree with the "group" concepts*

The participants that felt Objective 4 had been met added the following statements.

- *In progress*
- *Components outlined and delineated*
- *Excellent idea and local health department can pass this out too, especially without the emergency management team and our hospital/healthcare coalition*
- *Didn't work much in a calendar, but organizer yes*

Objective 5: I have formed an advisory group to further develop the Pan Flu Organizer.

Thirty-nine participants agreed they had met the objective above, eight felt they had not, two were unsure, and seven did not respond.

In responding to why they felt the objective had been not been met, the eight participants who stated that they had not met the objective made the following comments as to why not.

- *PCPs are not able to take time for this "organizer"—doing action plans, situational awareness, regarding H1N1 (influenza) mass vaccination and patient surge*
- *The output and purpose of the "advisory group" is not clear*

The participants that felt Objective 5 had been met added the following statements.

- *People committed to be on a group to review this*
- *I volunteered to review and hope to see a ListServ*
- *Go Team!*

Effectiveness, Design, and Conduct of the Meeting

The Participant Evaluation Survey was designed to determine overall perception of the effectiveness, design, and conduct of the meeting. Ten statements were assessed using a five-level Likert scale with **1** indicating **Strongly Disagree, 2** indicating **Disagree, 3** indicating **Undecided** or **Not Applicable, 4** indicating **Agree,** and **5** indicating **Strongly Agree.**

Table 3 shows the complete results, where **N** indicates number of respondents for a particular question. The highest number of respondents is indicated in **bold typeface**.

Table 3: Participant Evaluation Survey—Meeting Effectiveness, Design, and Conduct

Assessment Factor	Participant Responses (N)				
	Strongly Disagree	Disagree	Undecided/ Not Applicable	Agree	Strongly Agree
	1	2	3	4	5
1. Information and instructions provided before the meeting began were adequate. (N = 51)	0	1	6	**32**	12
2. The meeting was well structured and organized. (N = 50)	0	1	3	21	**25**
3. There was appropriate time for questions and discussions. (N = 51)	0	1	2	**26**	22
4. The meeting content was relevant to my agency. (N = 51)	0	0	1	24	**26**
5. Participation in the meeting was appropriate for someone in my position. (N = 51)	0	0	2	16	**33**
6. The participants included the appropriate level and mix of disciplines. (N = 50)	0	4	2	19	**25**
7. The meeting encouraged discussion between agencies. (N = 51)	0	0	1	16	**33**
8. There was appropriate time for interaction with peers. (N = 50)	0	3	4	**28**	15
9. The rooms were comfortable in terms of lights, seating, and temperature. (N = 51)	1	5	4	**24**	17
10. During discussions, the facilitators and participants could be heard. (N = 50)	0	4	2	20	**24**

Comments from the participants regarding the effectiveness, design, and conduct of the meeting were favorable in general. Several themes emerged, including 1) setup, 2) mix of participants, and 3) meeting design and conduct. These comments are included below.

1. *Setup*

The majority of the comments related to the meeting facilities and set-up were positive. However, four participants expressed that they would have liked to have moved to different tables each day in the plenary room in order to meet more of the participants. Some specific comments include the following.

- *Space at the tables was limited, which made it harder to take notes; maybe have one less person at each table; thanks for a great meeting*
- *Discussions at the tables were difficult to hear because of the hum of discussion at other tables*
- *I would have preferred mixing the table participants for more interaction*
- *It might have helped to move table participants around to really meet others*

2. *Mix of Participants*

Participants had several suggestions for additional partners they would have liked to have had represented at the meeting.

- *There should have been more representation from small primary care practices, including office managers, and less from public health*
- *It's a shame that there were not more frontline (target audience/primary care) in attendance*
- *There were not enough representatives from other parts of the health system*
- *There are additional partners that might be considered—Emergency Support Function leads, insurance, vendors, health maintenance organizations, private sector, insurers, managed care, the Centers for Medicare and Medicaid Services*

Several participants expressed that networking with their peers was a valuable part of the meeting.

- *Networking with participants was most valuable to me; I enjoyed hearing from folks on the ground*
- *Evening options for networking would have been great, not anything facilitated but just an option*

However, four participants felt that communication between the PCPs and other participants could have been improved:

- *Some of the "observers" kept some dialog from taking seed*
- *There was not enough listening of emergency planning folks and public health folks to primary care input; in many cases PCPs did not get the appropriate level of voice*
- *There was too much emphasis on only hearing from PCPs in the room and not other individuals representing the broader health system*

3. Meeting Design and Conduct

Overall, comments surrounding the conduct and structure were favorable. Some specific comments include the following.

- *Very well organized conference; I enjoyed understanding the voices of other disciplines and what their frustrations were as well as how their positions effect the way disasters are managed*
- *Very good flexibility and "adapting on the fly" to issues and changes in focus as they arose; stayed very close to focus of the meeting*
- *Well coordinated and well facilitated meeting; facilitators handled strong personalities well and brought out comments from more quiet attendees*
- *Thank you for the opportunity to participate in this meeting; great job!*
- *Topics were excellent*
- *Briefings by CDC were very helpful*
- *Keynotes on first day were well planned and well delivered*
- *Interactive breakouts provided excellent insight and information*

In addition, several participants gave the following recommendations on how the meeting design could have been improved.

- *Consider pre-conference meetings/reading, even "thought exercises"*
- *Have a meeting just on recommendations for establishing lines of communication and coordination was probably needed first; it may have been too advanced to jump to an office plan*
- *Include an overview of emergency preparedness, National Incident Management System, and the National Response Framework in the beginning; have emergency management give a presentation on what emergency management does and does not do*
- *Plan more small group interception—breakouts—which allowed the best chance for learning and interaction*

Outcome

Participants came to the meeting with the understanding that community collaboration was essential and that providers needed more tools to successfully fulfill their obligations to prepare for pan flu. The three-day meeting seemed to result in participants' increased understanding of how to improve collaborative efforts within their community. This was evident by the identification of both issues and strategies considered to be critical components of pan flu planning tools for PCP offices.

The meeting succeeded in achieving its intended objectives resulting in enabling participants to:

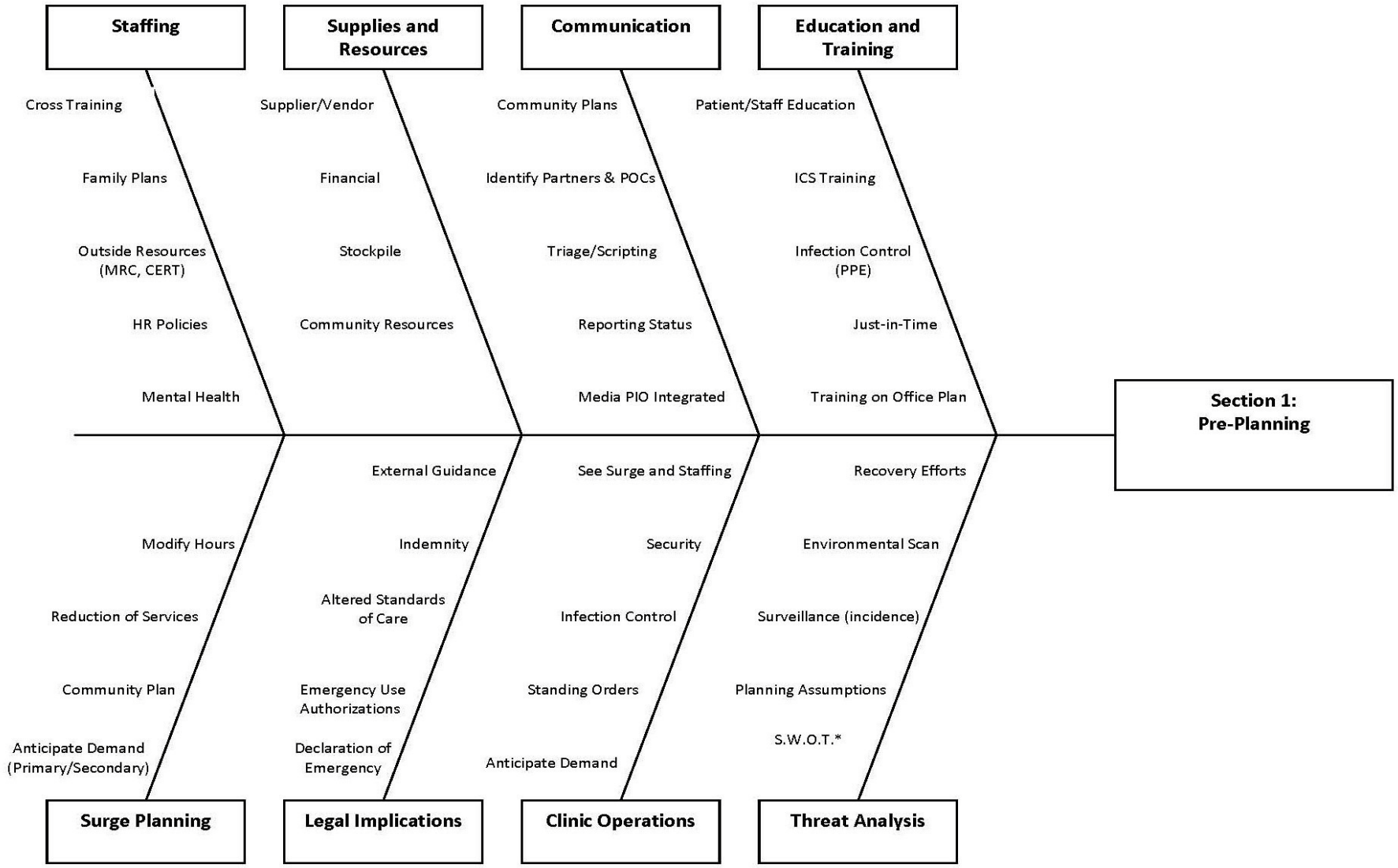
1. Better understand both the role of PCPs and how to engage them in community influenza pandemic planning
2. Identify strategies for integrating PCPs into community planning
3. Develop a Draft Pan Flu Office Plan Template
4. Develop the Pan Flu Organizer framework
5. Establish a review committee for the further development of proposed tools

Appendix A: Unique Ideas

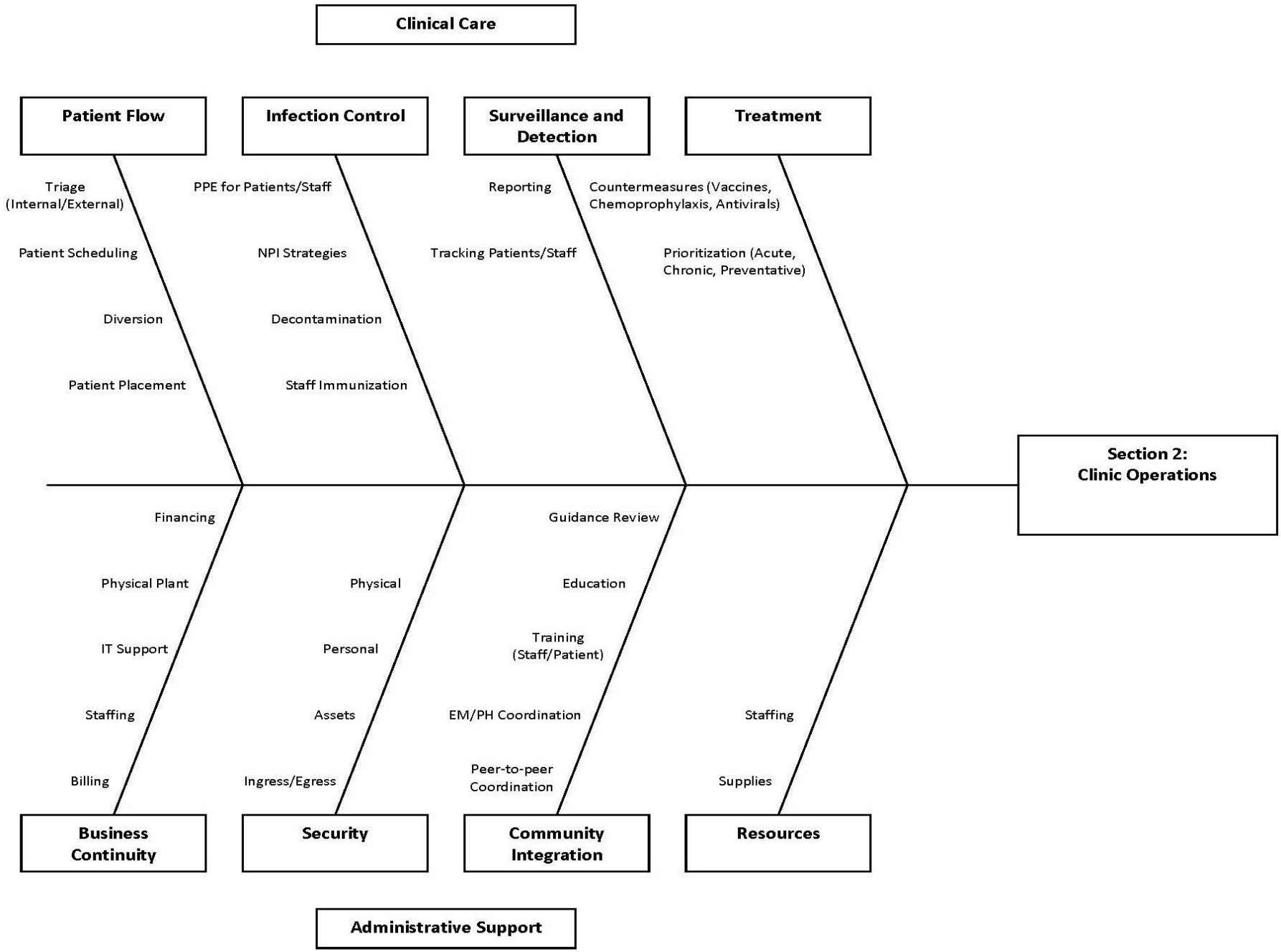
During Role Play #1, participants were asked to discuss with their tables their experiences during the initial H1N1 influenza outbreak, and present to the plenary group those things they heard that were unique. Those experiences were presented during the plenary session as follows.

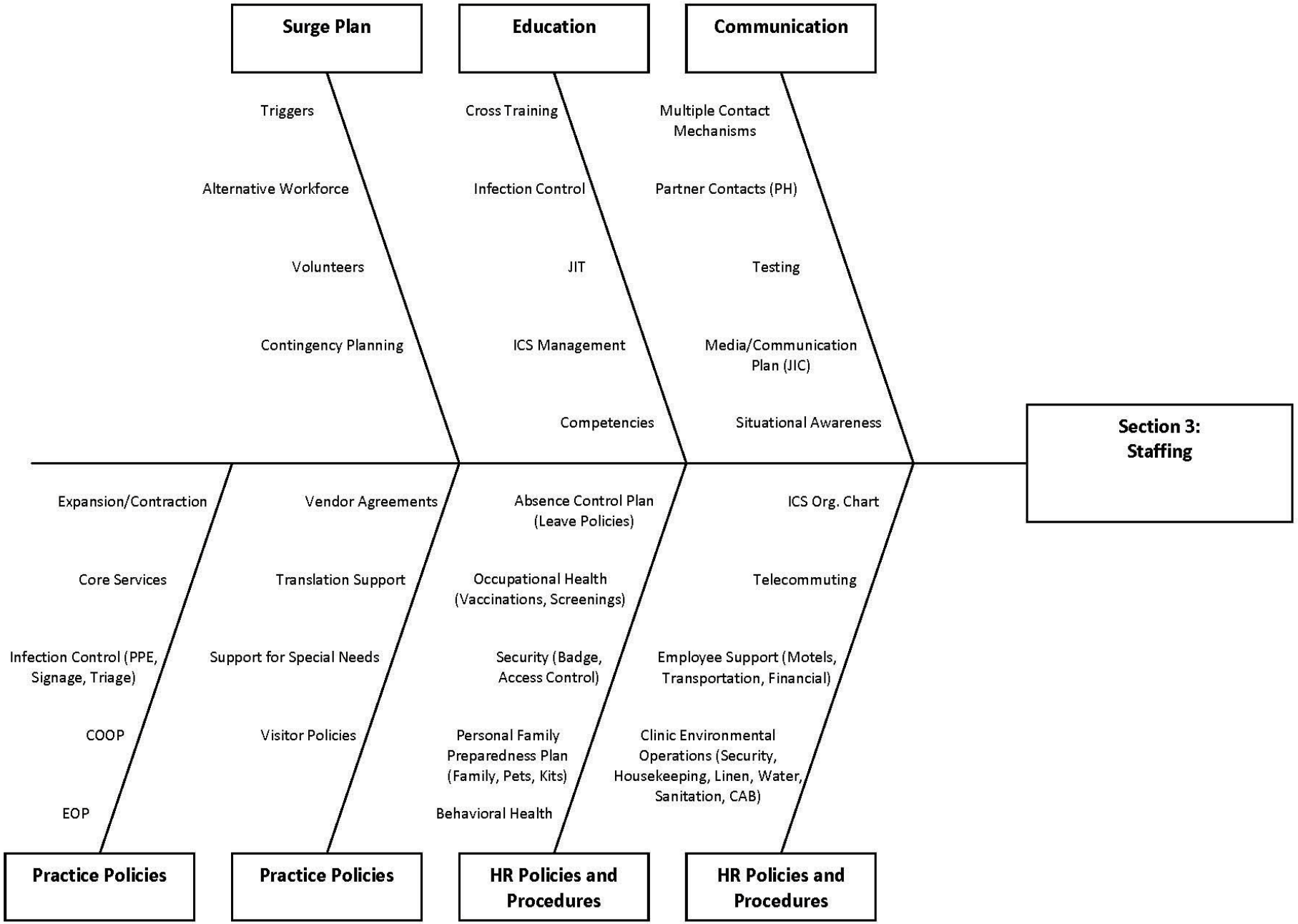
- Vaccinate children while they are in school, and consider vaccinating teachers first as well
- Utilize drive-through vaccination clinics and Saturday hours to help PCP offices deal with increased activity
- Educate PCPs about the incident command system, and follow those principles for communication
- Push communication to providers to save time by developing a database for faxing and e-mailing information
- Utilize pharmacies as an additional means of communication
- Set up a reverse alert system between PCPs and public health—build a portal for physicians to filter and share information on a clinical side before messages are sent out to the public; keep information clinically relevant
- Direct e-mail notifications to office managers rather than providers
- Include the local elected officials, the media, and medical groups/societies in the communication process
- Use templates to easily disseminate information between partners, and consider disseminating daily news releases as audio files
- Ensure that communication within local communities is clear and consistent; faxes and e-mails between partners help ensure consistent messaging
- Set up a phone hotline, and make provisions for translating into local languages

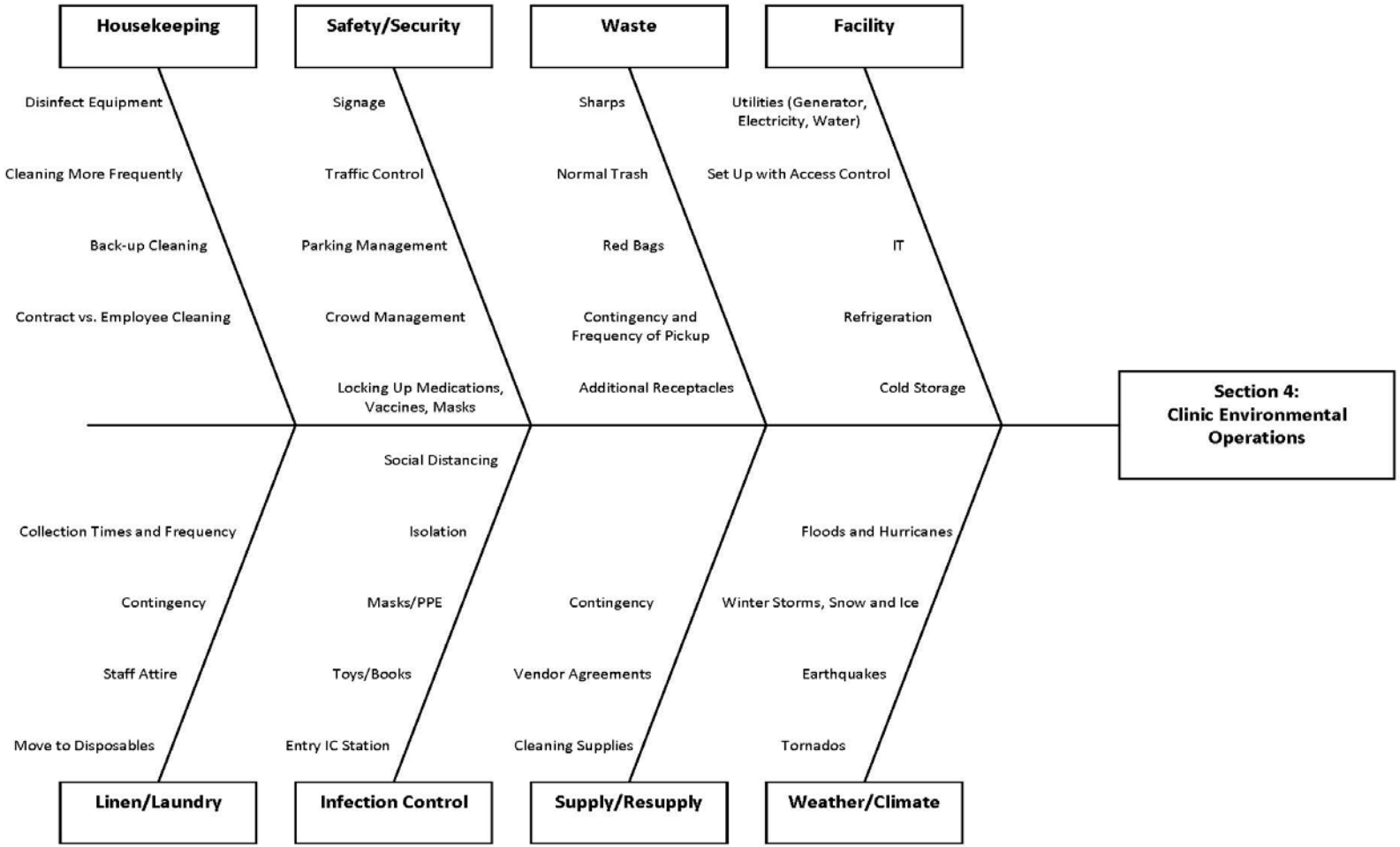
Appendix B: Fishbone Diagrams

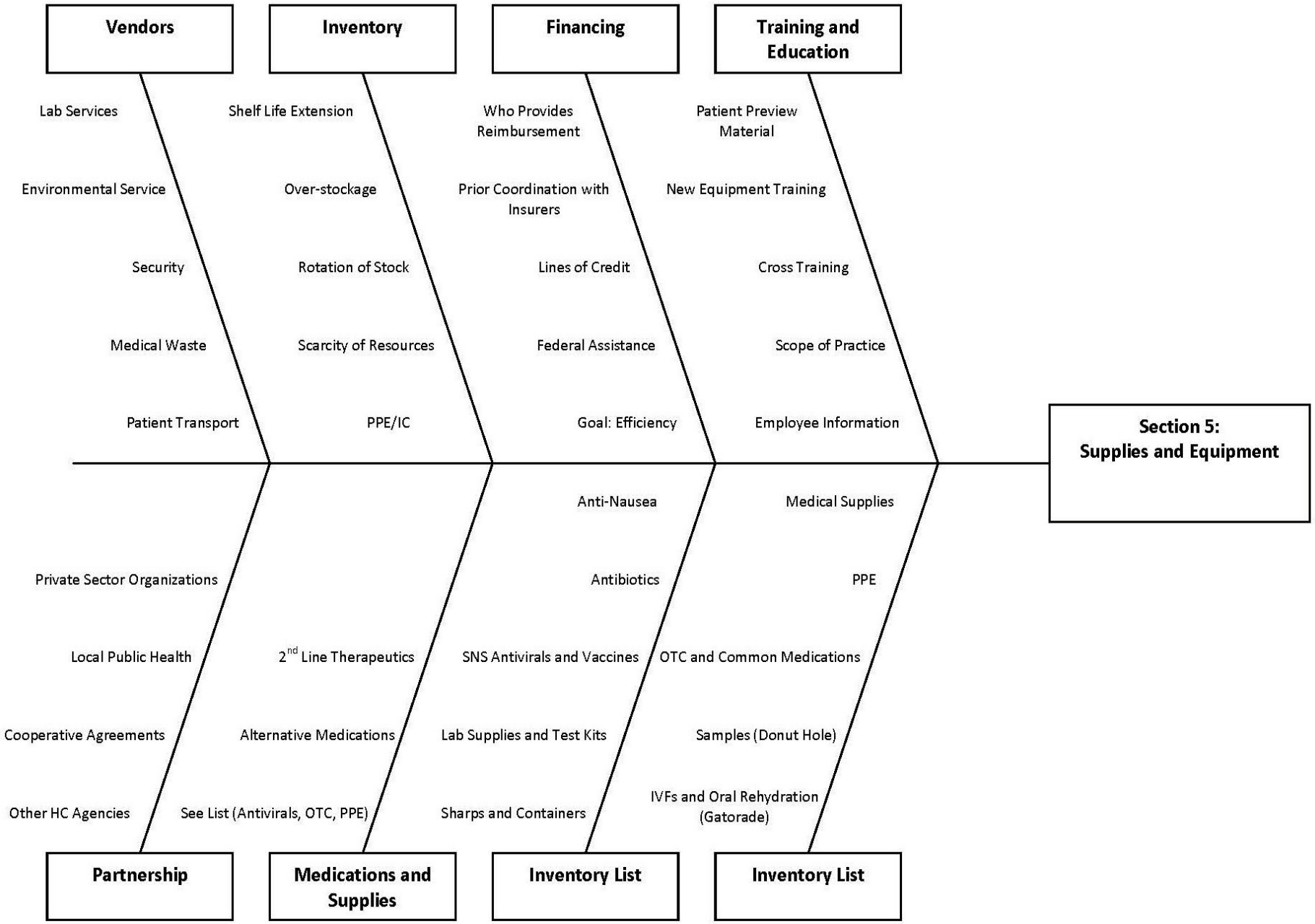


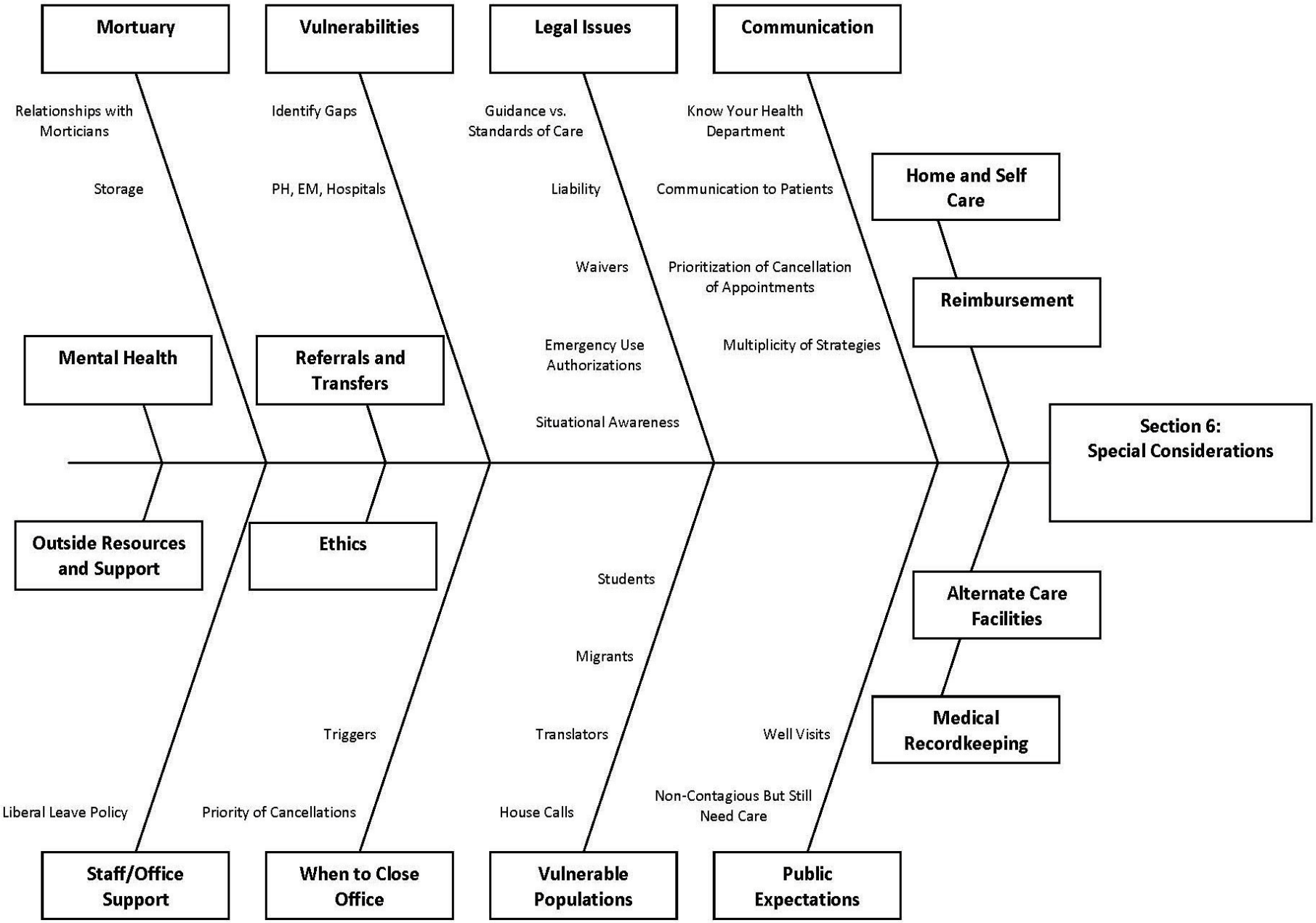
*Strengths, Weaknesses, Opportunities, Threats


Clinical Care
Patient Flow
Infection Control
Surveillance and Detection
Treatment
Triage (Internal/External)
Patient Scheduling
Diversion
Patient Placement
PPE for Patients/Staff
NPI Strategies
Decontamination
Staff Immunization
Reporting
Tracking Patients/Staff
Countermeasures (Vaccines, Chemoprophylaxis, Antivirals)
Prioritization (Acute, Chronic, Preventative)
Section 2: Clinic Operations
Financing
Physical Plant
IT Support
Staffing
Billing
Physical
Personal
Assets
Ingress/Egress
Guidance Review
Education
Training (Staff/Patient)
EM/PH Coordination
Peer-to-peer Coordination
Staffing
Supplies
Business Continuity
Security
Community Integration
Resources
Administrative Support


Surge Plan
Education
Communication
Triggers
Alternative Workforce
Volunteers
Contingency Planning
Cross Training
Infection Control
JIT
ICS Management
Competencies
Multiple Contact Mechanisms
Partner Contacts (PH)
Testing
Media/Communication Plan (JIC)
Situational Awareness
Section 3: Staffing
Expansion/Contraction
Core Services
Infection Control (PPE, Signage, Triage)
COOP
EOP
Vendor Agreements
Translation Support
Support for Special Needs
Visitor Policies
Absence Control Plan (Leave Policies)
Occupational Health (Vaccinations, Screenings)
Security (Badge, Access Control)
Personal Family Preparedness Plan (Family, Pets, Kits)
Behavioral Health
ICS Org. Chart
Telecommuting
Employee Support (Motels, Transportation, Financial)
Clinic Environmental Operations (Security, Housekeeping, Linen, Water, Sanitation, CAB)
Practice Policies
Practice Policies
HR Policies and Procedures
HR Policies and Procedures


Housekeeping
Safety/Security
Waste
Facility
Disinfect Equipment
Cleaning More Frequently
Back-up Cleaning
Contract vs. Employee Cleaning
Signage
Traffic Control
Parking Management
Crowd Management
Locking Up Medications, Vaccines, Masks
Sharps
Normal Trash
Red Bags
Contingency and Frequency of Pickup
Additional Receptacles
Utilities (Generator, Electricity, Water)
Set Up with Access Control
IT
Refrigeration
Cold Storage
Section 4: Clinic Environmental Operations
Collection Times and Frequency
Contingency
Staff Attire
Move to Disposables
Social Distancing
Isolation
Masks/PPE
Toys/Books
Entry IC Station
Contingency
Vendor Agreements
Cleaning Supplies
Floods and Hurricanes
Winter Storms, Snow and Ice
Earthquakes
Tornados
Linen/Laundry
Infection Control
Supply/Resupply
Weather/Climate


Vendors
Inventory
Financing
Training and Education
Lab Services
Environmental Service
Security
Medical Waste
Patient Transport
Shelf Life Extension
Over-stockage
Rotation of Stock
Scarcity of Resources
PPE/IC
Who Provides Reimbursement
Prior Coordination with Insurers
Lines of Credit
Federal Assistance
Goal: Efficiency
Patient Preview Material
New Equipment Training
Cross Training
Scope of Practice
Employee Information
Section 5: Supplies and Equipment
Private Sector Organizations
Local Public Health
Cooperative Agreements
Other HC Agencies
2nd Line Therapeutics
Alternative Medications
See List (Antivirals, OTC, PPE)
Anti-Nausea
Antibiotics
SNS Antivirals and Vaccines
Lab Supplies and Test Kits
Sharps and Containers
Medical Supplies
PPE
OTC and Common Medications
Samples (Donut Hole)
IVFs and Oral Rehydration (Gatorade)
Partnership
Medications and Supplies
Inventory List
Inventory List


Mortuary
Vulnerabilities
Legal Issues
Communication
Relationships with Morticians
Storage
Identify Gaps
PH, EM, Hospitals
Guidance vs. Standards of Care
Liability
Waivers
Emergency Use Authorizations
Situational Awareness
Know Your Health Department
Communication to Patients
Prioritization of Cancellation of Appointments
Multiplicity of Strategies
Home and Self Care
Reimbursement
Mental Health
Referrals and Transfers
Section 6: Special Considerations
Outside Resources and Support
Ethics
Students
Migrants
Translators
Triggers
Priority of Cancellations
House Calls
Well Visits
Non-Contagious But Still Need Care
Liberal Leave Policy
Alternate Care Facilities
Medical Recordkeeping
Staff/Office Support
When to Close Office
Vulnerable Populations
Public Expectations

Appendix C: Issues and Strategies

Increase in Walk-in Patients
Strategies
• Partner with nearby providers to spread patient surge more evenly • Post signs regarding triage policies near the entrance to your office • Communicate to patients the importance of scheduling appointments

Patient Triage
Strategies
• If possible, designate separate waiting areas for ill patients and well patients • Determine if retail health clinics can be used to treat patients

Surveillance
Strategies
• Connect with local health department and monitor CDC communications • Refer to sentinel providers in local community

Communication with Patients

Strategies

- Develop a Website for patients and staff to get messages out
- Work with the media to get your message out to the public
- Have the practice manager reach out to their colleagues for support and information and to obtain education for patients through a national professional association
- Determine in advance what trusted source will provide free, easy to use materials
- Use existing patient handouts from sources like CDC and professional organizations
- Using an e-mail database, e-mail patients regarding the pattern of a pandemic, what the indications are that they need to be seen, and what to expect at the doctor's office
- Have a recording on your phone to educate patients
- Develop a flu-ready flyer that summarizes flu information and make sure it is translated in your local languages
- Provide education to staff on how to talk to angry people

Communication with Partners

Strategies

- Encourage public health to become part of the team of healthcare workers and get involved in coalitions and committees
- Establish two-way methods of communication between PCPs and public health (i.e., CDC Health Alert Network [HAN], e-mails, blast fax)
- Designate someone in the office to manage information
- Sign up for the Clinician Ordered Communication Activity (COCA) for CDC updates by e-mailing coca@cdc.gov
- Network—invite providers from other offices for lunches with drug reps to get connections

"Worried Well"

Strategies

- Partner with community-based organizations, houses of worship, and private businesses to get messages out to the public
- Provide educational materials to patients
- Link with public health to share information back and forth and to coordinate messages to the public
- Advise patients to call the public health hotline or establish one of their own
- Communicate proactively with your established patients, when possible; reassure them that your office will continue to care for them

Business Continuity

Strategies

- Healthcare partners need to work with insurance companies, health plans, and government to attempt getting back to "normal"
- Consider implementing an incident management structure
- Conduct a staff debriefing to establish what worked and lessons learned; revise existing plans
- Take out a line of credit or small business loan for the practice
- Ask vendors to postpone payment
- Reach out to other community members to share best practices and points of needed coordination

Staff Fatigue

Strategies

- Identify your minimum healthcare team mix
- Talk with each staff member to determine their needs and work with them individually to support those needs
- Provide mental health services and financial counseling for staff, and look into available Employee Assistance Programs
- Consider using the Medical Reserve Corps, retirees, medical/nursing students, and temporary staffing agencies to augment staff
- If specialty clinics in your area have decided to close during a pandemic, discuss the possibility of utilizing some of their staff
- Cross-train staff whenever possible
- Rotate staff and use alternate work schedules to allow staff more time off
- Revise overtime and leave policies as needed
- Establish an ongoing staff appreciation program to boost morale
- Consider providing lunch/dinner, movie tickets, and other incentives for staff
- Trade healthcare services with massage therapists for staff massages
- Develop and implement a continuity of operations plan for your office
- Debrief staff after the pandemic to understand their concerns
- Media messaging to the public to respect providers and healthcare workers can go a long way towards increasing patients' gratitude and patience

Supplies and Resources

Strategies

- Identify "essential" supplies
- Identify primary and secondary (backup) vendors
- Consider commercial vendors (e.g., hardware stores, retail pharmacies) for supplies
- Renegotiate prices with suppliers after the pandemic is over
- Modify office hours and/or services provided until supplies can be replenished
- Assign responsibility in the office for logging and maintaining supplies
- Partner with hospitals and other PCPs to explore their ability to share resources
- Develop a computer database that tracks supplies at different locations (hospitals, clinics, long-term care) in the community
- Communicate with public health to establish a method to resupply antivirals through the Strategic National Stockpile (SNS); make sure public health has transportation plans and has communicated these in order to receive the SNS
- Explore the potential to stockpile supplies based on funding and storage space
- Have a personal protective equipment (PPE) plan describing when to wear, who should wear, and how to wear PPE
- Optimize PPE supply use by cohorting patients
- Develop or revise "use and reuse" policies
- Invoke "Force Majeure" clauses for liability protection

Appendix D: Pan Flu Organizer Outline

1. **Introduction**

   The introduction will provide background information on pan flu, and describe the relevance of primary care offices in the community response. It will detail the need for integrated community planning. While developed with an eye toward the response to an influenza pandemic the information contained in the Pan Flu Organizer (PFO) will assist PCP offices in being better able to respond to any widespread public health emergency in a community. In addition, the introduction will include a description of the *Integrating Primary Care Providers into Community Pandemic Influenza Planning* Stakeholder Meeting, and for the deliverable development process.

2. **General Office Plan Template**

   a. *Introduction to the template*

      The introduction to the template will include a brief description of the process undertaken by CDC and ORISE staff and the stakeholder meeting participants. It will provide instructions for using the template, and identify resources for providers to use while creating their plan.

   b. *Templates*

      Several templates may be included: the abbreviated office plan template, the comprehensive office plan template, and a narrative "fill-in-the-blank" template.

   c. *Fishbone diagram examples*

      Photos and examples of the "fishbone diagrams" completed by participants at the stakeholder meeting will be included as well as blank diagrams. Detailed instructions for using the diagrams as a planning tool will be included.

3. **Planning Calendar**

   a. *Introduction to the calendar*

      The introduction will briefly describe the planning calendar and its intended use.

   b. *Calendar*

      The planning calendar will take the comprehensive office plan template, and break the tasks into monthly timelines. It will be set up on a 12-month timeline but can be completed in any length of time. Tasks will be succinct and be similar in appearance to a checklist.

4. **Staffing Strategies**

   In this section, strategies related to staffing will be discussed in-depth, and tasks in the planning calendar expanded upon. Issues will be broached and the section will identify key considerations when planning for a pandemic. The section may also include resources providers can use to develop their staffing strategies. Information will likely be organized into subject areas, including but not limited to: education and training, occupational health, and infection control.

5. **Patient Strategies**

   Caring for patients will be discussed in-depth in this section, and tasks in the planning calendar expanded upon. Issues will be broached, and the section will identify key considerations when planning to provide patient care during a pandemic. The section may also include resources providers can use to develop their patient strategies. Information will likely be organized into subject areas, including but not limited to: communicating with patients, clinic services, and self-care information.

6. **Vaccination Programs**

   Because vaccination is likely to be a central focus of the primary care office during a pandemic, this section will address concerns and strategies related to the distribution and administration of vaccines. It will likely include subjects such as provider agreements, algorithms, and information on the Vaccine Adverse Event Reporting System (VAERS).

7. **"How to Coordinate with Partners" (Fact Sheets)**

   The role that primary care providers play in the community's response and the importance of coordination between PCPs and other community partners will be described, as well as challenges to creating an integrated response. These fact sheets will provide information for communicating and coordinating with partners to provide patient care during a pandemic. Fact sheets will be developed for many partners, including but not limited to: hospitals, public health, emergency management, and other community providers.

8. **"How Partners Can Reach Out to Primary Care Providers" (Fact Sheets)**

   Fact sheets will be developed for community partners to assist them with integrating PCPs into the community pan flu planning process. These sheets will contain information provided by PCPs detailing effective methods of communication, challenges, and operational considerations. Fact sheets will be developed for many partners, including but not limited to: hospitals, public health, emergency management, and other community providers.

9. Financial Considerations

Financial considerations, limitations, and strategies, such as lines of credit and staff pay issues, will be addressed in this section.

10. Mutual Aid Agreement, Memorandum of Agreement, and Memorandum of Understanding

This section will describe a Mutual Aid Agreement (MAA), Memorandum of Agreement (MOA), and Memorandum of Understanding (MOU), and their benefits during a pandemic. It will discuss what to include in the agreement, and how to begin the process of establishing a MAA, MOA, and/or MOU. It will provide examples of different agreements, including but not limited to, agreements with vendors.

11. Overview of the Incident Command System and Unified Command

Although primary care offices may not be involved in a community's Incident Command System (ICS), many stakeholder meeting participants felt it valuable to educate providers on ICS and Unified Command (UC), and how their office might fit into a community response. This section will contain a brief introduction to ICS, and will likely include examples of emergency operations plans.

12. Checklists

Checklists developed by federal partners, professional associations, and others will be included in this section.

13. Forms

This section will contain many relevant forms and worksheets that may be useful to PCPs, whether during the planning process or the pandemic itself. These may include federally-created forms, as well as "best practice" documents from stakeholder meeting participants. Examples of forms in this section include but are not limited to: employee scheduling and status logs; notification trees; and medication information sheets.

14. Resources

The final section of the PFO will be a comprehensive resource section, containing general tools that primary care offices may find helpful.

Appendix E: Agenda

Day I

12:00 p.m. to 1:00 p.m.	**REGISTRATION AND NETWORKING**
1:00 p.m. to 2:00 p.m.	**Welcome** • Safety announcement • Welcoming Remarks (CDC) • Welcoming Remarks (ORISE) • Participant Introductions • Workshop Overview - Pre-Assessment - Purpose - Goal - Objectives - Agenda • Administrative announcements • Charge to the room
2:00 p.m. to 2:30 p.m.	**Presentation:** *An Historical Perspective* Jacob Lauer, University of Kansas
2:30 p.m. to 3:00 p.m.	**Presentation:** *A Provider's Perspective* Asha Devereaux, MD, MPH, Coronado, California
3:00 p.m. to 3:30 p.m.	**BREAK**
3:30 p.m. to 4:00 p.m.	**Presentation:** *Legal and Ethical Issues for Primary Care Offices* Elisabeth Belmont, JD, Portland, Maine
4:00 p.m. to 4:30 p.m.	**Presentation:** *A Community's Effort* Jon Surbeck and Deb Blandin, Weld County, Colorado
4:30 p.m. to 5:00 p.m.	**Wrap-up Day 1/Overview Day 2**
5:00 p.m.	**ADJOURN**

Day II

7:00 a.m. to 8:00 a.m.	**CONTINENTAL BREAKFAST AND NETWORKING**
8:00 a.m. to 8:15 a.m.	**H1N1 Information Update from CDC** Daniel Jernigan, MD, MPH, Atlanta, Georgia
8:15 a.m. to 9:15 a.m.	**Session I:** Role-play #1–Early Pandemic (1st Wave)
9:15 a.m. to 10:30 a.m.	**Session II:** Develop Office Plan Template
10:30 a.m. to 10:45 a.m.	**BREAK**
10:45 a.m. to 11:15 a.m.	**Vaccine Guidance Update from CDC** Suchita Lorick, DO, MPH, Atlanta, Georgia
11:15 a.m. to 11:45 a.m.	**Antiviral Guidance Update from CDC** Lisa Rotz, MD, Atlanta, Georgia
11:45 a.m. to 12:45 p.m.	**WORKING LUNCH**
12:15 p.m. to 12:45 p.m.	**Question and Answer Session**
12:45 p.m. to 12:50 p.m.	**MOVE TO BREAKOUT ROOMS**
2:20 p.m. to 2:45 p.m.	**BREAK**
2:45 p.m. to 4:15 p.m.	**Session IV:** Role-play #3–Late Pandemic (3rd Wave to Recovery)
4:15 p.m. to 4:20 p.m.	**RETURN TO PLENARY ROOM**
4:20 p.m. to 4:45 p.m.	**Discussion of Role-plays #2 and #3**
4:45 p.m. to 5:00 p.m.	**Wrap-up Day 2/Overview Day 3**
5:00 p.m.	**ADJOURN**

Day III

7:00 a.m. to 8:00 a.m.	**CONTINENTAL BREAKFAST AND NETWORKING**
8:00 a.m. to 9:30 a.m.	**Session V:** Develop Pan Flu Organizer
9:30 a.m. to 9:45 a.m.	**BREAK**
9:45 a.m. to 10:45 a.m.	**Session V continued:** Develop Pan Flu Organizer
10:45 a.m. to 11:30 a.m.	**Form Reviewer Committee**
11:30 a.m. to 12:00 p.m.	**Concluding Remarks**

- CDC
- ORISE
  - Next Steps
  - Hot Wash
  - Post-Assessment
  - Participant Evaluation

12:00 noon **MEETING ADJOURNS**

Appendix F: Hot Wash

I. *What was the most valuable part of the Meeting?*

- Who we brought to the meeting–bringing different disciplines; the number of physicians involved in talking on the subject; networking
- Learning more about primary care from a single physician to a big clinic was very educational
- My faith in medical school has been reinforced by having Jake here; helpful to see from that point of view
- A lot of gaps were identified through the process
- Understanding what the conflicting expectations are from different levels

II. *How could the Meeting have been improved?*

- I would have liked to see the CDC-campus tour
- It would have been nice to meet participants at other tables
- Arrange an evening networking event
- Could have used a brief description of the people attending and how they fit in the equation; have "real experience" stories about dealing with surge (e.g., SARS and Canada)
- Managed care should have been invited

III. Is there information or training related to the subject matter that you feel you still need?

The lingo used may not be understood by everyone (e.g., ICS and JIC); maybe a short amount of time could be used to bring everyone up to speed

IV. *What are the next steps?*

- Involving everyone at the local level in the planning; from the local level, communicating to others what the local PCP role is
- Communicate with patients on what is going on at the primary care practice
- Have professional societies disseminate the results of this meeting to their constituencies; utilize partner links on association's Websites
- Public health needs to start reaching out to PCPs
- Continuing Medical Education (CME) credit for learning this material would add an incentive
- Some kind of format to keep everyone connected and up to date with progress; a Web 2.0 format would be good for discussion among the participants
- How about a second annual meeting (in Portland, Oregon)
- Gather feedback on the products that come out of the meeting (Who used it? Is it good?)
- Data from the conversations with providers would be nice (Who was it they talked to? What did they come up with?)

Appendix G: Participant List

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Appendix H: Acronyms and Abbreviations

Preparedness and Emergency Response Acronyms

ACC.....Acute Care Center

ACS.....Alternate Care System*

ACF.....Acute Care Facilities

CERT.....Community Emergency Response Team

COOP.....Continuity of Operations Plan

DMAT.....Disaster Medical Assistance Team

DPH.....Department of Public Health

ECS.....Emergency Communication System

ED.....Emergency Department

EM.....Emergency Management

EMA.....Emergency Management Agency

EMAC.....Emergency Management Assistance Compact

EMS.....Emergency Medical Services

EOC.....Emergency Operations Center

EOP.....Emergency Operations Plan

ESAR-VHP.....Emergency System for Advanced Registration of Volunteer Healthcare Personnel

FEMA.....Federal Emergency Management Agency

HAN.....Health Alert Network

IAP.....Incident Action Plan

IC.....Incident Commander

ICS.....Incident Command System

ILI.....Influenza-like Illness

JIC.....Joint Information Center

JIT......"Just-in-Time" Training

**ACS can also be an abbreviation for Alternate Care Site.*

LTAC.....Long-Term Acute Care

LTC.....Long-Term Care

MAA.....Mutual Aid Agreement

MEMS.....Modular Emergency Medical System

MMRS.....Metropolitan Medical Response System

MOA.....Memorandum of Agreement

MOU.....Memorandum of Understanding

MSEHPA.....Model State Emergency Health Powers Act

NCP.....National Contingency Plan

NGO.....Non Government Agency

NIMS.....National Incident Management System

NRF.....National Response Framework

OSC.....On-Scene Coordinator

PAHPA.....Pandemic and All-Hazards Preparedness Act

PCP.....Primary Care Provider

PH.....Public Health

PHE.....Public Health Emergency

PHSA.....Public Health Service Act

PFO.....Pan Flu Organizer

PIO.....Public Information Officer

POD.....Point of Distribution/Dispensing

PPE.....Personal Protective Equipment

PSA.....Public Service Announcement

PSAP.....Public Safety Answering Points

RHPC.....Regional Healthcare Preparedness Coordinator

RMERT.....Regional Medical Response Team

SME.....Subject Matter Expert

SNS.....Strategic National Stockpile

SOP.....Standard Operating Procedures

TTX.....Table Top Exercise

UC.....Unified Command

UEVHPA.....Uniform Emergency Volunteer Health Practitioners Act

Organization/Agency Acronyms

AAACN.....American Academy of Ambulatory Care Nursing
AAFP.....American Academy of Family Physicians
AAMA.....American Association of Medical Assistants
AAMEDA.....American Academy of Medical Administrators
AANP.....American Academy of Nurse Practitioners
AAP.....American Academy of Pediatrics
AAPA.....American Academy of Physician Assistants
ACCP.....American College of Clinical Pharmacy
ACP.....American College of Physicians
AHA.....American Hospital Association
AHRQ (HHS).....Agency for Healthcare Research and Quality
AIRS.....Alliance of Information and Referral Systems
AMA.....American Medical Association
AMWA.....American Medical Women's Association
ANA.....American Nurses Association
APCO.....Association of Public-Safety Communication Officials
ARC.....American Red Cross
ASPCC.....American Association of Poison Control Centers
ASPR (HHS).....Office of the Assistant Secretary for Preparedness and Response
ASTHO.....Association of State and Territorial Health Officials
CDC (HHS).....Centers for Disease Control and Prevention
CHCANYS.....Community Health Care Association of New York State
CMS.....Centers for Medicare and Medicaid Services
COGH (CDC/HHS).....Coordinating Center for Global Health
DHQP (CDC/HHS).....Division of Healthcare Quality Promotion
HHS.....Department of Health and Human Services
DHS.....Department of Homeland Security
DOD.....Department of Defense
DOT.....Department of Transportation

DPH.....Department of Public Health

DRH.....Division of Reproductive Health

DSLR (CDC/HHS).....Division of State and Local Readiness

GEMA.....Georgia Emergency Management Association

GHA.....Georgia Hospital Association

HCMC.....Hennepin County Medical Center

HPP (HHS) .....Hospital Preparedness Program

HSREB (CDC/HHS).....Health Services Research and Evaluation Branch

ICU (CDC/HHS).....Influenza Coordination Unit

IHS.....Indian Health Services

IOM.....Institute of Medicine

ISD (CDC/HHS).....Immunization Services Division

JC.....Joint Commission on Accreditation of Healthcare Organizations

MGMA.....Medical Group Management Association

MRC.....Medical Reserve Corps

NACCHO.....National Association of City and County Health Officials

NCCDPHP.....National Center for Chronic Disease Prevention and Health Promotion

NCHM (CDC/HHS).....National Center for Health Marketing

NCPDCID (CDC/HHS).....National Center for Preparedness, Detection, and Control of Infectious Diseases

NEMA.....National Emergency Management Association

NJHA.....New Jersey Hospital Association

OHA (DHS).....Office of Health Affairs

OPEO (HHS).....Office of Preparedness and Emergency Operations

ORISE.....Oak Ridge Institute for Science and Education

OSI (CDC/HHS).....Office of Strategy and Innovation

PAHCOM.....Professional Association of Healthcare Office Management

POMAA.....Physician Office Managers Association of America

USPHS.....United States Public Health Service

VA.....Department of Veterans Affairs

WHO.....World Health Organization