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The Health Care Response to Pandemic Influenza

American College of Physicians*

The threat of an H5N1 influenza virus (avian flu) pandemic is substantial. The success of the current U.S. influenza pandemic response plan depends on effective coordination among state and local public health authorities and individual health care providers. This article is a summary of a public policy paper developed by the American College of Physicians to address issues in the U.S. Department of Health and Human Services Pandemic Influenza Plan that involve physicians. The College's positions call for the following: 1) development of local public health task forces that include physicians representing all specialties and practice settings; 2) physician access to 2-way communication with public health authorities and to information technology tools for diagnosis and syndrome surveillance; 3) clear identification and authorization of agencies to process licensing and registration of volunteer physicians; 4) clear guidelines for overriding standard procedures for confidentiality and consent in the interest of the public's health; 5) clear and fair infection control measures that do not create barriers to care; 6) analysis of and solutions to current problems with seasonal influenza vaccination programs as a way of developing a maximally efficient pandemic flu vaccine program; 7) federal funding to provide pandemic flu vaccine for the entire U.S. population and antiviral drugs for 25% of the population; and 8) planning for health care in alternative, nonhospital settings to prevent a surge in demand for hospital care that exceeds supply.

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Editor's Note: This issue has 3 articles about pandemic influenza. The current article is a condensed version of the American College of Physicians position paper on planning for an influenza pandemic. Another article is an assessment of current readiness for an influenza pandemic in the United States, written by John Bartlett, MD. The remaining article is a republication of an eyewitness account of the 1918 Spanish influenza pandemic by Isaac Starr, MD, who cared for influenza victims as a medical student in Philadelphia. Dr. Starr's article first appeared in Annals of Internal Medicine *in 1976. It is a sure antidote against complacency about our preparedness for a future pandemic.*

Since 2003, the H5N1 subtype of the influenza virus, also known as avian flu, has infected 228 people and killed 130—a mortality rate of more than 50% (1). On 2 November 2005, the U.S. Department of Health and Human Services (HHS) issued the HHS Pandemic Influenza Plan (2), which makes it clear that U.S. officials believe the threat of pandemic influenza is substantial. According to HHS, when a pandemic virus strain emerges, approximately 75 million to 105 million U.S. citizens could develop the disease and between 209 000 and 1 903 000 of them could die. The HHS plan describes the roles of federal departments and agencies and the critical capacities necessary for states and localities in the event of a flu pandemic. However, the plan indicates that the success of the health care response rests primarily with state and local public health authorities. The American College of Physicians' policy positions address issues raised in the HHS plan that explicitly or implicitly call for the involvement of physicians.

Position 1: The American College of Physicians supports the development of local pandemic influenza task forces that include physicians representing all specialties and practice settings.

The HHS plan recommends that state health authorities establish local pandemic influenza task forces that will ensure community readiness to provide emergency support to health care facilities. One responsibility of the task forces is to improve communication with medical care providers. The College believes that the health care response to any public health emergency, including pandemic influenza, must fully integrate the nation's physicians to decrease patient morbidity and mortality rates and to minimize social and economic disruption. It is imperative that physicians in all health care settings be aware of the issues posed by pandemic influenza and be prepared to participate in the health care response.

In addition to the responsibilities outlined in the HHS plan, local task forces should 1) provide all licensed physicians with state and local plans for the pandemic influenza health care response and update physicians on developments affecting the plans and 2) determine how to procure and stock medical supplies for health care providers at all care provision sites.

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*This paper is an abridged version of a full-text position paper (available at www.acponline.org/college/pressroom/as06/pandemic_policy.pdf) written by Laura Barnitz, BJ, MA, and updated and adapted for publication in *Annals of Internal Medicine* by Michael Berkwits, MD, MSCE. The original position paper was developed for the Health and Public Policy Committee of the American College of Physicians: Jeffrey P. Harris, MD (*Chair*); David L. Bronson, MD (*Vice Chair*); CPT Julie Ake, MD; Patricia P. Barry, MD; Molly Cooke, MD; Herbert S. Diamond, MD; Joel S. Levine, MD; Mark E. Mayer, MD; Thomas McGinn, MD; Robert M. McLean, MD; Ashley E. Starkweather; and Frederick E. Turton, MD. It was approved by the Board of Regents on 3 April 2006.

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Position 2: The American College of Physicians believes that health care providers in every locality should have access to 2-way communication with public health authorities and health information technology tools.

The HHS plan relies on the existing national influenza surveillance system to monitor influenza infections and the emergence of new strains (3). Physicians are integrated into this system primarily through the Sentinel Provider Network, which comprises approximately 2300 health care providers who report weekly outpatient incidents linked to influenza and who submit specimens to laboratories for testing. In the plan (4), HHS also encourages public health offices to supply health care providers with specimen submission forms and guidance on the use of diagnostic tests for the detection of influenza. For physicians, it is important that these systems and tools are easily accessible, that reporting does not take much time, and that the cost of participating is affordable.

Public health authorities should 1) identify interoperable communications systems available to public safety agencies in each locality and determine how health information can be communicated using those systems; 2) expand the Sentinel Providers Network and train physicians in the use of diagnostic tools; and 3) involve local health care providers in the development of syndromic surveillance systems that will aid in the rapid detection of infectious disease outbreaks.

Position 3: The American College of Physicians believes that federal or state agencies should be clearly identified and authorized to determine licensing and registration of volunteer health care providers.

An influenza pandemic could spread very rapidly throughout the country. If there is a need for volunteers at the time of a crisis, local organizations will not have the resources to determine if volunteers are who they present themselves to be. Ensuring that volunteer physicians and health care providers are licensed to provide medical care is the responsibility of government.

Pandemic preparedness plans should 1) clearly identify the government agencies responsible for overseeing volunteer health care providers; 2) clearly identify the process by which local authorities can request volunteers; and 3) fully inform health care providers whom to contact and which processes to follow if they wish to volunteer.

Position 4: The American College of Physicians recognizes the paramount importance of patient–doctor confidentiality. If breaching confidentiality is necessary, it should be done in a way that minimizes harm to the patient and that heeds applicable federal and state law.

In the event of pandemic influenza, some expectations of confidentiality will probably be altered or suspended. It is critical that public and health care providers clearly understand the laws governing surveillance, monitoring, and reporting during a pandemic.

Public health authorities should 1) provide clear and timely information to physicians to ensure that physicians understand when a public health emergency creates legal obligations to adjust standard confidentiality practices; 2) encourage physicians to continue to undertake an informed consent process whenever individuals are examined, tested, or treated, even in situations in which physicians are obligated to override patient refusal of consent; and 3) inform the public of the consequences of not consenting to a necessary examination, test, or treatment.

Position 5: The American College of Physicians believes that infection control measures should be clear, fair, and as least restrictive as is necessary to protect public health. Physicians should not be penalized for failure to follow emergency orders that are not clear and timely and do not provide for due process to resolve situations outside the physician's control.

In the HHS plan (5), state and local partners are called on to identify potential isolation and quarantine facilities; to establish procedures for medical evaluation and isolation of persons who exhibit signs of influenza-like illness; to establish procedures for delivering care, food, and services to persons in isolation or quarantine; and to establish procedures for issues related to employment compensation. Infection control practices that are not adequately explained to the public in advance may result in patients being too fearful to seek treatment.

Public health authorities should 1) inform the public and physicians about infection control measures in advance and 2) monitor whether infection control measures are creating barriers to patients receiving care.

Position 6: The American College of Physicians believes that ending chronic delays in the delivery of seasonal influenza vaccine and achieving vaccination targets are public health prerequisites for developing a successful response to pandemic influenza.

Physicians serving patients at risk for seasonal influenza regularly encounter delays in vaccine distribution. If these problems cannot be solved for the management of seasonal influenza, it is likely that the emergence of pandemic influenza could completely overwhelm the U.S. health care system. Analyzing seasonal influenza vaccination programs could help inform public health authorities on measures to best prepare for pandemic influenza.

Public health authorities should 1) develop local working groups with physicians to plan for successful outreach to high-risk populations; 2) streamline seasonal influenza vaccine procurement and distribution methods; 3) plan methods of introducing the public to the practice of vaccinating high-risk and high-priority groups first, including all public safety officers and health care providers in direct contact with patients; and 4) ensure that physicians in every locality have access to seasonal influenza and pneumococcal polysaccharide vaccines and antiviral medications.

In addition, the HHS plan incorporates recommen-

dations of the Advisory Committee on Immunization Practices (ACIP) and the National Vaccine Advisory Committee (NVAC) for tiers of priority groups for vaccination. The following are the top 3 priority groups: 1) vaccine and antiviral manufacturers and others essential to manufacturing (approximately 40 000 people); 2) medical workers and public health workers involved in direct patient contact (9 million people); and 3) persons 65 years of age or older who have 1 or more conditions that put them at high risk for influenza (6). Distributing vaccine first to customers who ordered more or ordered first will undermine efforts to provide effective health care and will not allow the realization of HHS plan recommendations for treating the most ill patients first.

Local vaccination and treatment plans should ensure that physicians have access to influenza vaccine and antiviral medications for patients in high-risk or high-priority groups.

Position 7: The American College of Physicians supports measures to increase pandemic influenza vaccine and antiviral medications in the Strategic National Stockpile. In the event of pandemic influenza, stockpiled vaccine and antivirals should be distributed equitably to all state public health authorities according to the numbers of people in high-risk and high-priority groups.

The HHS plan calls for federal subsidies to states to purchase prepandemic experimental vaccine and antiviral medication as needed to supplement government purchases. Requiring states to purchase antiviral agents individually will increase barriers to care for patients in states with fewer public funds or in states that order antiviral medications too late.

Congress and federal agencies should 1) provide funding on an as-needed basis for procurement of pandemic influenza vaccine to cover the entire U.S. population and antiviral medications sufficient to treat 25% of the U.S. population, plus additional courses sufficient to provide prophylaxis for all public safety officers and health care workers in direct contact with patients; 2) establish equitable cost-sharing and subsidy plans with states that want to procure antiviral medications in amounts *exceeding their share* of the Strategic National Stockpile; and 3) establish equitable cost-sharing and subsidy plans with states that want to procure other medications indicated for pandemic preparedness.

Position 8: The American College of Physicians supports the use of nonhospital-based health care providers to counsel, diagnose, treat, and monitor patients outside of hospital settings to decrease the likelihood of surges that would overwhelm hospital capacity.

The HHS plan focuses on the provision of care in hospitals without providing guidance on designing systems for home health care or follow-up care for patients returning home. The limited consideration for treating patients outside of hospitals and the lack of guidance for health care providers in ambulatory settings are the greatest weaknesses of the HHS plan.

Public health authorities should 1) ensure that vaccine and antiviral medications are available in all care settings, with safeguards ensuring access for high-risk and high-priority groups first; 2) consult with local physicians to identify alternative community-based care sites for patient diagnosis, counseling, and treatment; 3) identify community-based physician leadership for staffing alternative care sites and ensure that sites have supplies, diagnostic tools, communications systems, and security; 4) work closely with health care providers in all care settings to coordinate care management plans for patients inside and outside of hospitals; and 5) assist physicians and other health care providers in developing community-based care management plans for treating and monitoring patients at home.

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