CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Pandemic Influenza Operations and Response Plan

September 2009

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Approvals

This Pandemic Influenza Operations and Response Plan is prepared in accordance with the National Strategy for Pandemic Influenza and the resultant Implementation Plan.

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Record of Changes

The CMS Pandemic Influenza Operations and Response Plan is a controlled document. Distribution of revised versions is the responsibility of the Office of Operations Management (OOM). Any outdated versions of this plan should be destroyed. When a new version is published, it supersedes all previous versions. Significant changes or updates to the plan are recorded below.

Version 2.0 of the CMS Pandemic Influenza Operations and Response Plan was updated in September 2009 to reflect changes in pandemic planning requirements and an emerging health threat. This update represents a significant change in prior versions of the CMS Pandemic Influenza Operations and Response Plan by integrating agency operational continuity and pandemic response requirements. Additionally, this update includes:

- Altering the plan format in response to feedback received from past versions of the plan.
- Updating the content within the Plan to reflect current organization structure and procedures.
- Adding/revising content in response to the National Strategy for Pandemic Influenza and the resultant Implementation Plan.
- Identifying and expanding the description of CMS component roles and responsibilities during a pandemic.
- Updating procedures and guidance for social distancing procedures, human capital, and pandemic response.
- Adding/revising content in response to HHS HQ, OPM, and White House pandemic planning requirements.

Executive Summary

The Department of Health and Human Services (HHS) requires its Operating Divisions to prepare and update a Pandemic Influenza Plan annually. In addition, the National Strategy for Pandemic Influenza and the HHS Pandemic Influenza Implementation Plan outline sustainable roles and responsibilities for all agencies, including CMS throughout a pandemic event.

In response to Departmental and Presidential requirements, CMS has developed plans documenting how the agency will maintain operational continuity of day-to-day operations, sustain viable pandemic response activities, and provide for the execution of its essential functions. This CMS Pandemic Influenza Operations and Response Plan is intended to provide a nation-wide singular guide for how CMS will operate during a pandemic event. As such, this plan is designed to focus on actionable triggers in monitoring pandemic events, guidelines for maintaining the continuity of day-to-day operations, and how the agency will respond to likely public health consequences.

Pandemic Monitoring and Surveillance (Section 6):
This plan details the methods to, quickly provide senior leadership the necessary information to assess the impact a pandemic event has on the agency's operations. These surveillance and monitoring activities include:
- Monitoring changes in Federal Government Response Stages
- Monitoring CDC and media reports
- Participation in ASPR and CDC pandemic coordination conference calls
- Conducting CMS attendance and performance tracking

Maintaining Operational Continuity (Section 5, 7):
Social distancing practices and Personal Protective Equipment (PPE) are central elements to the resiliency of CMS during a pandemic event. The social distancing measures at the agency's disposal include:
- Widespread use of telework
- Staggering duty schedules
- Encouraging use of teleconferences
- Other tactics designed to limit the transmission of a pathogen.

In addition, HHS and CMS have invested considerable time in planning to ensure its workforce is adequately protected. Deployment of personal protective equipment including medical screening, fit-tested respirators, masks, gloves, and alcohol-based wipes to the workforce is included in this plan.

Pandemic Response (Sections 8, 9, 10):
In accordance with the HHS Pandemic Influenza Implementation Plan, CMS has several key roles in mitigating the affects of a pandemic on the nation. This plan details the processes the agency will implement to ensure that these tasks are carried out swiftly and efficiently. These response requirements include the coordination of waivers and communication with Medicare, Medicaid, and CHIP beneficiaries, providers, and other key partners.

Acronyms

AOF	Alternate Operating Facility
ASPR	Assistant Secretary for Preparedness and Response
AV	Antiviral
AWS	Alternate Work Schedule
BARDA	Biomedical Advanced Research and Development Authority
CDC	Centers for Disease Control and Prevention
CEOC	CMS Emergency Operations Center
COGCON	Continuity of Government Readiness Condition
COOP	Continuity of Operations
DHS	Department of Homeland Security
ESF	Emergency Support Function
FCD	Federal Continuity Directive
HHS	Department of Health and Human Services
IMT	Incident Management Team
IT	Information Technology
MEF	Mission Essential Function
NCR	National Capital Region
NEF	National Essential Function
OEP	Occupant Emergency Plan
OPM	Office of Personnel Management
PCT	Pandemic Coordination Team
PMEF	Primary Mission Essential Function
PPE	Personal Protective Equipment
PSC	Program Support Center
RTO	Recovery Time Objective
SitRep	Situation Report
SME	Subject Matter Expert

SNI	Special Needs Individuals
SOC	Secretary's Operation Center
WH	White House
WHO	World Health Organization

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1.0 INTRODUCTION

Planning for pandemic influenza involves coordinating the efforts of many internal and external stakeholders to ensure the resilience of CMS during a pandemic influenza event. Unlike ordinary influenza, a pandemic influenza occurs when a novel strain of an infectious agent emerges with the ability to infect and pass efficiently between humans. Pandemics typically result in varying degrees of illness and death without discriminating between old or young, healthy or unhealthy. In an effort to combat the severe consequences of worldwide spread; local, state, tribal, Federal, and international health authorities strive to regularly track potential pandemic-causing agents.

A pandemic influenza affecting the United States may not only severely impact our public health system by straining medical resources but it may also impact our nation's economy, infrastructure, and capability to respond to other disasters. Severe and widespread pandemic influenza will inevitably result in major disruptions of all Federal agencies, including challenging our ability to sustain the nation's National Essential Functions (NEFs), Primary Mission Essential Functions (PMEFs), Mission Essential Functions (MEFs), and day-to-day operations. CMS has developed this Pandemic Influenza Operations and Response Plan, hereinafter referred to as the CMS Pandemic Plan, to prepare and respond to these challenges in accordance with Federal guidance.

Pandemic Planning Distinctions
Pandemic planning presents unique challenges. Unlike natural disasters, technological disasters, malicious acts, or terrorist events, the impact of a pandemic is anticipated to be much greater in scale and duration. The current global culture and economy effectively ensure that the effects of a pandemic event will be widespread and threaten not just a limited geographic region, but potentially every continent. In addition, while traditional disasters and disruptions normally have limited time durations, a pandemic generally occurs in multiple waves, each lasting two to three months. Consequently, no individual or organization will be unaffected from the adverse impacts that might result from a pandemic event. The most significant challenge to result from a severe pandemic event will be staffing shortages due to absenteeism. These challenges highlight the need for all Federal agencies, no matter their size, to plan for the unique pandemic-specific consequences above and beyond their "traditional" continuity of operations (COOP) planning.

This Pandemic Operations and Response Plan identifies two major components of pandemic planning for CMS:

1. **Operational Continuity** describes how CMS will mitigate the effects of a pandemic on CMS' day-to-day operations. This component is designed to be consistent and complementary with the CMS Continuity of Operations (COOP)

Plan. CMS has several options at its disposal to ensure its operational continuity, including: monitoring pandemic information, trigger-based decision-making processes, protecting personnel tactics, and ensuring continuity of operations (COOP) viability in a pandemic environment.

2. **Pandemic Response** describes how CMS will respond during various phases of a pandemic to mitigate negative impacts on CMS programs (providers and contractors), beneficiaries, and stakeholders. For example, one pandemic response area of responsibility, under the HHS Pandemic Influenza Plan, requires CMS to track and conduct surveillance of Medicare patients during a pandemic.

Many policies and procedures developed for the COOP Plan such as Delegations of Authority and Devolution, are utilized in this CMS Pandemic Plan. Additionally, this Plan includes actionable processes and procedures to minimize the impact on CMS' day-to-day operations for the entire duration of a pandemic (assumed to exceed the 30-day requirement of Federal Continuity Directive (FCD) – 1).

1.1 Purpose and Guiding Principles

In conjunction with CMS' COOP Plan, this Plan represents policies and actions that are specific to an influenza pandemic. The procedures outlined in this Plan may also be extrapolated, where appropriate, for other highly contagious, severe pathogens or other biological events.

Purpose
- Serve as a tool and reference guide in communicating CMS' pandemic preparedness and response.
- Assist CMS leadership decision-making before, during, and after a pandemic.
- Ensure compliance with CMS and Department regulations, guidance, and directives.
- Demonstrate adherence to DHS and White House continuity planning mandates and directives.

Guiding Principles
- **Protection of CMS employees, contractors, and visitors**
    - Protect their health and safety.
    - Maximize the workforce available to maintain day-to-day operations.
    - Minimize influenza spread and reduce impact on public health.
- **Continuity of CMS day-to-day operations**
    - Continue day-to-day business operations to the maximum extent possible throughout all stages of the pandemic.

- **Execution of CMS pandemic response**
  - Ensure all CMS Centers, Offices, and Consortia/Regional Offices can fulfill their pandemic response responsibilities.
  - Communicate and coordinate pandemic preparedness and response to all stakeholders of the organization.
  - Support the efforts of public health authorities in mitigating the consequences of a pandemic.

1.2   Scope

This CMS Pandemic Plan is applicable to all CMS employees, facilities, contractors and visitors at all CMS occupied facilities throughout the United States. This Plan is intended to be utilized and implemented with an all-hazards approach in conjunction with all CMS and HHS emergency response plans, COOP plans, and Occupant Emergency Plans (OEP).

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2.0 PANDEMIC INFLUENZA BACKGROUND[1]

A pandemic is a global disease outbreak. Pandemic influenza occurs when a new influenza virus emerges for which people have little or no immunity and for which there is no vaccine. The disease spreads easily from person to person, causing serious illness that can sweep across the country and around the world in a very short amount of time. Pandemic influenza may begin with diseases from any number of animal sources, including swine (pig) or avian (bird) flu viruses.

Efforts to develop a universal vaccine or antiviral medications with sustained efficacy are complicated by the propensity of influenza viruses to mutate. As a result, people may not have immunity against a new influenza strain. During a pandemic, a novel influenza virus spreads within the human population with little or no pre-existing immunity. The extent and severity of a pandemic depend on the specific characteristics of the virus. In the 20th century, the world witnessed several human pandemics, each producing clinically apparent illness in approximately 30 percent of the world's population. It is estimated that 200,000 to 2 million Americans may die during the next severe influenza pandemic.

20th Century Pandemics Death Toll
1918-1919   U.S.... 675,000+   Worldwide...50,000,000+
1957-1958   U.S....70,000+   Worldwide...1-2,000,000
1968-1969   U.S....34,000+   Worldwide...700,000+

A pandemic could have a significant and prolonged disruptive impact on multiple social and economic sectors of a community. A high rate of absenteeism in workplaces as a result of illness or caring for ill family members, the imposition of public health interventions (such as school and business closings) social distancing, or fear of infection could threaten the social and economic infrastructure and result in disruption of essential services. To mitigate the consequences of a pandemic, comprehensive preparedness and response planning are imperative by all aspects and members of a community.

2.1 The Current Influenza Pandemic Threat[2]

There are currently cases of human infection with novel influenza A (H1N1) throughout the world, including the United States. On June 11, 2009, the World Health Organization (WHO) indicated that a global pandemic of novel influenza A (H1N1) was underway by raising the worldwide pandemic alert level to Phase 6. This action was a reflection of the spread of the new H1N1 virus, not the severity of illness caused by the virus. More than 70 countries had reported cases of novel influenza A (H1N1) infection and there were ongoing community level outbreaks of novel H1N1 in multiple parts of the world. As of September 2009, the World Health Organization (WHO) is coordinating

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[1] HHS Pandemic Influenza Plan "http://www.hhs.gov/pandemicflu/implementationplan/pdf/Pandemic.pdf"
[2] Current as of September 25, 2009: http://www.cdc.gov/h1n1flu/update.htm

a global response to human cases of the H1N1 virus and monitoring the corresponding threat of an influenza pandemic. The (WHO) H1N1 Web site, www.who.int/csr/disease/swineflu/en/index.html contains current information on the international situation.

In concert with international efforts, the Department of Health and Human Services (HHS) has been coordinating the US pandemic response through its lead agency, the Centers for Disease Control and Prevention (CDC). In late March and early April 2009, cases of human infection with this H1N1 virus were first reported in Southern California and near San Antonio, Texas. As shown in Figure 2.1, all U.S. states have since reported cases of H1N1 viral infection in humans. The latest U.S. information can be found on the Centers for Disease Control and Prevention (CDC) H1N1 Web site, www.cdc.gov/h1n1flu.

Figure 2.1 – Current Spread of H1N1 Flu
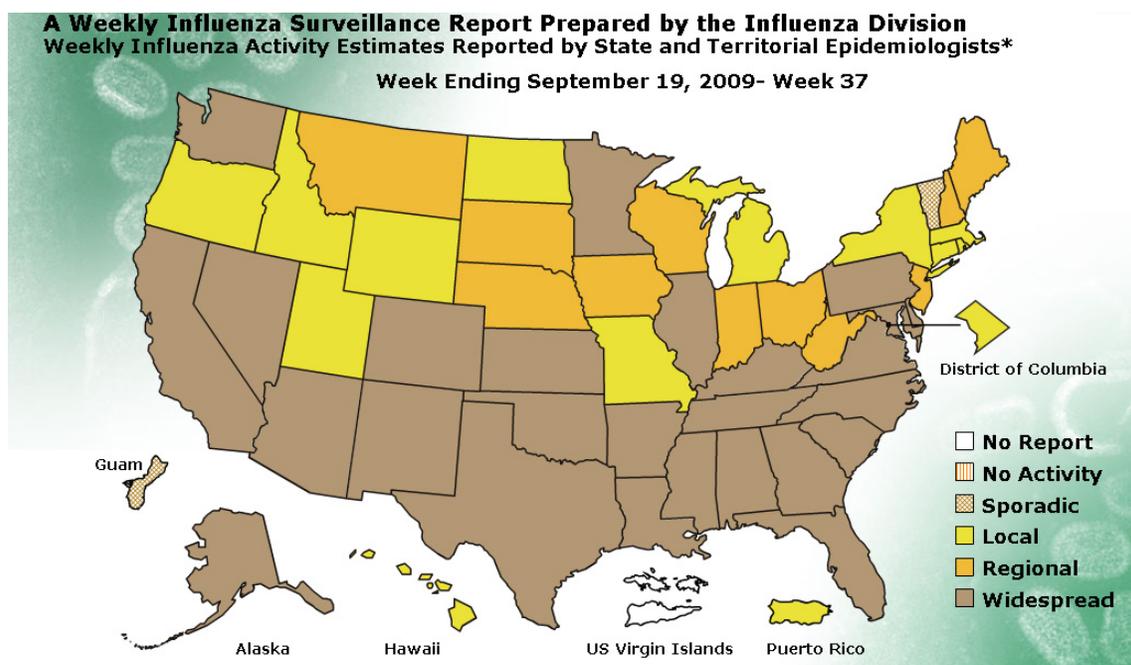
*This map indicates geographic spread and does not measure the severity of influenza activity.

2.2   Seasonal Influenza vs. Pandemic Influenza

It is important for CMS personnel to understand the difference between seasonal and pandemic influenza. Table 2.2 includes a breakdown of the distinctions between seasonal and pandemic flu.

Table 2.2 – Seasonal vs. Pandemic Influenza[3]

Factor	Seasonal Flu	Pandemic Flu
Frequency	Occurs annually, usually in winter, in temperate climates; outbreaks follow predictable seasonal patterns.	Occurs rarely (three times in 20th century).
Human Immunity	Usually some immunity built up from previous exposure.	No previous exposure; little or no pre-existing immunity.
Likelihood for Medical Complications	Healthy adults usually not at risk; the very young, elderly and those with certain existing conditions have increased risk.	Healthy people may be at increased risk.
Health System Capability	Health systems can usually meet public and patient needs.	Health systems may be overwhelmed.
Vaccine Availability	Vaccine developed based on known flu strains and available for annual flu season.	Vaccine probably would not be available in the early stages of pandemic influenza.
Antiviral Availability	Adequate supplies of antivirals are usually available.	Effective antivirals may be in limited supply.
Mortality	Average U.S. deaths approximately 36,000/yr.	Number of deaths could be quite high (e.g., U.S. 1918 death toll approximately 675,000).
Symptoms	Fever, cough, runny nose, muscle pain. Deaths often caused by complications, such as pneumonia.	Symptoms may be more severe and complications more frequent.
Impact on Society	Generally causes modest impact on society (e.g., some school closing, encouragement of people who are sick to stay home).	May cause major impact on society (e.g. widespread restrictions on travel, closings of schools and businesses, cancellation of large public gatherings).
Impact on Economy	Manageable impact on domestic and world economy	Potential for severe impact on domestic and world economy
For additional information on seasonal flu, visit http://www.hhs.gov/flu.		

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[3] Accessed September 25, 2009 "http://www.flu.gov/general/season_or_pandemic.html"

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2.3   Spread vs. Severity of Pandemic Influenza[4]

Pandemic influenza can vary in severity, mainly in terms of the number of affected people who contract the virus and develop severe illness or die as a result. Pandemic severity may also change over time and will differ across regions of the world, in different countries and even between different communities within a particular area.

Pandemic severity varies depending on several factors:

- A nation's ability to provide health care to the population
- The availability of antiviral medications to treat those who are infected
- Differences in how the disease affects people in different age groups
- Effectiveness of efforts to reduce human-to-human transmission of influenza

A pandemic severity index (Figure 2.3) has been developed to assist public health officials to correspond the timing of the spread and severity of the outbreak with the appropriate use of public health and community resources to minimize impact of the pandemic. The CDC has developed a pandemic severity index to describe the severity of a pandemic in terms of the likelihood of people dying from the disease.

Figure 2.3 – Pandemic Severity Index

Case Fatality Ratio		Projected Number of Deaths* US Population, 2006
≥2.0%	Category 5	≥1,800,000
1.0 -<2.0%	Category 4	900,000 - <1,800,000
0.5 -<1.0%	Category 3	450,000 -<900,000
0.1% - <0.5%	Category 2	90,000-<450,000
<0.1%	Category 1	<90,000

* Assumes 30% Illness Rate
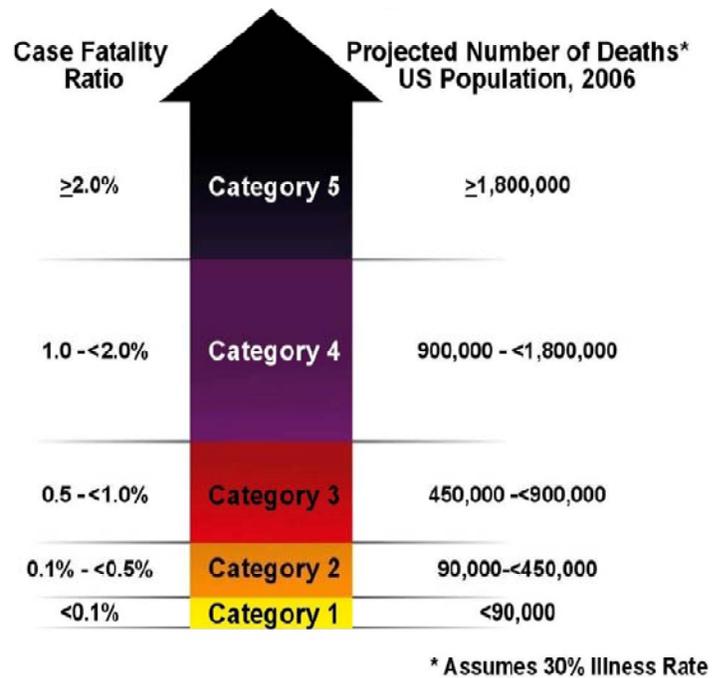
Table 2.3 outlines the elements of the moderate and severe pandemic scenarios, based on historical example.

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[4] Accessed on September 25, 2009 from "Federal Guidance to Assist States in Improving State-Level Pandemic Influenza Operating Plans"

Table 2.3 – Projected Number of Episodes of Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic Influenza Scenarios*[5]

Characteristic	Moderate (1958/68-like)	Severe (1918-like)
Illness	90 million (30%)	90 million (30%)
Outpatient medical care	45 million (50%)	45 million (50%)
Hospitalization	865,000	9,900,000
ICU care	128,750**	1,485,000**
Mechanical ventilation	64,875**	742,500**
Deaths	**209,000**	**1,903,000**

* Estimates based on extrapolation from past pandemics in the United States. Note that these estimates do not include the potential impact of interventions not available during the 20th century pandemics.
** At the present time, there are only 60,000 ICU beds in the United States, with an average utilization rate of around 85%, resulting in an available surplus of only 9000 beds.

2.4   Influenza Mitigation Strategies

The best protection against pandemic influenza—a vaccine that is well-matched to the virus causing illness—is not likely to be available at the outset of a pandemic. Strategies that do not involve vaccines or medications may serve as a first line of defense to help delay or mitigate the spread of influenza. Please see Table 2.4.

Table 2.4 – Influenza Prevention Strategies[6]

Primary Strategies
• Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
• Wash your hands often with soap and water, especially after you cough or sneeze. Alcohol-based hand cleaners are also effective.
• Avoid touching your eyes, nose, or mouth.
• Try to avoid close contact with sick people.
• If you get the flu, CDC recommends that you stay home from work or school for 7 days after symptoms begin, or until you are fever free for 24 hours.
• While sick, limit contact with others to keep from infecting them.

For additional information on non-pharmaceutical strategies please see http://www.cdc.gov and http://www.pandemicflu.gov.

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[5] Accessed September 25, 2009 "http://www.hhs.gov/disasters/discussion/planners/playbook/panflu/index.html"
[6] Accessed September 25, 2009 "http://www.cdc.gov/flu/protect/preventing.htm"

2.5 World Health Organization (WHO) Phases, Federal Government Response Stages, and CDC Intervals

World Health Organization (WHO) Phases

The WHO Influenza Pandemic Phases describe the progression of a pandemic geographically (spread). The six phases range from Phase 1 (when the virus is only present in animals) through Phase 6 (in which there is sustained transmission among humans). Four designated Periods divide the six WHO phases into Periods representing sequential processes of a typical pandemic scenario: Inter-Pandemic, Pandemic Alert, Pandemic, and Recovery. Based on the epidemiological aspects of the disease and the characteristics of the circulating viruses, the Director-General of WHO makes the decision to declare or upgrade to each phase.

Federal Government Response Stages

The United States government has developed the Federal Government Response Stages in order to capture both geographic spread and severity of a pandemic event. The Federal Government Response Stages do not always coincide with the WHO's Phases. For example, WHO has currently declared a Phase 6 pandemic for the H1N1 virus, while the Federal Government has not officially declared the corresponding Response Stage. This is because a WHO Phase Six pandemic declaration is based on the sustained worldwide spread —not the severity—of illness caused by the H1N1 virus.

Centers for Disease Control and Prevention Pandemic Intervals[7]

Within its leading role in pandemic response and preparedness, the Centers for Disease Control and Prevention (CDC) also uses intervals that represent sequential units of time occurring along a hypothetical pandemic curve. These intervals could happen in any community while sustained and efficient transmission of influenza is confirmed.

While it is difficult to forecast the duration of a pandemic, the CDC expects there will be definable intervals between when the pandemic begins, when transmission escalates and peaks, when resolution is achieved, and when subsequent waves begin. While there will be one epidemic curve for the United States, that larger curve incorporates many smaller curves that occur on a community by community basis. Therefore, the intervals serve as additional points of reference within the phases and stages to provide a common orientation and better epidemiologic understanding of what is taking place. Figure 2.5.A compares all three major metrics that describe the status of a pandemic.

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[7] Accessed September 25, 2009 "http://www.pandemicflu.gov/news/guidance031108.pdf"

Figure 2.5.A – WHO Phases, Federal Government Response Stages, & CDC Intervals

WHO Phases	Federal Government Response Stages		CDC Pandemic Intervals
INTER-PANDEMIC PERIOD			
1 / 2	0	New domestic animal outbreak in at-risk country	INVESTIGATION
PANDEMIC ALERT PERIOD			
3	0	New domestic animal outbreak in at-risk country	INVESTIGATION
3	1	Suspected human outbreak overseas	INVESTIGATION
4 / 5	2	Confirmed human outbreak overseas	RECOGNITION
PANDEMIC PERIOD			
6	3	Widespread human outbreaks in multiple locations overseas	RECOGNITION
6	4	First human case in North America	INITIATION
6	5	Spread throughout United States	ACCELERATION
6	5	Spread throughout United States	PEAK
6	5	Spread throughout United States	DECELERATION
RECOVERY PERIOD			
6	6	Recovery and preparation for subsequent waves	RESOLUTION

The CDC Pandemic Intervals are also a valuable means for communicating the status of the pandemic by quantifying different levels of disease, and linking that status with triggers for interventions. The intervals are designed to inform and complement the use of the Pandemic Severity Index (Figure 2.3) for choosing appropriate community mitigation strategies. The Pandemic Severity Index (PSI) guides the range of interventions to consider and/or implement given the epidemiological characteristics of the pandemic. Figure 2.5.B further illustrates the CDC Pandemic Intervals.

Figure 2.5.B – CDC Pandemic Intervals

WHO Phase	Inter		Pandemic Alert Period			Pandemic Period	
	1	2	3	4	5	6	

USG Stage	New Domestic Animal Outbreak in At-Risk Country	Suspected Human Outbreak Overseas	Confirmed Human Outbreak Overseas	Widespread Outbreaks Overseas	First Human Case in N.A.	Spread Throughout United States	Recovery
	0	1	2	3	4	5	6

For planning, intervals provide additional specificity for implementing state and community level interventions during stages 4, 5 and 6.

CDC Intervals: Investigation | Recognition | Initiation | Accel | Peak | Decel | Resolution

Pre- Pandemic Intervals
- Investigation
- Recognition

Pandemic Intervals
- Initiation
- Acceleration
- Peak Transmission
- Deceleration
- Resolution

The use of the Federal Government Response Stages and CDC Pandemic Intervals enables CMS to provide an optimal pandemic response while maintaining its operational continuity. Understanding the implications of the metrics that describe the severity and spread of a pandemic is central in the decision-making processes for CMS senior leadership. As a result Figure 2.5.C cross-walks the WHO pandemic phases, associated pandemic periods, and CDC pandemic intervals to describe CMS' readiness posture throughout the pandemic lifecycle.

Figure 2.5.C – Comparison of CDC Pandemic Intervals

CDC Pandemic Intervals	CMS Response Posture
INTER-PANDEMIC PERIOD	
INVESTIGATION	Preparedness and Monitoring Activities
PANDEMIC ALERT PERIOD	
INVESTIGATION	Preparedness and Monitoring Activities, Heightened Protective Actions
RECOGNITION	
PANDEMIC PERIOD	
RECOGNITION	Intensive Monitoring Activities, Social Distancing Protocols in Effect, Programmatic Response In Effect
INITIATION	
ACCELERATION	
PEAK	
DECELERATION	
RECOVERY PERIOD	
RESOLUTION	Recovery Activities

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3.0   PLANNING ASSUMPTIONS

The planning assumptions below are outlined in the HHS Pandemic Influenza Plan[8]:

- Susceptibility to the pandemic influenza subtype will be universal.
- The clinical disease attack rate will be 30% in the overall population. Illness rates will be highest among school-aged children (about 40%) and decline with age. Among working adults, an average 20% will become ill during a community outbreak.
- Of those who become ill with influenza, 50% will seek outpatient medical care
- 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. Because the virulence of the influenza virus that causes the next pandemic cannot be predicted, two scenarios are presented based on extrapolation of past pandemic experiences (Table 2.3).
- Risk groups for severe and fatal infections cannot be predicted with certainty.
- The typical incubation period for influenza averages two days.
- Persons who become ill may shed virus and can transmit infection for one-half to one day before the onset of illness.
- On average about two secondary infections will occur as a result of transmission from someone who is ill.
- In an affected community, a pandemic outbreak will last about 6 to 8 weeks. At least two pandemic disease waves are likely.
- The seasonality of a pandemic cannot be predicted with certainty. The largest waves in the U.S. during the 20th century occurred in the fall and winter.
- Absenteeism, due to illness, the need to care for ill family members, and fear of infection, may exceed 40% during the peak of outbreak.
- Disruption of societal infrastructure, including transportation, commerce, utilities, and public safety, will likely occur.

3.1   CMS-Specific Assumptions

- CMS will receive pandemic updates and follow directives from HHS, ASPR, CDC, DHS, and the White House.
- CMS will follow local emergency management and public health directives.
- CMS will work collaboratively with all HHS components and other Federal, state, tribal, and local agencies to enact an effective response.
- CMS employees, contractors, and visitors are responsible for adhering to personal infection control and prevention procedures.
- Pandemic severity may necessitate the activation of the COOP Plan (i.e., agency implementation of only the Mission Essential Functions).
- Human capital policy actions will be based on OPM/HHS guidance.
- All CMS components will monitor availability of personnel and staffing capabilities.

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[8] HHS Pandemic Influenza Plan "http://www.hhs.gov/pandemicflu/implementationplan/pdf/Pandemic.pdf"

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4.0 ROLES AND RESPONSIBILITIES

Response to a pandemic requires an effective team structure. The Executive Team and Pandemic Coordination Team (PCT) each have a specific role in overall pandemic operations and response. Operation of the teams is also tied to the periods of a pandemic identified in Section 2.5.

4.1 Organizational Structure

The CMS Pandemic Plan utilizes a modified organizational structure adapted for the unique impacts of a pandemic, as illustrated in Figure 4.1.A below:

Figure 4.1.A – CMS Pandemic Organizational Chart
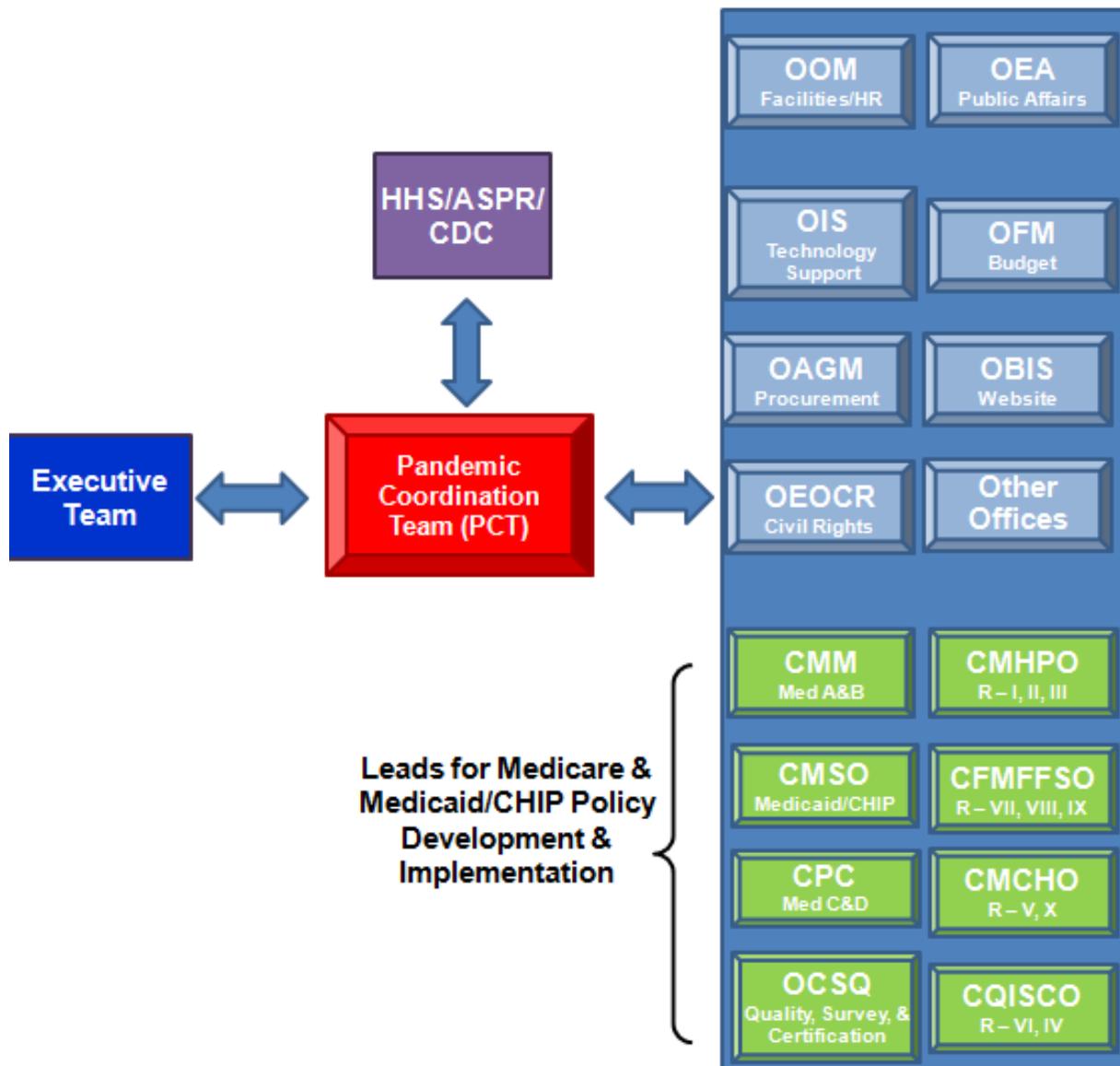
Figure 4.1.A depicts that the Pandemic Coordination Team (PCT) serves as the central coordinating group for CMS' pandemic response operations. This team coordinates both operational continuity and pandemic response actions amongst the Executive Team, HHS HQ, and all CMS Centers/Offices/Consortia. The detailed organizational structure of the PCT is shown in Figure 4.1.B:

Figure 4.1.B – Pandemic Coordination Team Organizational Chart
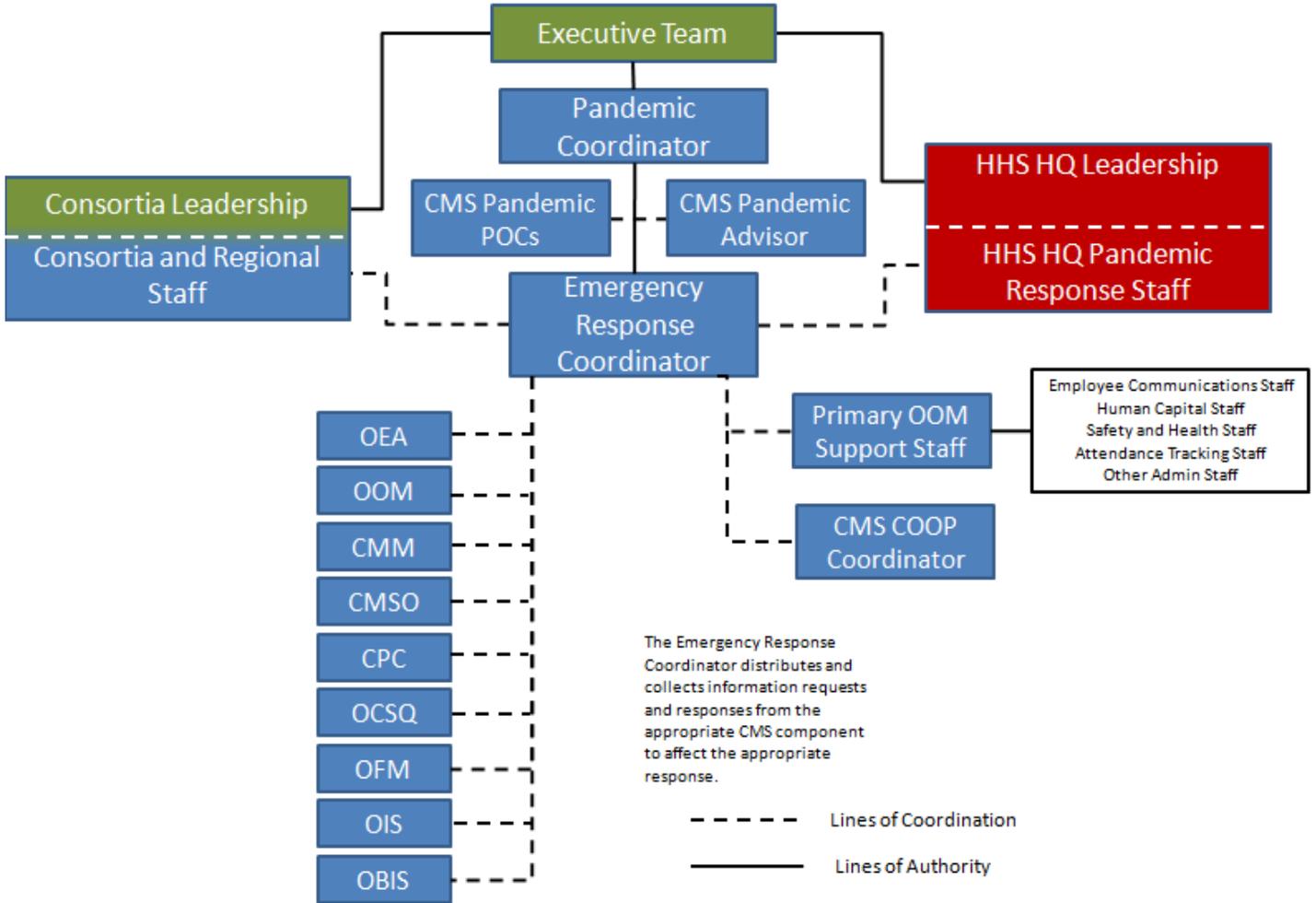
Tables 4.1.A and 4.1.B capture the roles and responsibilities of the Executive Team, Pandemic Coordination Team, and the CMS Centers/Offices and Consortia.

Table 4.1.A – Executive Team Roles and Responsibilities

Executive Team
Executive Team Composition: • Administrator   • Deputy Administrator   • Chief Operating Officer   • Deputy Chief Operating Officer   • Director, Office of Financial Management (OFM)   • Director, Office of Operations Management (OOM) – Executive Oversight Lead   • Director, Office of Information Services (OIS)   • Director, Center for Medicaid & State Operations (CMSO)   • Director, Center for Medicare Management (CMM)   • Director, Center for Drug and Health Plan Choice (CPC)   • Director, Office of Clinical Standards and Quality (OCSQ)   • Director, Office of External Affairs (OEA)   • Director, Office of Acquisitions and Grants (OAGM)   • Consortia Administrator, Quality Improvement and S&C Operations (CQISCO)   • Consortia Administrator, Medicare Health Plans Operations (CMHPO)   • Consortia Administrator, Financial Management & FFS Operations (CFMFFSO)   • Consortia Administrator, Medicaid and Children's Health Operations (CMCHO)
Operational Continuity Responsibilities
1. Serve as the leaders for continued CMS operations.   2. Directs the implementation of employee protection measures.   3. Notifies all CMS Component Offices and Consortia of operational status.   4. Provides instructions to assist with continuance of essential functions.   5. Addresses the pay status, administrative leave, travel policy, telework policy, and other HR policies of employees.   6. Conducts necessary impact assessment of pandemic consequences on CMS day-to-day operations based on input from CMS, HHS, and CDC surveillance activities.   7. Directs the CMS COOP Lead in activating the CMS COOP Plan, if necessary.
Pandemic Response Responsibilities
1. Communicates with senior HHS officials on CMS' pandemic response.   2. Ensures that the designated CMS teams participate as members of interagency emergency response teams during an event.   3. Coordinates dissemination of media information through the Office of External Affairs.   4. In coordination with HHS, makes decisions on CMS policy implementation in response to the pandemic.   5. Provide leadership and guidance to CMS teams and personnel in mitigating the affects of the pandemic on CMS' stakeholders.

Table 4.1.B – Pandemic Coordination Team Roles and Responsibilities

Pandemic Coordination Team
Pandemic Coordination Team Composition:

- Executive Oversight
- Pandemic Coordinator
- Pandemic Advisor
- Emergency Response Coordinator
- CMS COOP Coordinator
- Primary OOM Support Staff
  - Employee Communications Staff
  - Human Capital Staff
  - Safety and Health Staff
  - Attendance Tracking Staff
  - Other Administrative Staff

Operational Continuity Responsibilities

1. Serves as the communications hub with the HHS Secretary's Operations Center (SOC), CMS Regional Offices, the Executive Team, and other necessary organizations during a pandemic.
2. Provides support to leadership.
3. Collects the status information and provides status reports to the Executive Team.
4. Creates and maintains logs of activities and decisions.
5. Troubleshoots operational continuity issues.
6. Coordinates actions required to sustain operational continuity with CMS internal and external stakeholders.

Pandemic Response Responsibilities

1. Serves as the data collection point for CMS pandemic response activities.
2. Troubleshoots pandemic response requirements.
3. Liaises with HHS HQ, ASPR, CDC, and other Federal partners and key stakeholders in implementing the emergency response activities to the pandemic.
4. Coordinates data requirements from external entities with the appropriate CMS component.

Executive Oversight:

- Provide overall guidance and leadership to supporting team members.

Pandemic Coordinator:

- Coordinates CMS pandemic planning and execution.
- Serves as agency executive liaison to other Departmental agencies such as ASPR and CDC.
- Represents agency on Task Forces and other key planning briefings.
- Ensures pandemic plan is current and in compliance with Federal directives.
- Oversees and executes CMS pandemic activities.
- Ensures situational awareness.
- Primary contact for all CMS pandemic activities.

Pandemic Coordination Team

Pandemic Advisor:
- Supports and advises on pandemic planning and execution.
- Coordinates and advises regional offices on steps needed to protect employees.
- Participates on workgroups with OPDivs and StaffDivs.
- Actively participates in Department and agency calls.
- Coordinates, tracks and reports the status of actions and issues needing resolution.
- Regularly convenes component POCs to coordinate activities.

CMS Emergency Response Lead:
- Serves as CMS liaison with ASPR and the SOC during response phase.
- Triage mission assignments and tasks assigned to CMS.
- Coordinates emergency activities with Regional staff including 1135 waivers.
- Assists Pandemic Coordinator in executing plan activities.
- Coordinates, tracks, and reports the status of actions and issues needing resolution.

CMS COOP Coordinator:
- Coordinates COOP plan with pandemic plan.
- Supports execution of COOP Plan.
- Provides information to CMS senior leadership to ensure MEF Continuity Teams are staffed and trained.
- Supports command and control in case of complete devolution.
- Backs up Emergency Response Coordinator as necessary.

Primary OOM Support Staff:
- Track all open and closed action items for CMS.
- Prepares and maintains communication plan and materials for employees; manages website content with OBIS.
- Provides consultation on Employee-Labor Relations, recommends and develops pay and leave policy, recommends staffing policy.
- Coordinates use and dissemination of Personal Protective Equipment for CMS employees.
- Provides resources for mental health issues for CMS employees.
- Tracks and coordinates speakers list and coordination.
- Maintains project tracking and inventory of documents.
- Maintains attendance tracking and monitoring.
- Track travel and maintain reporting.
- Coordinate human resources issues including updating PDs for emergencies.
- Coordinates telework implementation with OIS.
- Coordinates and provides employee training for employees on pandemic.

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5.0   OPERATIONAL CONTINUITY

During any period of CMS' response to a pandemic, CMS must maintain its ability to:
- Continue routine, day-to-day operations during the pandemic
- Continue performance of its Mission Essential Functions (MEFs) when day-to-day operations cannot be sustained, requiring activation of the COOP Plan

The following subsections of Section 5.0 highlight essential elements and processes to maintain both aspects of operational continuity.

5.1   Concept of Operations

CMS' process for maintaining continuity during day-to-day operations depends upon surveillance during each of the four periods of a pandemic to determine how CMS can best make decisions, notify appropriate entities, and implement necessary actions. Figure 5.1.A captures this basic process.

Figure 5.1.A – Day-to-Day Operational Continuity - Concept of Operations
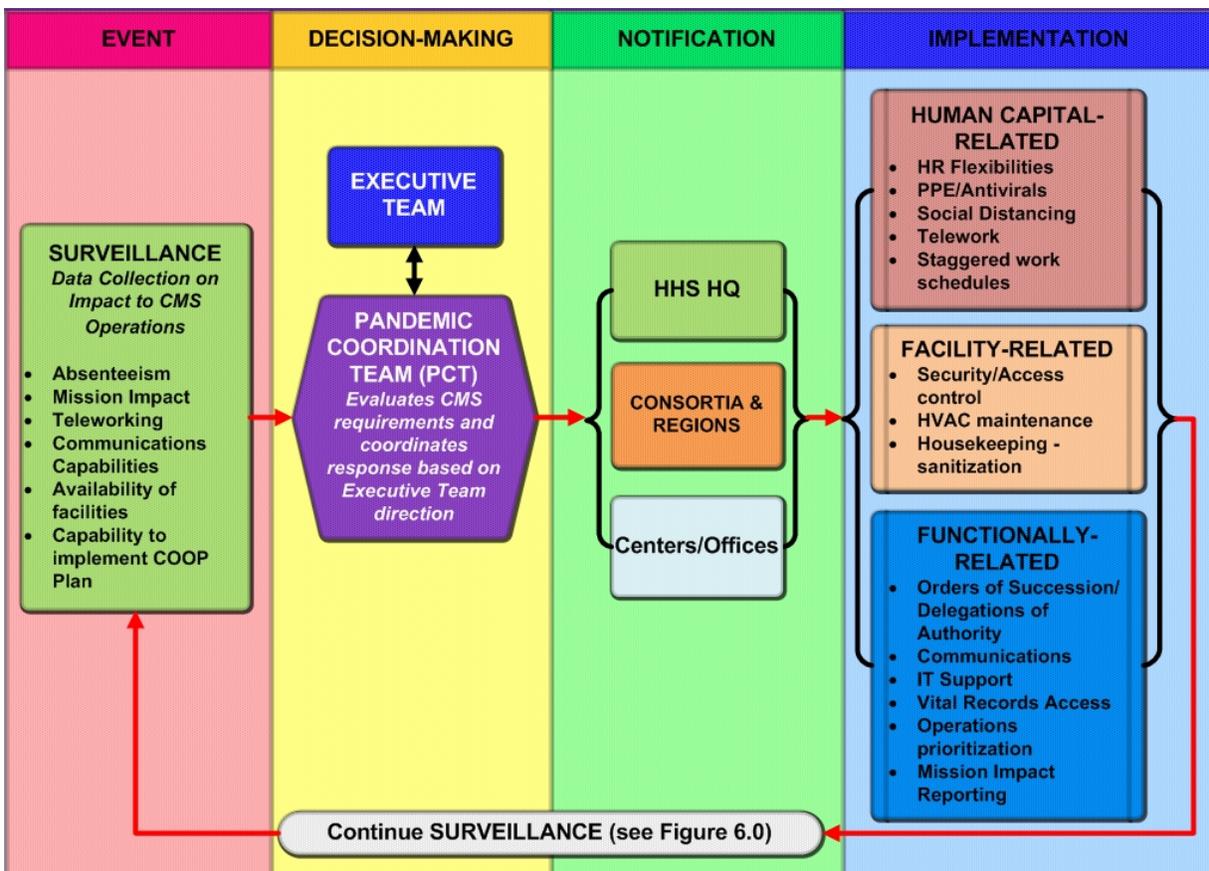
While continuing to sustain day-to-day operations during a pandemic, CMS will also ensure it maintains the ability to continue its MEFs. Some examples of scenarios that may threaten performance of CMS' MEFs include:
- A facility disruption during the pandemic.

- An increase in the Continuity of Government Condition Readiness Level (COGCON).
- A change in the Homeland Security Alert System.
- An impact of the pandemic that is so severe that the agency's operations only support MEFs.

Figure 5.1.B illustrates how CMS will activate the COOP Plan during a pandemic event.

Figure 5.1.B – COOP Activation During a Pandemic Event
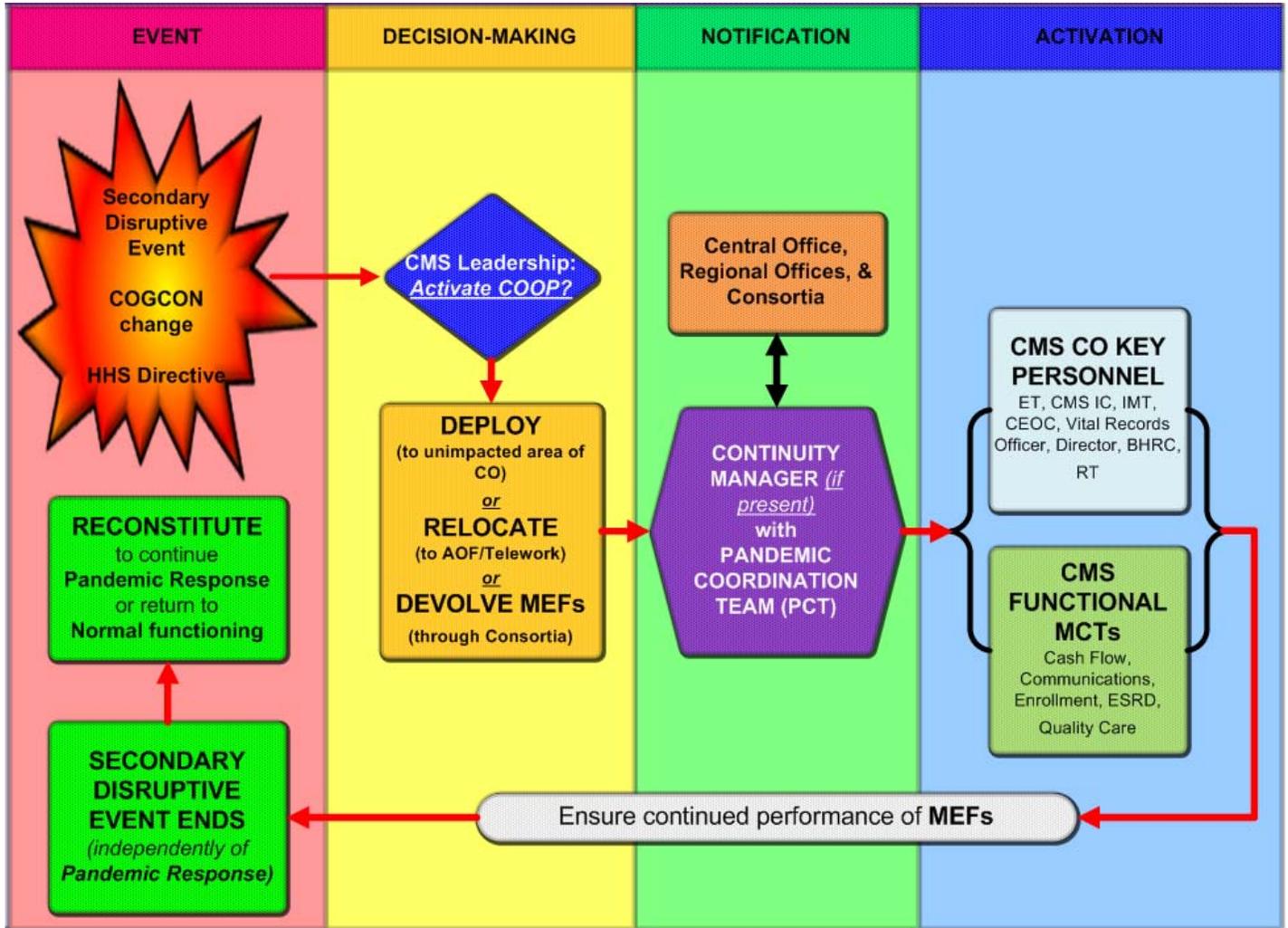
COOP activation during a pandemic event ends with reconstitution of CMS to approximate pre-disruption status, independently of whether the pandemic is still ongoing.

Sections 5.1.1 through 5.1.4 describe the operational continuity implementation actions during the Federal Response Stages that occur within the Inter-Pandemic Period, Pandemic Alert Period, Pandemic Period, and Recovery Period of a pandemic. Each of these periods is organized by decision-making, protective actions, preparedness activities, communications, and recovery activities. Additional information on how the pandemic periods are defined can be found in Section 2.0 of this plan.

5.1.1 Inter-Pandemic Period

Table 5.1.1 captures COOP activation and operations during a disruptive event that occurs within CMS' Inter-Pandemic Response Period.

Table 5.1.1 – Inter-Pandemic Operational Continuity Actions

Executive Team (ET)	Pandemic Coordination Team (PCT)	OOM	OFM	OIS	OAGM	Other Centers/ Offices	Consortia/ Regional Offices	Actions
	X							Liaison with ASPR and other partner agencies
	X	X						Collect quarterly baseline data regarding absenteeism
X	X	X	X	X	X	X	X	Update Orders of Succession, key partner contact lists, key employee phone trees
		X		X				Assess & update teleworking infrastructure and capability; ensure technological availability for staff
	X							Secretary's Operations Center (SOC) calls
	X							Situation Reports for SOC
	X	X						Coordinate questions and answers and distribute as appropriate
	X	X						Track agency activities, coordinate preparedness activities*
X	X	X	X	X	X	X	X	Review pandemic plans for relevance and currency
X	X	X	X	X	X	X	X	Review and develop necessary policies and processes for pandemic planning
		X	X	X	X	X	X	Prepare timely response to questions, obtain leadership clearance, and post to website
	X	X						Serve on task forces for Departmental initiatives

Executive Team (ET)	Pandemic Coordination Team (PCT)	OOM	OFM	OIS	OAGM	Other Centers/ Offices	Consortia/ Regional Offices	Actions
	X							Arrange presentations and speakers regarding pandemic preparedness
	X	X						Implement education and training initiatives**
	X	X						Conduct regular tests and exercises of operational continuity capabilities
X	X	X						Implement necessary Personal Protective Equipment (PPE) testing, medical screening, and other preparatory activities

*OEOCR will be used to ensure reasonable accommodation requirements are included in the preparedness activities.

** Note the CMS webinar is not 508 Compliant. An alternative training strategy must be employed to support employees who require reasonable accommodations.

Protective Actions

- *Inter-Agency Participation*
  - Participate in HHS HQ task forces on pandemic planning/preparedness
  - Participate in HHS HQ pandemic readiness conference calls
  - Information sharing with stakeholders and employees
- *Reporting*
  - Conduct quarterly data collection of absenteeism and mission impact reporting (see Appendix A)
  - Compile quarterly data collection activities into "baseline" assessments

Preparedness Activities

- *Preparation*
  - Review and update Pandemic Influenza plans
  - Update Orders of Succession for all CMS offices
  - Update contact lists for external clients and phone trees (see Appendix D for an example)
  - Assess and update teleworking capabilities
  - Identify personnel who require teleworking capability to continue essential functions and other key functions
  - Conduct exercise activities to test Pandemic Plan and, in particular, teleworking and back-up systems
  - Take inventory and update employee emergency kits with appropriate PPE
- *Training*
  - CMS will continue to provide information during scheduled annual training See Table 5.2.8.B for training topics.

- o Update CMS website with relevant pandemic preparedness/mitigation information

Communications

- **Internal**
  - o COOP and Executive Teams:
    - Inform members of an outbreak as reported by International and National sources
      - ✓ Communication Tool(s): Telephone Tree and Email Distribution
      - ✓ Frequency: As necessary
    - Provide "refresher" training on pandemic plan
      - ✓ Communication Tool(s): Briefing
      - ✓ Frequency: Annually
  - o Workforce:
    - Provide information during training sessions
      - ✓ Topic: Pandemic Influenza overview with Personal & workplace preparedness
      - ✓ Communication Tool(s): Briefing, Intranet and/or website
      - ✓ Frequency: Annually
- **External**
  - o Stakeholders: Communications will continue as normal but also focus on answering questions (FAQs) regarding pandemic plans, relative CMS program policy, and updates of the CMS website
  - o HHS: Communications will continue as normal
  - o Other partners: Communications will continue as normal
  - o Media: Communications will continue as normal

Recovery

- Implement corrective actions from tests, exercises, and lessons learned from the Inter-Pandemic Period if the pandemic event does not advance to further stages.

5.1.2 Pandemic Alert Period

Table 5.1.2 outlines the additional steps necessary during the pandemic alert period to mitigate risk and ensure CMS' operational continuity.

Table 5.1.2 – Pandemic Alert Operational Continuity Actions

Executive Team (ET)	Pandemic Coordination Team (PCT)	OOM	OFM	OIS	OAGM	Other Centers/ Offices	Consortia/ Regional Offices	Actions
	X							Continue liaison with ASPR and other partner agencies
	X							Continue SOC calls and Situation Reports for SOC
	X	X						Coordinate with OPM for Federal Agency status and with Building Manager for building status
X	X	X						Coordinate questions and answers and distribute as appropriate and post to website
X	X							Update and confirm Orders of Succession & Delegations of Authority
	X	X	X	X	X	X	X	Ensure a minimum three-deep succession in all key positions
	X							Weekly updates for pandemic response and COOP rosters
	X			X				Coordinate with OIS to verify telework capability and IT/COMM infrastructure
X		X	X	X	X	X	X	Encourage voluntary teleworking for workforce personnel
X	X	X	X	X	X	X	X	Encourage good hygiene and other personal protective measures throughout the workforce
	X	X						Inventory and coordinate ramp up for the distribution of PPE agency-wide
X	X	X	X	X	X	X	X	Ensure distribution and accessibility of CMS Pandemic Plan to all pandemic response and COOP personnel
	X	X						Hold pandemic preparedness refresher briefings and distribute up-to-date materials
	X	X	X	X	X	X	X	Test notification systems; confirm latest backup of all key Vital Records and Systems; inform PCT
X								Approve any necessary pandemic policy and planning initiatives

Executive Team (ET)	Pandemic Coordination Team (PCT)	OOM	OFM	OIS	OAGM	Other Centers/ Offices	Consortia/ Regional Offices	*Actions*
	X	X						Begin implementation of staggered work schedules (determination of appropriate schedules, offices eligible, etc)
X	X	X						Begin bi-weekly surveillance activities – agency-wide monitoring
X			X	X	X	X	X	Provide OOM completed pandemic impact assessment reports on a bi-weekly basis
X	X	X	X	X	X	X	X	Hold CMS senior leadership briefings

Protective Actions

- ***Preparation***
    - Implement all objectives identified in the prior period response
    - Coordinate with Federal Executive Boards, OPM and other knowledgeable sources to determine if/when CMS operations should be restricted or suspended
    - Ensure alternate operating facility (AOF) readiness and confirm systems are on-line and ready to perform back-up role, if necessary
- ***Protection***
    - Begin more frequent cleaning of CMS work spaces to limit spread of infection
    - Begin dissemination of personal protective equipment for employees at high risk
    - Provide resources and a work environment that promotes personal hygiene, including:
        - no-touch trash cans
        - hand sanitizer
        - disinfectants
    - Phase-in alerts for social distancing and telework policies

Preparedness Activities

- ***Training***
    - Due to the need for social distancing, training will be integrated into the Communications function. All training material will be sent via Email and uploaded to the CMS Intranet and website so they can serve as resources for employees.

Communications

- *Internal*
    - o Executive Team:
        - Status update Pandemic Influenza cases/outbreaks and explanation of the change in Federal Response Stage
            - ✓ Communication Tool(s): Intranet, Web/Email distribution, and Telephone Trees
            - ✓ Frequency: As cases/outbreaks are reported
        - Situation assessment and implementation of Pandemic Influenza Plan
            - ✓ Communication Tool(s): Teleconferencing (Note: Some staff require reasonable accommodations to participate in teleconferencing.)
            - ✓ Frequency: Daily
    - o Pandemic Coordinator:
        - Status update Pandemic Influenza cases/outbreaks and explanation of the change in Federal Response Stage
            - ✓ Communication Tool(s): Intranet, Web/Email distribution, and Telephone Trees
            - ✓ Frequency: As cases/outbreaks are reported
    - o Workforce:
        - Status update Pandemic Influenza cases/outbreaks and explanation of the change in Federal Response Stage and operational status/work-leave policies for CMS employees
            - ✓ Communication Tool(s): Intranet, CMS Website and Email Distribution
            - ✓ Frequency: As cases/outbreaks are reported and decisions are made regarding operational status
- *External*
    - o Stakeholders: Communicate any changes in operating status
    - o HHS: Communicate any changes in operating status
    - o Other partners: Communicate any changes in operating status (Phone updates: As necessary)
    - o Media: Communicate any changes in operating status (Phone updates: As necessary)

Recovery
- Implement corrective actions from tests, exercises, and lessons learned from the Inter-Pandemic and Pandemic Alert Periods of the pandemic ends at this stage.

5.1.3 Pandemic Period

Table 5.1.3 outlines the additional steps necessary during the pandemic alert period to mitigate risk and ensure CMS' operational continuity.

Table 5.1.3 – Pandemic Period Operational Continuity Actions

Executive Team (ET)	*Pandemic Coordination Team (PCT)*	*OOM*	*OFM*	*OIS*	*OAGM*	*Other Centers/ Offices*	*Consortia/ Regional Offices*	*Actions*
	X							Situation Report updates with ASPR & SOC calls with greater frequency
		X	X	X	X	X	X	Implement and maintain full surveillance measures and weekly data collection; relay to PCT
X	X	X	X	X	X	X	X	Communicate official operating and policy status with key stakeholders
X	X							Coordinate with OPM for Federal Agency status and with Building Manager for building status
X	X							Prepare for potential declarations of Federal Response Stage changes
X	X					X	X	Coordinate questions and answers and distribute as appropriate and post to website
X			X	X	X	X	X	Prepare for potential to declare succession & Delegations of Authority; inform PCT
	X							Confirm daily, operational capability to implement Mission Essential Functions
	X							Prepare alternate operating facility and notification systems for potential activation
	X							Daily updates for pandemic response and COOP rosters
	X							Verify key personnel are available and prepared for potential deployment
				X			X	Confirm IT/COMM and other infrastructure needed for potential devolution of functions
X	X					X	X	Enforce distribution and use of PPE and other personal protective measures throughout the workforce (see Section 7.0)
	X	X						Distribute PPE, vaccines/antivirals, and other targeted protective measures for personnel

Executive Team (ET)	Pandemic Coordination Team (PCT)	OOM	OFM	OIS	OAGM	Other Centers/ Offices	Consortia/ Regional Offices	*Actions*
X	X	X	X	X	X	X	X	Implement telework and other social distancing measures to fullest extent available
		X				X	X	Implement HR Flexibilities for hiring and leave, when necessary
X	X	X						Provide regular pandemic response and operational continuity guidelines to workforce
X	X	X	X	X	X	X	X	Implement any necessary operational continuity policy and planning initiatives
X	X	X					X	Coordinate with Federal Executive Board and local public health and emergency management officials on local pandemic conditions

Implementation Actions

- Implement workforce protection and operational continuity actions to ensure a broad base of workforce capability to maintain mission critical operations
- Implement all tasks and activities identified in prior pandemic period
- Ensure orders of succession are in place and implemented when necessary
- Cancel all official travel based on DHS or other Federal travel guidance
- Implement social distancing and telework - use teleconferencing measures to conduct meetings
- Implement available leave policies for employees and/or family members with flu-like symptoms
- Follow OPM and HHS guidelines for ill employees reporting to work.
- Implement liberal leave policies for ill employees and/or family members with flu-like symptoms
- Advise employees with flu-like symptoms to stay at home and seek appropriate medical care in accordance with OPM guidance
- Require employees on travel believed to be exposed, or exhibiting flu-like symptoms to follow OPM and HHS guidance
- Reassign staff and hire contractors as needed to assure completion of essential and mission-critical functions
- Expand teleworking and social distancing measures

Communications

- *Internal*
  - Executive Team:
    - Status update for Pandemic Influenza cases/outbreaks and explanation of the change in Federal Response Stage
      - ✓ Communication Tool(s): Intranet, Web/Email distribution, and Telephone Trees
      - ✓ Frequency: As cases/outbreaks are reported
    - Situation assessment and implementation of Pandemic Influenza Plan
      - ✓ Communication Tool(s): Teleconferencing
      - ✓ Frequency: Every 12 hours
  - Workforce:
    - Status update for Pandemic Influenza cases/outbreaks and explanation of the change in Federal Response Stage and operational status/work-leave policies for CMS employees
      - ✓ Communication Tool(s): Email distribution, Intranet and Website
      - ✓ Frequency: As cases/outbreaks are reported and daily in regards to operational status
    - Require CMS staff to check in with supervisor regarding work status
      - ✓ Communication Tool(s): Email and/or Telephone
      - ✓ Frequency: Daily
- *External*
  - Stakeholders: Communicate any changes in operating status with greater frequency
  - HHS: Communicate any changes in operating status with greater frequency
  - Other partners: Communicate any changes in operating status with greater frequency
  - Media: Communicate any changes in operating status with greater frequency

5.1.4 Recovery Period – Full Recovery

Table 5.1.4 outlines the additional steps necessary during the pandemic alert period to mitigate risk and ensure CMS' operational continuity.

Table 5.1.4 – Recovery Period Operational Continuity Actions

Executive Team (ET)	Pandemic Coordination Team (PCT)	OOM	OFM	OIS	OAGM	Other Centers/ Offices	Consortia/ Regional Offices	Actions
	X							Situation Report updates with ASPR & SOC; prepare for subsequent pandemic waves
X		X	X	X	X	X	X	Maintain surveillance measures and bi-weekly data collection; relay to PCT
	X							Prepare agency-wide surveillance and incident reporting for After-Action Reports
X	X	X	X	X	X	X	X	Continue to communicate official operating and policy status with key stakeholders
	X	X						Coordinate with OPM for Federal Agency status and with Building Manager for building status
X	X							Prepare for potential declarations of Federal Response Stage changes
X	X					X		Coordinate questions and answers and distribute as appropriate and post to website
X	X	X						Continue recommendations of maintaining good hygiene, optional PPE use, and other personal protective measures throughout the workforce
	X	X			X			Inventory and restock PPE & vaccine/antiviral supplies when available
X	X	X	X	X	X	X	X	Prepare for phase-down from full telework and other social distancing measures
	X	X				X	X	Review/reconcile actions and issues resulting from implementation of HR Flexibilities and other pandemic-related policies

Implementation Actions

- Reduce implementation of shift work and telework procedures in-between subsequent waves, as necessary

- Implement necessary workforce and operational recovery steps to mitigate operational disruptions from affected staff and implement necessary plans to review and reconcile where needed actions taken during pandemic period.

Preparedness Activities

- Provide information to workforce via emails on:
  - Continued personal health preparedness
  - Resuming Pre-Pandemic operating conditions
  - Recovery/catch-up of work priorities deferred during the pandemic

Communications
- *Internal*
  - Executive Team:
    - Status Pandemic Influenza cases/outbreaks and explanation of the change in Federal Response Stage
      - ✓ Communication Tool(s): Intranet, Web/Email distribution, and Telephone Trees
      - ✓ Frequency: As cases/outbreaks are reported
    - Situation assessment and implementation of Pandemic Influenza Plan
      - ✓ Communication Tool(s): Teleconferencing
      - ✓ Frequency: Daily
  - COOP Team: Continue to inform team members of outbreaks of subsequent waves (as needed)
    - Status Pandemic Influenza cases/outbreaks and explanation of the change in Federal Response Stage
      - ✓ Communication Tool(s): Intranet, Web/Email distribution, and Telephone Trees
      - ✓ Frequency: As cases/outbreaks are reported
  - Workforce:
    - Status Pandemic Influenza cases/outbreaks and explanation of the change in Federal Response Stage, operational status/work-leave policies and instructions for returning to work
      - ✓ Communication Tool(s): Email distribution, Intranet and Website
      - ✓ Frequency: As cases/outbreaks are reported and daily in regards to operational status and instructions
    - Continued personal health and preparedness and resuming pre-pandemic agency functions
      - ✓ Communication Tool(s): Intranet, CMS Website and Email Distribution

External
- Stakeholders: Communicate recovery status
- HHS: Communicate recovery status
- Other partners: Communicate recovery status

5.2   Key Operational Continuity Elements

5.2.1 Orders of Succession and Delegations of Authority

CMS has developed Orders of Succession and Delegations of Authority within this Pandemic Plan to ensure the continuation of both normal business operations and Mission Essential Functions in the event that CMS leadership is unavailable during a pandemic.

The Orders of Succession contained in this Plan are to be executed in the event that the Administrator or key agency position holders are unavailable to fulfill their duties. An incumbent is determined to be "unavailable" if they cannot fulfill the duties and responsibilities that are inherent to their position or office or, in case of absence, they cannot be contacted within an amount of time that is reasonable for the circumstances.

This Plan shall be activated only upon the circumstances specified in each order of succession. In addition, any individual who exercises authority under this plan must adhere to all limitations associated with that order of succession. The authority to act as the Administrator must be exercised in accordance with the provisions of the Federal Vacancies and Reform Act of 1998. The "Acting" title is applicable and reserved only in instances in which the CMS Administrator position and other key agency positions are vacant.   The most senior CMS official or the Secretary of Health and Human Services (HHS) can activate this plan.

CMS has established the following Order of Succession for the <u>Administrator</u>:

Table 5.2.1.A – Orders of Succession

Order	Successor
1	Deputy Administrator
2	Chief Operating Officer
3	Director, Center for Medicare Management
4	Deputy Chief Operating Officer
5	Director, Office of Financial Management
6	Deputy Director, Center for Medicare Management
7	Deputy Director, Office of Financial Management

Based on the requirements of the disruption, the Executive Team will determine whether or not the Administrator is incapable or unavailable. Upon activation of the Orders of Succession, the successor must notify the Secretary's Operations Center

(SOC) 202-619-7800 and the CMS Emergency Operations Center (CEOC) 410-786-2000.

Succession of Executive Authority to a Consortia Administrator
A *Delegation of Authority for the Emergency Operations Executive* (EOE Delegation) has been prepared to ensure continuity of executive authority. The Consortia Administrators (CA) in Dallas and Kansas City retain a copy of the EOE Delegation.

Emergency Operations Executive (EOE)

The EOE is a limited authority, and the CA who exercises this authority shall be called the "Emergency Operations Executive" rather than "Acting Administrator." If the CMS Administrator and all of his or her successors are unavailable or incapable of performing their responsibilities, the Dallas CA, or alternately, the Kansas City CA, will assume the authority of the EOE. The EOE will be assumed in the following order:
- Consortia Administrator, Dallas.
- Consortia Administrator, Kansas City.
- Consortia Administrator, Chicago.
- Consortia Administrator, New York.

The EOE will notify the HHS Secretary, any available CMS Central Office leadership, and all other ROs that he/she has assumed the EOE authority. That CA will remain the EOE until the Administrator or a successor becomes available. The EOE must ensure that CMS' Mission Essential Functions are maintained and that normal business operations are restored as soon as possible.

Only the Secretary, Administrator or their successor may terminate or re-delegate the authority to act as the EOE.

Orders of Succession for Key Agency Positions
Orders of Succession have been established for each Center and Office Director at CMS Headquarters. The continuity of the leadership within the centers/offices is just as critical as maintaining leadership at the agency head. Activation of the Orders of Succession for key agency positions is the responsibility of the Executive Team. When the succession is activated, senior leadership and all potential successors are notified of the leadership change. It is the responsibility of the successor to notify all staff within his/her Center or Office of the change in leadership. Table 5.2.1.B captures the Orders of Succession for key agency positions; Table 5.2.1.C captures current Delegations of Authority.

Table 5.2.1.B – Orders of Succession for Key Agency Positions

Office	Position	Successor #1	Successor #2	Successor #3
Office of the Administrator	**Administrator**	Deputy Administrator	Chief Operating Officer	Director, CMM
Center of Medicare Management (CMM)	**Director, CMM**	Deputy Director, CMM	Director, Hospital & Ambulatory Policy Group, CMM	Director, Chronic Care Policy Group, CMM
Office of Financial Management (OFM)	**Director, OFM**	Deputy Director, OFM	Director, Accounting Management Group, OFM	Director, Financial Services Group, OFM
Office of Information Services (OIS)	**Director, OIS**	Deputy Director, OIS	Director, Enterprise Databases Group	Director, Business Applications Management Group
Center for Drug and Health Plan Choice (CPC)	**Director, CPC**	Deputy Director, CPC	Director, Medicare Drug and Health Plan Contract Administration Group	Director, Medicare Drug Benefit and C&D Data Group
Center for Medicaid and State Operations (CMSO)	**Director, CMSO**	Deputy Director, CMSO	Director, Disabled & Elderly Health Programs Group	Director, Survey & Certification Group
Office of the Actuary (OACT)	**Chief Actuary and Director, OACT**	Director, Medicare and Medicaid Cost Estimates Group	Director, Parts C & D Actuarial Group	Director, National Health Statistics Group
Office of Acquisition and Grants Management (OAGM)	**Director, OAGM**	Deputy Director, OAGM	Group Director, MCG	Group Director, AGG
Office of Clinical Standards and Quality (OCSQ)	**Director, OCSQ**	Deputy Director, OCSQ	QMHAG Director	BOS Director

Office	Position	Successor #1	Successor #2	Successor #3
Office of External Affairs (OEA)	**Director, OEA**	Deputy Director, OEA	Director, Strategic Research & Campaign Management Group, OEA	Director, Inter-governmental Relations Group, OEA
Office of Equal Opportunity and Civil Rights (OEOCR)	**Director, OEOCR**	Deputy Director, OEOCR	Team Lead, Civil Rights	Team Lead, Affirmative Employment
Office of Legislation (OL)	**Director, OL**	Deputy Director, OL	Group Director, OL	Group Director, OL
Office of E-Health Standards and Services (OESS)	**Director, OESS**	Deputy Director, OESS	Lead Health Insurance Specialist, OESS	Lead Health Insurance Specialist, OESS
Office of Operations Management (OOM)	**Director, OOM**	Deputy Director, OOM	Director, Management Operations Group	Deputy Director, Management Operations Group
Office of Policy (OP)	**Director, OP**	Deputy Director, OP	Lead Social Science Research Analyst	Lead Health Insurance Specialist
Office of Research, Development and Information (ORDI)	**Director, ORDI**	Deputy Director, ORDI	Director, Medicare Demonstrations Program Group	Director, Information and Methods Group
Office of Strategic Operations and Regulatory Affairs (OSORA)	**Director, OSORA**	Deputy Director, OSORA	Director, Issuances and Records Management Group	Vital Records Liaison, Issuance and Vital Records Group
Office of Beneficiary Information Services (OBIS)	**Director, OBIS**	Deputy Director, OBIS	Director, Call Center Operations Group, OBIS	Director, Website Project Management Group, OBIS
Baltimore Human Resources Center (BHRC)	**Director, BHRC**	Deputy Director, BHRC	Director, Client Services Division	Director, Workforce Relations Division

Table 5.2.1.C – Delegations of Authority

Delegated Authority	Office	Position	Delegatee #1	Delegatee #2	Delegatee #3
Authorize Managed Care Organization Special Payments	CPC	Managed Care Organization (MCO) BFT Lead	Director, CPC	Deputy Director, CPC	Director, Medicare Advantage Group
Authorize Fee-For-Service Special Payments	OFM	Fee-For-Service (FFS) BFT Lead	Director, OFM	Deputy Director, OFM	Director, Accounting Management Group, OFM
Authorize Medicaid and State Payments	CMSO	Medicaid and State Payments BFT Lead	Director, CMSO	Deputy Director, CMSO	Director, Disabled & Elderly Health Programs Group
Approve Critical Payments and Authorizations	OFM	Critical Payments and Authorizations BFT Lead	Director, OFM	Deputy Director, OFM	Director, Accounting Management Group, OFM
Approve Travel Authorizations	OFM	Travel Authorizations BFT Lead	Director, OFM	Deputy Director, OFM	Director, Accounting Management Group, OFM
Approve Payroll Implementation	OOM/ MOG	Payroll/ITAS BFT Lead	Director, OOM	Deputy Director, OOM	Director, Management Operations Group
Emergency Procurement Authorization	OAGM	Emergency Procurement BFT Lead	Director, OAGM	Deputy Director, OAGM	Group Director, MCG
Authorize External Communications	OEA	External Communications	Director, OEA	Deputy Director, OEA	Director, Strategic Research & Campaign Management Group
Authorize CMS Policy Changes	OA	CMS Policy Changes	Administrator	Deputy Administrator	Chief Operations Officer

5.2.2 Deciding to Activate COOP Operations During Pandemic

There are two scenarios in which the COOP Plan is activated:

1.) If the impact of the pandemic is extraordinarily severe, CMS may need to activate its COOP Plan and only continue with its Mission Essential Functions (MEFs). For example, absenteeism may rise to levels that would not allow CMS to sustain operations even with broad-based teleworking. CMS would then activate its COOP Plan and only continue to perform its MEFs. At that time, the COOP Plan is activated and used in parallel with this Pandemic Plan.

2.) If, in the course of the pandemic, a separate disruption (like a hurricane, bomb, flood, etc) occurs to disrupt CMS' MEFs. In this scenario, the COOP Plan would need to be implemented in parallel with the Pandemic Plan to ensure the COOP operations integrate the necessary protective actions.

MEFs are the limited set of government functions that are required by law or executive order, and which must be performed uninterrupted, with minimal interruption, or requiring immediate execution during an emergency. The continuation of these functions is thoroughly documented in the CMS COOP Plan and supporting Business Continuity Plans (BCPs). CMS' MEFs are as follows:

- Ensure cash flow to external stakeholders for ensuring health care coverage.
- Communicate health, policy and emergency information to internal and external stakeholders.
- Enroll individuals into Medicare parts A, B, C, D, Medicaid and Children's Health Insurance.
- Track End Stage Renal Disease (ESRD) facilities and patients.
- Ensure quality care for beneficiaries.

COOP Strategies During a Pandemic

Should an event occur to disrupt day-to-day operations within CMS during a pandemic, two strategies are available to maintain operations: alternate operating facilities and devolution. These options may be used separately or in tandem to address different situations:

- **Alternate Operating Facilities (AOFs)**
Alternate Operating Facilities (AOFs) are available for CMS as a form of social distancing to increase dispersion of its workforce. A caveat for using the AOF option is that employees should not be transferred between the AOF and the CO. The AOF should only be utilized to isolate COOP personnel or to introduce employees not previously at the CO during the pandemic.

- **Devolution**
CMS may elect to transfer the performance of Mission Essential Functions to CMS locations with personnel who have been minimally impacted by the pandemic. Because a pandemic is, by definition, continually spreading, the process of devolving functions should occur relatively early in the pandemic stages to maximize effectiveness of distributing the execution of functions.

Communications

This section summarizes key operational communications activities, target audiences and the methods that will be used to disseminate information during an escalating pandemic event.

Key Communications Activities

- Distribute timely and appropriate pandemic bulletins and other information to employees for instructions and guidance, including personal and workplace preparedness.
- Integrate training information as a communications method when social distancing measures are implemented.
- Communication activities will be coordinated with CMS staff and key external partners.
- Consistent communications will be provided to the general workforce, press, Congress, and external agencies regarding the operational status of CMS.

During a pandemic it is vital that CMS maintain clear and consistent communications from a single source. The Administrator or designee will normally be the single source for communication within the organization. The Office of External Affairs (OEA) will lead CMS communication activities and ensure consistency with Departmental messaging. To best articulate the circumstances surrounding a pandemic, the following subjects should be addressed during the pandemic escalation:

- Operational status of CMS
- Explanation of changes in the Federal Response Stage and instructions
- Health Bulletins and travel advisories
- Pandemic Influenza overview and personal preparedness
- Work place preparedness
- Specifics about Pandemic Influenza and infection control measures
- Workplace staffing, compensation and benefits

Target Audiences

- Internal
  - Executive Team including Administrator
  - CMS employees
- External
  - HHS
  - Stakeholders and Other Key Partners
  - Media
  - Congress
  - White House

Message Development

Operating status messages will be generated by OOM (internally) and OEA (externally) regarding the operational status of CMS. Messages will be developed to address internal and external audiences.

Message Dissemination

A variety of tools and methods will be utilized to disseminate information to various audiences. These include the CMS website, Intranet, email, and the media. The method of dissemination will be determined according to the nature of the communication, the intended audience, phase and implemented policies (i.e., social distancing).

For internal audiences, the main methods for information dissemination will be CMS' website, CMS status line **410-786-6010** or **800-448-4232**, telephone, intranet and email distribution.

For external audiences, the main methods will be CMS' website, listservs, media, and other CMS partner communication networks. The Office of External Affairs (OEA) will act as the primary point of contact for CMS external communications. CMS Components will publish program-specific FAQs and associated policy directives for dissemination, as appropriate, through existing communications channels.

Vital Records
During a pandemic, CMS has three considerations for availability and accessibility of vital records:
- Vital records applicable to CMS' pandemic response
- Vital records applicable to CMS' day-to-day operations during a pandemic (such as standard operating procedures and essential functions)
- Vital records applicable to CMS for COOP activation during its response to a pandemic

The central theme to ensuring vital records are available prior to a pandemic is to conduct regular and consistent updates of electronic records and the digitization of hard-copy records. All components are required to manage, maintain, and digitize all necessary records for operational continuity during a pandemic. OSORA is the office of primary responsibility with maintaining the efficacy and efficiency of the CMS Vital Records Program.

Testing, Training & Exercise

Testing
CMS' continuity capabilities during a pandemic are dependent on several systems, processes, and procedures that must be periodically tested to ensure they are in proper working order to continue essential functions. During a pandemic, systems, processing,

and procedural testing should be adapted to accommodate a pandemic's unique impacts. Table 5.2.2.A captures a sample testing scenario.

Table 5.2.2.A – Pandemic Testing Scenario—Example

SCENARIO
• Efficient and sustained person-to-person transmission signals an imminent pandemic, originates outside North America.
• Within one month of the first confirmed case in the US, pandemic influenza spreads throughout the U.S. in waves with 60 days from first case to peak.
• Urban areas are affected first. [CMS CO is located in a suburban area, less than five miles from Baltimore City.]
• A significant percentage of CMS' population commutes daily from an affected community in Baltimore City, where the pandemic outbreak could last between 6 and 12 weeks and multiple waves (periods during which community outbreaks occur across the country) occur with each wave lasting 2-3 months.

Relevant Impacts[9]
• Absenteeism attributable to illness, the need to care for ill family, and fear of infection reaches 40 percent during the peak
• CMS receives no property damage, except to the extent that pandemic influenza-related absence from work may cause maintenance-related failures and/or accidents.
• HHS would need to assist CMS to provide prophylaxis and/or vaccination with pre-pandemic vaccine to protect deployed responders and mission essential personnel. However, the pandemic vaccine will not be available to CMS until the second wave (4-6 months after the pandemic virus had emerged).

Description of Tests	Participants	Possible Pandemic Testing Element	Location
Communications equipment	OIS, OOM, Guards, GSA	One scheduled charge cycle was missed; charge batteries for radios to only 25%	AOF, CO
Alert and notification procedures	Executive Team, OOM, PCT	Key Executive team members unavailable; third in Order of Succession initiates message	CO
Recovery and protection of vital and sensitive records and databases	OSORA, OOM	Most recently scheduled backup data set is unavailable; use next recent data set	AOF, CO
Infrastructure systems at primary and alternate sites	OIS	Primary IT Officer unavailable; Secondary IT Officer performs test	AOF, CO

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[9] Derived from "Property Damage" and "Service Disruption" Sections, as well as Sections 2.2, 5.1, & 5.4 of http://www.hhs.gov/disasters/discussion/planners/playbook/panflu/scenario.html

"Work at Home Day"	Designated staff from all components	Test IT infrastructure capabilities to assess load/access vulnerabilities	CO, Telework

Education

Employee education is essential for the sustainability of CMS' essential functions and for recovery from a pandemic. Educational materials will be provided to all employees whether through training sessions or email distribution by OOM.

- Federal Government Response Stage 0: CMS will continue to provide information on an as needed basis
- Federal Government Response Stages 1-2: CMS will provide voluntary informational sessions.
- Federal Government Response Stages 3-4: CMS employees will attend mandatory informational sessions in order to prepare. Stage 4 education materials will be accessible remotely to accommodate social distancing.
- Federal Government Response Stages 5-6: Sessions will be discontinued because of intensive pandemic activity. Materials will be posted on CMS' website and distributed via email.

Table 5.2.2.B – Pandemic Education Material Topics

• Personal hygiene and protection during a pandemic
• Explanation of the change in Federal Response Stages
• Social distancing procedures
• Precautions for taking care of ill family members
• Vaccine and anti-viral information
• Importance of staying home until fully recovered
• Leave and pay policies
    o Benefit plan changes
    o Leave Flexibilities
    o Pay Flexibilities
	• Compensation and employee pay policies for employees who may be asked to stay home from work
	• School and day care closure affects on employees
	• Discipline for conduct including unauthorized absences
	• Guidance on how to limit the spread of respiratory illness
	    o Preventing the spread of virus
	    o Mask usage guidance
	• Employee Assistance Program
	    o Bereavement and mental health support services
	• Other health and safety information related to a pandemic

Exercises

Exercises can serve to validate CMS' ability to implement its pandemic response. To maintain realism and validity, CMS' normal exercise schedule program can be adapted to those impacts using the pandemic scenario. All pandemic exercises are conducted on a "no-fault" basis, allowing for the promotion of honest, unrestricted levels of exercise play. Table 5.2.2.C describes exercise program components, along with potential adaptations that link relevant impacts to CMS with potential scenario injects.

Table 5.2.2.C – Exercise Program Components—Example

SCENARIO
• Efficient and sustained person-to-person transmission signals an imminent pandemic, originates outside North America.
• Within one month of the first confirmed case in the US, pandemic influenza spreads throughout the U.S. in waves with 60 days from first case to peak.
• Urban areas are affected first. [CMS CO is located in a suburban area, less than five miles from Baltimore City.]
• A significant percentage of CMS' population commutes daily from an affected community in Baltimore City, where the pandemic outbreak could last 6 to 12 weeks and multiple waves (periods during which community outbreaks occur across the country) occur with each wave lasting 2-3 months.

Relevant Impacts[10]
1. Absenteeism attributable to illness, the need to care for ill family, and fear of infection would reach 40 percent during the peak
2. CMS receives no property damage, except to the extent that pandemic influenza-related absence from work may cause maintenance-related failures and/or accidents.
3. HHS would need to assist CMS to provide prophylaxis and/or vaccination with pre-pandemic vaccine to protect deployed responders and mission essential personnel. However, the pandemic vaccine will not be available to CMS until the second wave (4-6 months after the pandemic virus had emerged).

Potential Test Scenario Injects
1. Only 60% of Mission Essential Function (MEF) Continuity Team (MCT) members are available, even after reaching into alternate members.
2. A scheduled survey of beneficiaries has been delayed 1 week and not yet performed because the contracted specialist is ill and unavailable to repair a server malfunction.
3. Several of the available Quality Care MCT members are not vaccinated, but will need to visit a nearby region onsite within the week.

Description of Exercises	Participants	Location
Tabletop Exercise	Executive Team	CO
National exercise participation	Homeland Security or other National Sponsor	To be announced by the Sponsor

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[10] Derived from Sections 2.2, 5.1, & 5.4 of
http://www.hhs.gov/disasters/discussion/planners/playbook/panflu/scenario.html

6.0 OPERATIONAL CONTINUITY SURVEILLANCE

CMS must retain its ability to perform its day-to-day and essential functions during a pandemic (see Figure 6.0).

Figure 6.0 – Surveillance & Evaluation
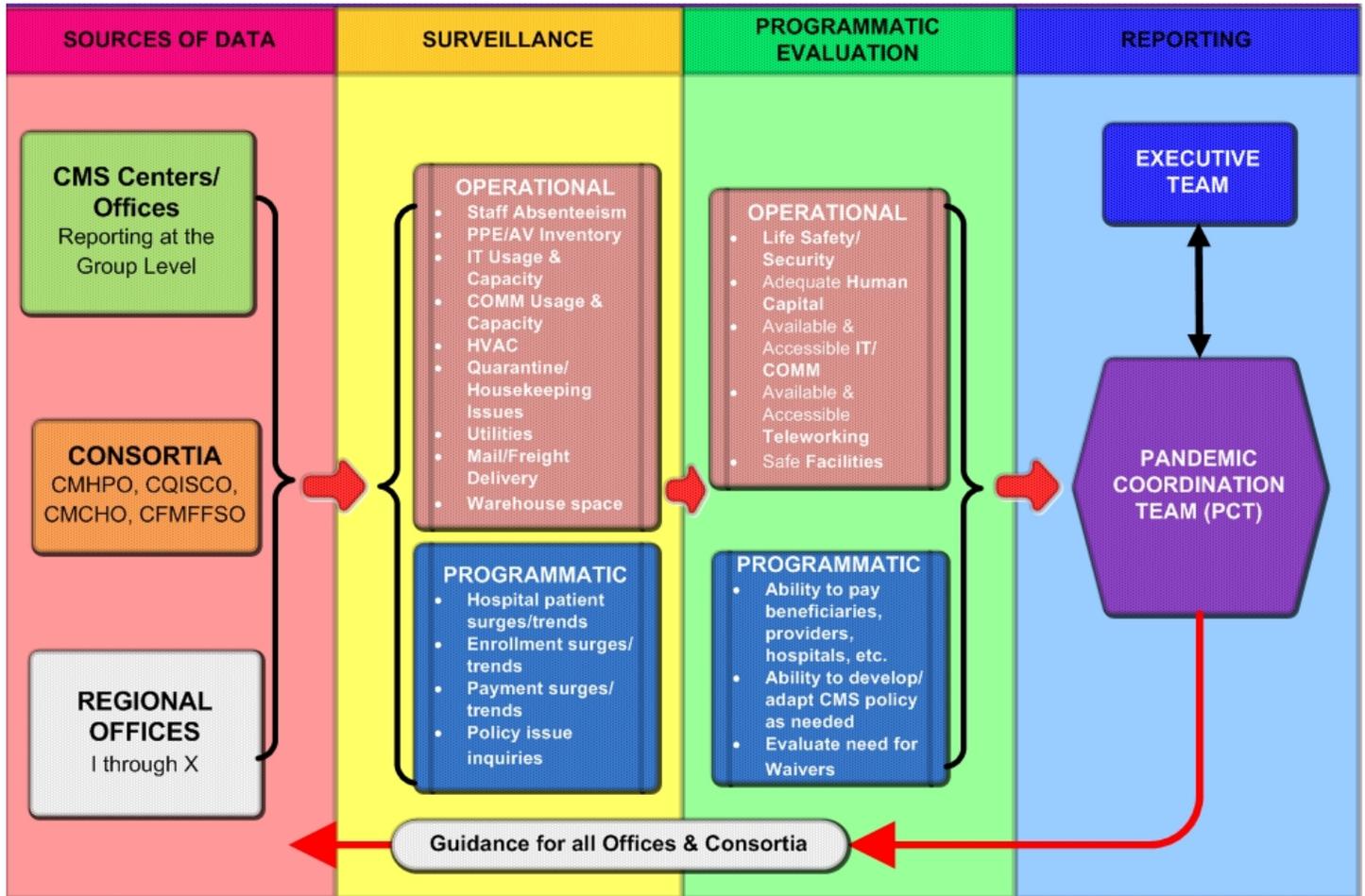
6.1 Sources of Data

To coordinate operational continuity during CMS' response to a pandemic, the PCT receives operational and functional surveillance data from three principal sources: the Consortia, Regional Offices, and Centers/Offices at the Group Level (see Figure 6.0). The goal of operational continuity evaluations during a pandemic focuses on determining whether CMS is able to continue performance of its day-to-day and essential functions.

Absenteeism

Absenteeism is tracked during the pandemic periods using the CMS Mission Impact Report (example included in Appendix A) and reports from the Integrated Time and Attendance System (ITAS). Absenteeism tracking frequency is determined by pandemic period:

- Inter-Pandemic: Quarterly
- Pandemic Alert: Bi-Weekly
- Pandemic: Weekly
- Recovery: Bi-Weekly

Each first line supervisor will be instructed to verify the number of employees within their Group and the number of employees absent related to the pandemic. This will include employees that are working at home while taking care of family members. This information is obtained by the supervisors. The information will be submitted to the Office of Operations Management for review and assessment at the requisite intervals. A representative from the Pandemic Coordination Team will notify CMS managers of the specific recipient and timeframe for reporting. In addition to this "manual" reporting process, OOM will query ITAS for attendance reports to augment and validate the input received from first line supervisors. OOM will track and report trends of absenteeism to the PCT Executive Lead, who will in turn provide the information to the Executive Team to support decision-making.

PPE/AV Inventory

FOH leads tracking, shipping, receiving, and inventory for the Central Office during a pandemic. Copies of inventory reporting for pandemic items will be sent to the PCT for surveillance. PPE/AV Inventory tracking frequency is determined by pandemic period:

- Inter-Pandemic: Quarterly
- Pandemic Alert: Monthly
- Pandemic: Bi-Weekly
- Recovery: Monthly

IT/COMM Usage and Capacity

OIS shall lead surveillance of information technology (IT) infrastructure and connectivity for CMS primary and alternate facilities, communicating incidents related to the pandemic (resolved or unresolved) to the PCT. Surveillance in the form of systems testing should occur upon declaration of the Pandemic Alert Period to ensure IT/COMM capabilities during a pandemic.

Mission Impact

Equally important as absenteeism for tracking the progression of a pandemic, is the impact of the pandemic on CMS' operations. The CMS Mission Impact Report (example included in Appendix A) will be used to capture information from first line supervisors on the effects that absenteeism and pandemic response efforts have on

their day-to-day operations.   Reporting of mission impact data will be submitted to the PCT. Mission impact is assessed by considering issues of quality, timeliness, and capability to complete projects. Mission impact tracking frequency parallels that for absenteeism:

- Inter-Pandemic: Quarterly
- Pandemic Alert: Bi-Weekly
- Pandemic: Weekly
- Recovery: Bi-Weekly

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7.0   Operational Continuity Implementation Actions

7.1   Human Capital Flexibilities

CMS receives Office of Personnel Management (OPM) guidance and direct authorization to implement Human Capital policies through the Program Support Center (PSC) and the Baltimore Human Resources Center (BHRC). For all aspects of CMS' Pandemic Plan, including COOP activation, human capital issues are overseen by the Human Capital Officer, who serves as a member of the Incident Management Team (IMT) and the Pandemic Coordination Team (PCT). The role of Human Capital Officer is usually served by the Director of OOM.

Because the occurrence of a pandemic greatly impacts CMS' workforce, human capital pandemic planning must take into consideration any threats to physical safety and emotional well-being of CMS personnel and contract staff during the incident. CMS places its highest priority upon the preservation of human capital and will take all necessary precautions to ensure the safety of its personnel. In addition, it is of the utmost importance that CMS personnel take the necessary steps to preserve the health and well-being of themselves and their families. To support the workforce, Attachment C includes guidance for employees can better prepare for a pandemic event. Preserving Human Capital to the fullest extent possible will also enable CMS to continue its daily operations and Mission Essential Functions.

7.1.1 Leave Flexibility Available During a Pandemic

The Administrator, DA, COO and Director, OOM will have some flexibility in deciding which leave policies to implement during a pandemic. However, basic guidelines and policies from the Office of Personnel Management (OPM) and Article 31 of the CMS Master Labor Agreement will need to be followed.

OPM's policy is at http://www.opm.gov/pandemic/agency1d-leave.pdf.   The CMS policies on time and leave can be found in Article 31 of the CMS Master Labor Agreement, http://cmsnet.cms.hhs.gov/pinfo/2007MLA.pdf. In addition, HHS Instruction 630-1, titled "Leave and Excused Absence," outlines HHS policy and procedures concerning the administration of leave and excused absences. These can be found at http://www.hhs.gov/ohr/manual/630-1.pdf. The documents identify the general provisions for requesting and charging leave, approving leave, using leave without pay, managing employees who are absent without leave, using the Family and Medical Leave Act (FMLA), granting sick leave, using voluntary leave transfer programs, using compensatory time off and credit hours during an emergency situation.

Enforcement of Leave Use[11]

When a supervisor observes an employee exhibiting medical symptoms, he or she can express general concern regarding the employee's health and remind the employee of his or her leave options for seeking medical attention, such as requesting sick or annual leave. If the employee has no leave available, supervisors are directed to consult with OOM for further guidance. When these leave options are not practical, a viable alternative in many cases is for the employee to work from home, either under a voluntary telework agreement, or under an agency's order directing employees to work from home or an alternative duty station during a pandemic influenza.

The feasibility of working from home is dependent on several factors, including the nature of the employee's duties, the availability of any necessary IT/COMM capabilities (high-speed internet access, etc.), and computer and communication connectivity. If none of the above options is possible, CMS has the authority to place an employee on paid, excused absence and order him or her to stay at home or away from the workplace. The duration of any such excused absence is dependent on the specific circumstances *but is typically a short period.* Placing an employee on excused absence is fully within an agency's discretion and does not require the consent or request of the employee. Supervisors should check with OOM for CMS policy on excused absence.

7.1.2 Official Travel Restriction Policies

Official government travel will be monitored if a pandemic escalates. In order not to perpetuate the spread of a virus, official government travel will be controlled with these guidelines:

- Only emergency travel would be considered
- Travel requests may be denied if intended travel is to an affected area
- Employees already on travel may have their travel orders extended
- Large meetings/seminars/conferences that require personnel to travel to CMS will be cancelled

7.1.3 Tracking Employee Travel

At Federal Response Stage 3, CMS will institute mandatory tracking of all employees that have business-related travel outside the continental United States. Employees who have traveled on official business will be required to report their itineraries to their supervisor upon return. Employees should be mindful of CDC and State Department travel restrictions regarding personal travel. This information should be retrieved from: http://www.pandemicflu.gov/travel/index.html. First line supervisors will be required to track and report business-related travel information to Office of Financial Management (OFM).

At Federal Response Stage 4, CMS will institute mandatory tracking of all employees who have traveled on official business more than 50 miles from their normal duty station. Employees who travel will be required to report their itineraries to their first line

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[11] Accessed September 25, 2009: http://www.chcoc.gov/Transmittals/TransmittalDetails.aspx?TransmittalId=2452

supervisor immediately upon return. First line supervisors must track and report this information to OFM.

OFM will be required to compile, review, and assess all travel information. OFM will track and identify trends to report to the Director, OOM. This will be important information used to determine if employees that have traveled to infected areas should report to work. OOM, in conjunction with the PCT, Executive Team, and HHS HQ evaluate the need to block official travel based on the spread and severity of the virus. As a matter of general policy, CMS will implement the travel restrictions and recommendations issued by the CDC. These travel restrictions will be implemented through agency-wide notifications and a block on all official travel. Follow-on guidance will be distributed to employees to recommend similar actions regarding personal travel.

7.1.4 Evacuation Payments

Evacuation pay is a form of pay protection that allows employees to continue to receive their normal pay, allowances, and differentials on their regular pay days, as feasible, when employees are ordered to evacuate from their regular worksites to work from home (or an alternative worksite mutually agreeable to the agency and the employee) under an evacuation order during a pandemic. Evacuation pay is used only when the standard time and attendance procedures cannot be followed, e.g., the employee cannot report the use of annual or sick leave or the agency and payroll providers cannot process normal time and attendance reports. Upon return to work, the employee will be required to report any annual leave, sick leave or leave without pay that could not be documented because of the inability to communicate with the time and attendance and/or payroll offices. CMS will consider evacuation pay on an as needed basis in consultation with OPM and HHS.

7.1.5 Employer – Labor Relations Considerations

There is some flexibility in labor-management agreements during an emergency. In an emergency, management has the right to alter working conditions without bargaining prior to implementing the change. However, post-implementation bargaining may be required. In this regard, if management follows applicable procedures contained in existing collective bargaining agreements, bargaining would not be required over the procedure. In situations where an agency wishes to use different procedures, or where there are no existing contractual procedures or past practices covering the action, an agency may have post-implementation bargaining obligations. With regard to any of these situations, supervisors and managers should seek guidance and advice from OOM.

7.1.6 Additional Human Capital Guidance

Further OPM guidance for workforce management and pandemic can be found in the Appendices of this Plan and at the U.S. Office of Personnel Management's (OPM) "Human Capital Management Policy for Pandemic Influenza" located at: http://www.opm.gov/pandemic/agency/quick_reference.asp and http://www.opm.gov/pandemic/opm-pandemic_allissuances.pdf.

7.2   CMS Workforce Protection Program

CMS will insure protection of its workforce in preparation for resurgence of the H1N1 influenza. CMS will institute a workforce protection program to supply vaccines, personal protective equipment (PPE) and antiviral medication (AV) based on employee risk, job criticality, and the severity of the pandemic event.

The workforce protection program seeks to accomplish two objectives: be able to implement HHS/CDC directives and guidance, and be scalable in the response to ensure the "right fit" of workforce protection. Depending on the pandemic phase, CMS will progressively implement more aggressive strategy based on the severity of the pandemic event and HHS/CDC guidance.

PPE and Antiviral Types

Respirator – Protect mouth and nose
Gloves – Protect hands
Antiviral and Vaccine – Medical protection from infection
Wipes – Disinfect equipment and other sources of contamination

Personal Protective Measure Prioritization Tiers

CMS has stratified CMS personnel through Agency surveys into the following four tiers based on occupational risk definitions and personnel mission designations to categorize the workforce for purposes of distribution of PPE and AV:

- Tier 1: Very high risk and high risk (approximately 6 percent of CMS workforce)
- Tier 2: Mission critical who must work on-site (approximately 10 percent of CMS workforce)
- Tier 3: Mission critical who can telework (approximately 49 percent of CMS workforce)
- Tier 4: Non-mission critical (approximately 35 percent of CMS workforce)

Occupational Risk Definitions

Very High Exposure Risk:

- Healthcare employees (for example, doctors, nurses, dentists) performing aerosol-generating procedures, bronchoscope, some dental procedures or invasive specimen collection).
- Healthcare or laboratory personnel collecting or handling specimens from known or suspected pandemic patients (for example, manipulating cultures from known or suspected pandemic influenza patients).
- Healthcare delivery and support staff exposed to known or suspected pandemic patients (for example, doctors, nurses, and other hospital staff who must enter patients' rooms).
- Medical transport of known or suspected pandemic patients in enclosed vehicles (for example, emergency medical technicians).
- Performing autopsies on known or suspected pandemic patients (for example, morgue and mortuary employees).

Medium Exposure Risk:
- Employees with high-frequency contact with the general population (such as schools, high population density work environments, and some high volume retail).

Lower Exposure Risk (Caution):
- Employees who have minimal occupational contact with the general public and other coworkers (for example, office employees).

Personnel Mission Designations

Mission Critical:
- Personnel assigned to functions whose omission would negatively impact the ability of the agency to perform our health related missions.
- Personnel assigned to augment or replace mission-critical personnel in the event of death, illness, absence, or increased operational tempo.
- Includes mission essential personnel.

Non-mission Critical:
- Includes non-essential personnel.
- General administrative support staff functions are not typically identified as mission critical.

Scaled Approach to Implementing Personal Protective Measures

CMS employs a scaled approach to protect its workforce in response to the specific consequences and severity of a pandemic event. Based on guidance from HHS, ASPR, and CDC; CMS has the scaled approach captured in Table 7.2 to provide the "right fit" response.

Table 7.2 – Scaled Approach to Personal Protective Measures

Tier	Pre-emptive/Minimal Measures	Moderate Measures	Maximum Measures
Tier 1	Hand Sanitizer Wipes Gloves	Medical Screening Antiviral Vaccine Hand Sanitizer Wipes Gloves	Fit-Tested Respirators/Masks Medical Screening Antiviral Vaccine Hand Sanitizer Wipes Gloves
Tier 2	Hand Sanitizer Wipes Gloves	Vaccine Hand Sanitizer Wipes Gloves	Medical Screening Antiviral Vaccine Hand Sanitizer Wipes Gloves

Tier	Pre-emptive/Minimal Measures	Moderate Measures	Maximum Measures
Tier 3	Hand Sanitizer Wipes Gloves	Vaccine Hand Sanitizer Wipes Gloves	Vaccine Hand Sanitizer Wipes Gloves
Tier 4	Hand Sanitizer Wipes Gloves	Vaccine Hand Sanitizer Wipes Gloves	Vaccine Hand Sanitizer Wipes Gloves

Tier 1: Very high risk and high risk occupational groups (medical personnel, surveyors, first responders). This group receives PPE and must have medical clearance, training and fit testing to receive respirators and antiviral (AV).

Tier 2: Personnel designated mission critical who must work on-site, such as senior leadership, IT, and finance, as well as personnel who are mission essential because they enable critical business operations to continue, such as staff who are involved in security oversight and liaison with HR). This group receives AV and must have medical screening to receive AV.

Tier 3: Mission critical personnel who telework. This group can telework for a sustained period of time (i.e., 30+ days). This group is not designated to receive PPE in addition to the minimal personal protective measures supplies.

Tier 4: Non-essential personnel. This group is not designated to receive PPE or AV.

Pre-emptive Measures for Each Tier
It may not be necessary to distribute Personal Protective Measures and PPE in advance of a pandemic event. For this reason, the minimal response level will provide a baseline for providing basic supplies designed to promote proper sanitation and limit the spread of infection.

Vaccines
Vaccines for the seasonal flu and H1N1 will be available to CMS employees based on available supply through Federal Occupational Health (FOH) regardless of occupational risk. Employees may also receive these vaccines through their personal physician.

Shipment and Distribution of PPE and AV
CMS has an interagency agreement with Federal Occupational Health (FOH), a Service Unit within the Department of Health and Human Services' Program Support Center and a component of the U.S. Public Health Service, to take shipment, conduct medical screenings and distribute PPE and AV for Tier 1 and AV for Tier 2 CMS employees.

CMS employees will be provided information on PPE and AV through communications from the Office of Operations Management.

Employee Position Descriptions
New and existing employee position descriptions shall be updated to reflect position criticality for mission essential and mission critical positions with the following: "This position has been designated as mission critical / mission essential. When necessary and at the supervisor's discretion, the incumbent of this position may be required to continue operations from an alternative worksite in the event of an emergency. The incumbent of this position may also be required to perform specific tasks that are not outlined in this current PD, but which the incumbent has the knowledge and skills to perform."

7.3 **Social Distancing**

Social Distancing is used to limit disease spread by lowering physical proximity or contact during an influenza pandemic and can potentially include such strategies as building closures or travel restrictions.

7.3.1 Telework
Telework can serve as an effective method of increasing CMS's resiliency to continue its essential functions during a pandemic and can serve as an alternative to a COOP deployment. The decision to use telework is most appropriate under conditions where social distancing is required.

Pre-determined personnel have the capability to perform their day-to-day functions remotely with the use of CMS provided computers. The decision to implement telework for personnel is made by the Administrator based on OPM and HHS recommendations as a pandemic response measure.

Implementation of increased telework should be considered under the following conditions:

- When absenteeism indicates a progressive increase in affected employees
- When recommended by OPM and/or HHS
- When a Federal Government Response Stage 4 (First human-to-human case in North America) is declared

Telework will be implemented to the greatest extent possible if the need arises. Due to the exigency of the situation with the Pandemic Influenza, use of episodic telework may be authorized when caring for family members who are sick as a result of the H1N1 flu. The following controls are applicable for work at home:
- Signed telework agreement
- Employee's work can be performed at home
- Employee will fill out a day card documenting work performed

- Employee will request leave or leave without pay for any non-work periods occurring during regular working hours.

In addition, episodic telework may be authorized when caring for a child who may not be sick, but who is unable to attend school or daycare as a result of the H1N1 flu. In such cases the above controls will apply in addition to the requirement that the employee provide verification that the child's school/daycare is closed.

In the event that any CMS building needs to be evacuated and employees are ordered to work from home as a result of a H1N1 Influenza outbreak, evacuation payments (advance payments of pay, allowances, and differentials) may be provided if the Agency head or designated official has determined that payment is required to defray immediate expenses incidental to the evacuation. For more information on evacuation payments, see http://www.opm.gov/oca/pay/HTML/EVAC.HTM

All employees are considered eligible for telework except the following:
- Employees whose positions require, on a daily basis (i.e., every work day), direct handling of secure materials or on-site activity that cannot be handled remotely or at an alternative worksite, such as face-to-face personal contact in some medical, counseling, or similar services; hands-on contact with machinery, equipment, vehicles, etc.; or other physical presence/site dependent activity, such as an IT contractor or guard duty tasks

The key to successful use of telework in the event of a pandemic is an effective routine telework program. As many employees as possible should have telework capability (i.e., current telework arrangements, connectivity, and equipment commensurate with their work needs and frequent enough opportunities to telework to ensure all systems have been tested and are known to be functional – see Appendix B). This may entail creative thinking beyond current implementation of telework, drawing in employees who otherwise might not engage in remote access and ensuring their effectiveness as a distributed workforce.

Manager Pandemic Responsibilities
- Implement telework to the greatest extent possible in the group so systems are in place to support successful remote work in an emergency.
- Communicate expectations to all employees regarding their roles and responsibilities in relation to remote work in the event of a pandemic.
- Establish communication processes to notify employees of activation of this plan
- Integrate pandemic response expectations into telework/flexiplace agreements.
- With the employee, assess requirements for working at home (supplies and equipment needed for an extended telework period).
- Determine how all employees who may telework will communicate with one another and with management to accomplish work.
- Identify how to verify proper time and attendance practices.

Teleworker Pandemic Responsibilities
- Maintain current telework agreement specifying pandemic telework responsibilities, as appropriate.
- Perform all duties assigned by management, even if they are outside usual or customary duties.
- Practice telework regularly to ensure effectiveness.
- Be familiar with agency and workgroup pandemic plans and individual expectations for telework during a pandemic.

7.3.2 Staggered Work Schedules

Another method in limiting disease spread and assisting employees who are affected is the implementation of Alternate Work Schedule (AWS). There are two types:
- A **Flexible Work Schedule** consists of workdays with core hours and flexible hours. Core hours are the designated period of the day when all employees must be at work. Flexible hours are part of the workday when employees may choose their time of arrival and departure.
- A **Compressed Work Schedule** is a fixed work schedule under which the employee's arrival and departure times may not vary.
- **Controlled facility operations**
  - Depending on the severity of the pandemic, staff may be required to work altered schedules to limit their likelihood of infection. Some example shift schedules are:
    - 5 AM – 1:30 PM
    - 7 AM – 3:30 PM
    - 9 AM – 5:30 PM
    - 11 AM – 7:30 PM
    - 1 PM – 9:30 PM
  - The assignment and implementation of the shifts will consider:
    - Assignment by alphabet (i.e. all employees whose last names start with A-E will be assigned the first shift)
    - Assignment by geography (i.e. all employees who work in the South Building, Lower Level; Central Building Second Level; North Building Third Level are assigned the first shift)
    - Assignment by functional area and/or assignment.

The implementation of staggered work schedules will be coordinated by the Pandemic Coordination Team and implemented by necessary OOM staff and is always contingent on facility capabilities and employee safety.

7.3.3 Temporary Closing of CMS Workplaces/Facilities Notification

Article 31, Section 8 of the CMS Master Labor Agreement includes information about official closings due to inclement weather/emergency conditions
http://cmsnet.cms.hhs.gov/pinfo/2007MLA.pdf

Senior Leadership may decide that closing CMS facilities would be in the best interest of protecting employees and protecting essential Government business. Notification will

be done by current procedures used during inclement weather and other emergency situations. Announcements will be placed on the 410-786-6010 and 1-800-448-4232 CMS status lines, on predetermined radio and television stations and through broadcasts on email through Outlook. Reminders of these procedures are given to all CMS staff on a regular basis.

7.3.4 Other Social Distancing Considerations

Conference Room Use

Inter-Pandemic Period: No restrictions on use of conference rooms.

Pandemic Alert Period: No mandatory restrictions on use of conference rooms, encourage use of teleconferences as an optional alternative.

Pandemic Period: No conference room use may be permitted during the pandemic period, conference call use only.

Recovery Period: No mandatory restrictions on use of conference rooms, encourage use of teleconferences as an optional alternative.

Contractors

Contractors must abide by their corporate pandemic and telework plans, in so far as those plans do not conflict with the contract and/or CMS' mission. Each CMS component is expected to provide necessary oversight and guidance to their contract support to ensure corporate pandemic and telework plans will be sustainable throughout the duration of a pandemic. At such time as CMS implements social distancing methods such as teleworking for its workforce, examination and consideration must be made for contracting staff through CMS and corporate oversight.

CMS components will also coordinate with their contract staff to ensure CMS minimum security requirements are adhered to during pandemic operations.

Limitation of Outside Visitors
During periods of heightened pandemic threat major events at CMS will need to be deferred or canceled to limit social contact. Additional restrictions may be implemented during the Pandemic Alert Period on a case-by-case basis, based on the available epidemiological intelligence available and HHS/CDC guidance.

7.4 Operational Continuity Requirements for Special Needs Individuals

CMS has developed measures to support the capability of CMS employees who are considered Special Needs Individuals (SNI) to be productive throughout all stages of a pandemic event. SNI are CMS employees who have sensory, physical, or cognitive limitations or individuals with disabilities as defined by the ADA Amendments Act of 2009. Generally, the pandemic-specific measures fall into two categories:

- Ensuring access to pandemic preparedness, alert, and response information
- Promoting productivity in a social distancing environment (i.e. telework, staggered work schedules, etc).

Planning Considerations

Some of the pandemic-specific planning considerations incorporated into the operational continuity requirements for SNI employees are:
- Maintaining accessibility of information available for employees with special needs.
- Enabling a productive work environment for SNI employees during all periods of a pandemic.

Operational Continuity Requirements

CMS will implement the measures identified below during all phases of a pandemic to enable the productivity of SNI employees. These measures will be implemented on an as-needed basis in response to the specific protective actions employed by CMS (i.e. during times of increased social distancing).

- Ensure availability of Teletypewriters (TTY) and Telecommunication Display Devices (TTD) capabilities on all required teleconferences, when applicable.
- Ensure that all CMS intranet and internet resources are Section 508 compliant (i.e. text-equivalency for graphics, compatibility with assistive technology, and equivalent alternatives to multi-media).
- Ensure that pandemic-specific employee notices are published in alternative formats (i.e. large print, text-to-speech, etc).
- Ensure the availability of sign language interpreters for video-teleconferences.
- Ensure that guidance is provided and available to SNI employees on maximizing their effectiveness in a social distancing environment.

Other Considerations:

Any employee who is blind or has low vision, severe carpel tunnel or anyone who has missing upper extremities or no or limited use of hands or arms may not be able to work from home with full access capability if the remote access software is not 508 compliant. Additionally, supervisors should ensure reasonable accommodation requests are acted upon.

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8.0   PANDEMIC RESPONSE

In the event of a pandemic, CMS' responsibility is to minimize the adverse effects on the quality and availability of health care for its beneficiaries. If a pandemic should occur, CMS will maintain surveillance to identify any programmatic or operational issues that may arise. Some issues may require immediate response while others can be enacted over a period of time.   CMS' pandemic response is achieved through a three step process.

1. CMS Centers/Offices and Consortia/Regional Offices conduct surveillance of their programs with respect to the impact of the pandemic on beneficiaries, partners, and contractors. This information is collected and consolidated by points of contact designated in each Center/Office/Consortia/Region. A Field Emergency Response Procedures Manual was developed for the Consortia/Regional Offices to use during emergencies. This guide will be used as a Standard Operating Procedure during a pandemic response.
2. Program evaluation is conducted on the information collected during the surveillance. This evaluation is intended to analyze the collected data to determine if there is a need to initiate corrective or mitigative actions to respond to the consequences of the pandemic.
3. Based on the program evaluation of the surveillance activities, CMS will determine the appropriate actions to respond to the consequences of a pandemic, including the need for waivers.

CMS' pandemic response is focused on achieving the major pandemic response roles outlined in the HHS Pandemic Response Plan. Specifically, these roles include:

- Providing streamlined payment mechanisms and working with prescription drug plans and managed care plans, as necessary to ensure ready access to pandemic influenza vaccines and antiviral prescription drugs.
- Communicating specific guidance and supporting pandemic influenza response activities of the nation's hospitals, home health agencies, skilled nursing facilities, and other health care providers, suppliers, and practitioners that participate in Medicare, Medicaid, and Children's Health Insurance.
- Communicating influenza pandemic related information through existing outreach networks to Medicare, Medicaid and Children's Health Insurance beneficiary populations.
- Supporting tracking and surveillance of Medicare patients, including high-risk and vulnerable patients who have received pandemic influenza vaccine and antiviral prescription drugs, including review of Medicare claims and quality data.
- Supplying "real time' intelligence to other federal health care agencies on the status of local, regional, and national pandemic influenza response provider activities through State Survey Agency affected provider status reports, stakeholder association meetings and open door forums.

The following sections describe actions that CMS will employ during each pandemic period.

8.1 Pandemic Response Assumptions

The following are assumptions made to develop the pandemic response section:

- CMS will monitor Pandemic updates and follow directives from HHS, CDC, DHS, and White House.
- CMS operations may be impacted by pandemic waves generally lasting 30 to 80 days or more.
- Expect an increase demand for open-enrollment, call center assistance, and contract renewals.
- Anticipate communication and service disruption with third-party vendors.
- Pandemic severity may be such to necessitate the activation of the COOP plan (i.e. agency implementation of only the Mission Essential Functions)
- Susceptibility to the pandemic influenza virus will be global.
- Absenteeism will depend on the severity of the pandemic.
- Certain incidents may increase absenteeism such as school closings.
- Pandemic outreach begins as regional outreach. The Regional Offices will take the lead for this outreach.
- Outreach to the targeted areas will be driven by HHS HQ, Designation of a "targeted area" will prompt the initiation of activities.
- OEA will be the lead for all media communications.
- Communications during a pandemic will rely heavily on electronic communications and the Internet.

8.2 Pandemic Response Concept of Operations

For the purpose of pandemic response, CMS uses four Pandemic Periods correlating to both the World Health Organization (WHO) and Federal response stages during a pandemic outbreak. CMS' pandemic response is divided into the following Periods: Inter-Pandemic, Pandemic Alert, Pandemic, and Recovery.

The Inter-Pandemic Period occurs between pandemic outbreaks and is a continuous effort to promote awareness and education among personnel and key stakeholders. A Pandemic Alert Period is a heightened proactive period that will prepare if a pandemic should occur and monitor external activities. When a pandemic is declared by the WHO, CMS' Pandemic Period will be activated and begin surveying, assessing, responding, and mitigating any internal or external issues that may occur programmatically or operationally. Figure 8.2.B depicts the operational processes for identifying, coordinating and responding to programmatic and operational issues during a pandemic influenza.

Figure 8.2.A – Pandemic Response Concept of Operations
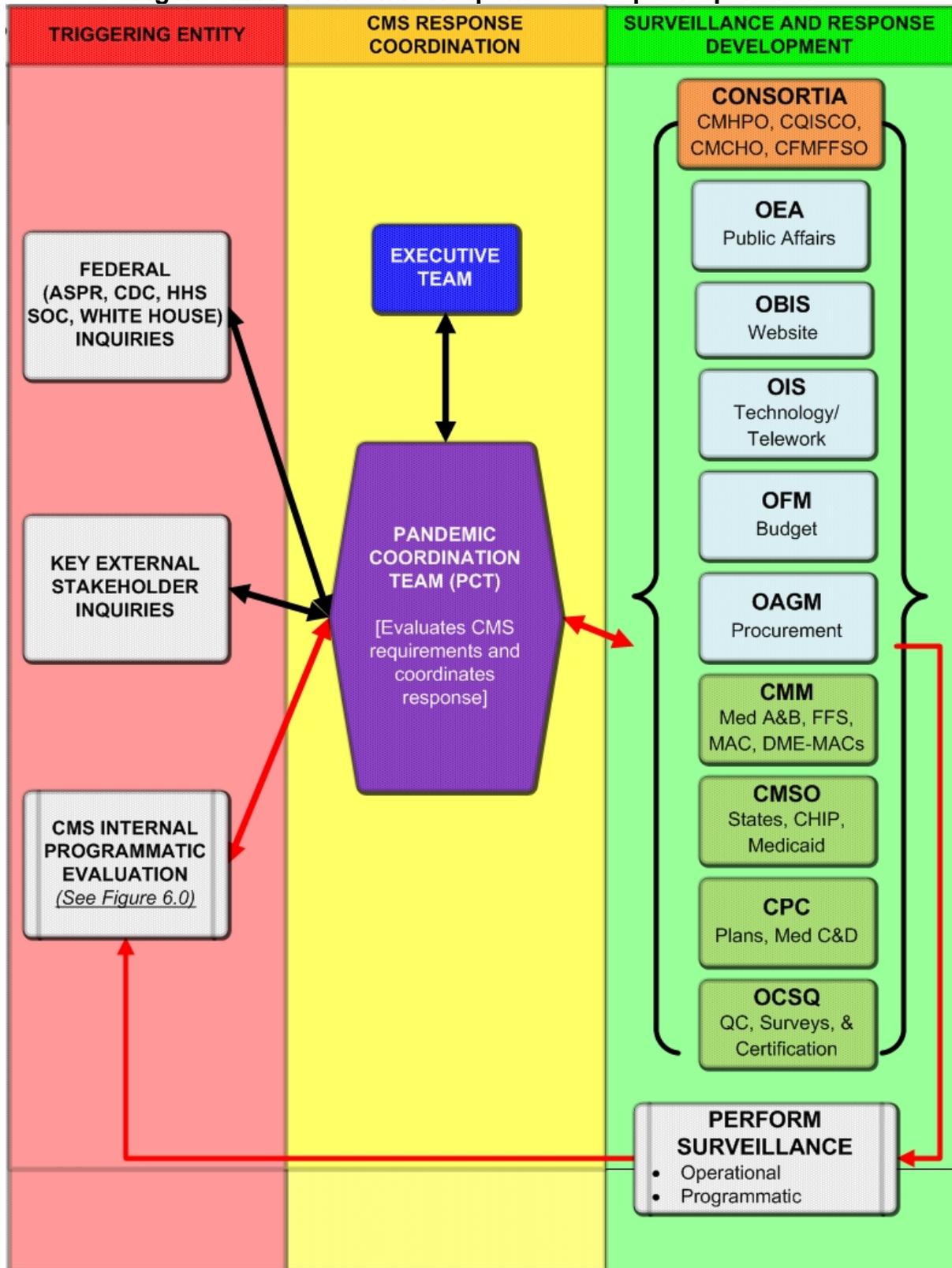
Once HHS/CDC declares a pandemic to be in a decelerated stage, recovery can begin. CMS will prepare and mitigate future outbreaks and survey internal components to verify that all systems, communications, and other required capabilities are available and operational.

Tables 8.2.1, 8.2.2, 8.2.3, and 8.2.4 summarize the activities and responsibilities for the Pandemic Coordination Team and the internal Centers/Offices during each pandemic period.

8.2.1 Inter-Pandemic Period

Table 8.2.1 – Inter-Pandemic Period Operations Summary

Executive Team (ET)	CMM	CMSO	CPC	OBIS	OCSQ	OEA	OFM	OEOCR	Other Centers/ Offices	Consortia/ Regional Offices	PCT	Actions
	X	X	X		X	X			X	X		Provide Pandemic guidance materials for key stakeholders
	X	X	X	X	X	X				X		Establish/develop pandemic communication protocols
X	X	X	X		X		X			X		Review and update any existing pandemic response policy
	X	X	X		X		X					Develop new pandemic response policy based on pandemic surveillance and preparedness activities
							X					Identify budgetary and financial management issues related to a pandemic
	X	X	X		X	X	X		X	X	X	Update CMS Pandemic Response Plans
											X	Monitor Federal Pandemic Stages
	X	X	X	X	X					X		Conduct quarterly surveillance activities, collecting data related to the impact of a pandemic on CMS lines of business/stakeholders
X	X	X	X	X	X	X	X	X	X	X	X	Participate in pandemic preparedness tests and exercises
				X		X						Modify/update CMS pandemic website with current guidance
X												Determine Pandemic Alert Period activation actions

8.2.2 Pandemic Alert Period
Table 8.2.2.A – Pandemic Alert Period Operations Summary

Executive Team (ET)	CMM	CMSO	CPC	OBIS	OCSQ	OEA	OFM	OEOCR	Other Centers/ Offices	Consortia/ Regional Offices	PCT	*Actions*
	X	X	X	X	X	X			X	X		Implement program surveillance activities on a minimum bi-weekly basis, submit report to PCT.
											X	Track, assign, and resolve all CMS emergency response mission requirements and issues.
	X	X	X		X			X		X		Conduct program evaluations of collected surveillance information from program data sources – to determine if any programmatic or policy actions are required
	X	X	X		X			X		X		Review existing pandemic policies, evaluate risk environment and develop corrective actions/policies to reconcile any policy vulnerabilities.
X			X			X			X	X		Provide guidance on pandemic-related Medicare enrollment issues
X	X		X				X					Provide guidance on pandemic-related Medicare payment issues
X		X								X		Provide guidance on pandemic-related Medicaid/CHIP issues
X	X	X	X		X	X				X		Provide guidance to stakeholders regarding recommended operational policies and procedures.
											X	Monitor Federal Pandemic Stages
				X		X						Modify/update CMS website with current guidance
X											X	Determine Pandemic Period activation response actions

8.2.3 Pandemic Period

Table 8.2.3.A – Pandemic Period Operations Summary

Executive Team (ET)	CMM	CMSO	CPC	OBIS	OCSQ	OEA	OFM	OEOCR	Other Centers/ Offices	Consortia/ Regional Offices	PCT	Actions
	X	X	X	X	X	X	X	X	X	X	X	Provide status reports as requested by Executive Team.
											X	Track, assign, and resolve all CMS emergency response mission requirements and issues.
X			X						X	X		Provide guidance on pandemic-related Medicare enrollment issues
X	X		X				X					Provide guidance on pandemic-related Medicare payment issues
X		X								X		Provide guidance on pandemic-related Medicaid/CHIP issues
X	X		X							X		Communicate with plans, Medicare contractors, and providers related to changes in Medicare policies
X	X	X	X	X		X						Conduct necessary policy review and development to cope with undesirable consequences on CMS beneficiaries
				X		X						Modify/update CMS website with current guidance
				X								Modify/update CMS pandemic website with current guidance

8.2.4 Recovery Period

Table 8.2.4.A – Recovery Period Operations Summary

Executive Team (ET)	CMM	CMSO	CPC	OBIS	OCSQ	OEA	OFM	OEOCR	Other Centers/ Offices	Consortia/ Regional Offices	PCT	Actions
	X	X	X	X	X		X		X	X		Maintain surveillance activities on a regular basis (as dictated by ASPR/CDC) for any new waves of influenza.
X	X	X	X			X		X	X	X		Review all policy changes and determine appropriate follow-on action/outcome.
	X	X	X		X				X	X		Conduct necessary reconciliation activities with pandemic-related policy and pandemic-related consequences to return to pre-pandemic conditions
				X		X						Modify/update CMS website with current guidance
										X	X	Provide status reports as requested by Executive Team.

9.0   PANDEMIC RESPONSE SURVEILLANCE

Within the Pandemic Response Concept of Operations (Figure 8.2.B), a key trigger set for a pandemic response from CMS is its own programmatic evaluation. Figure 9.0 summarizes the steps that pertain to CMS' internal surveillance leading towards programmatic evaluation (See Section 10.1).

Figure 9.0 – Pandemic Response Surveillance & Evaluation
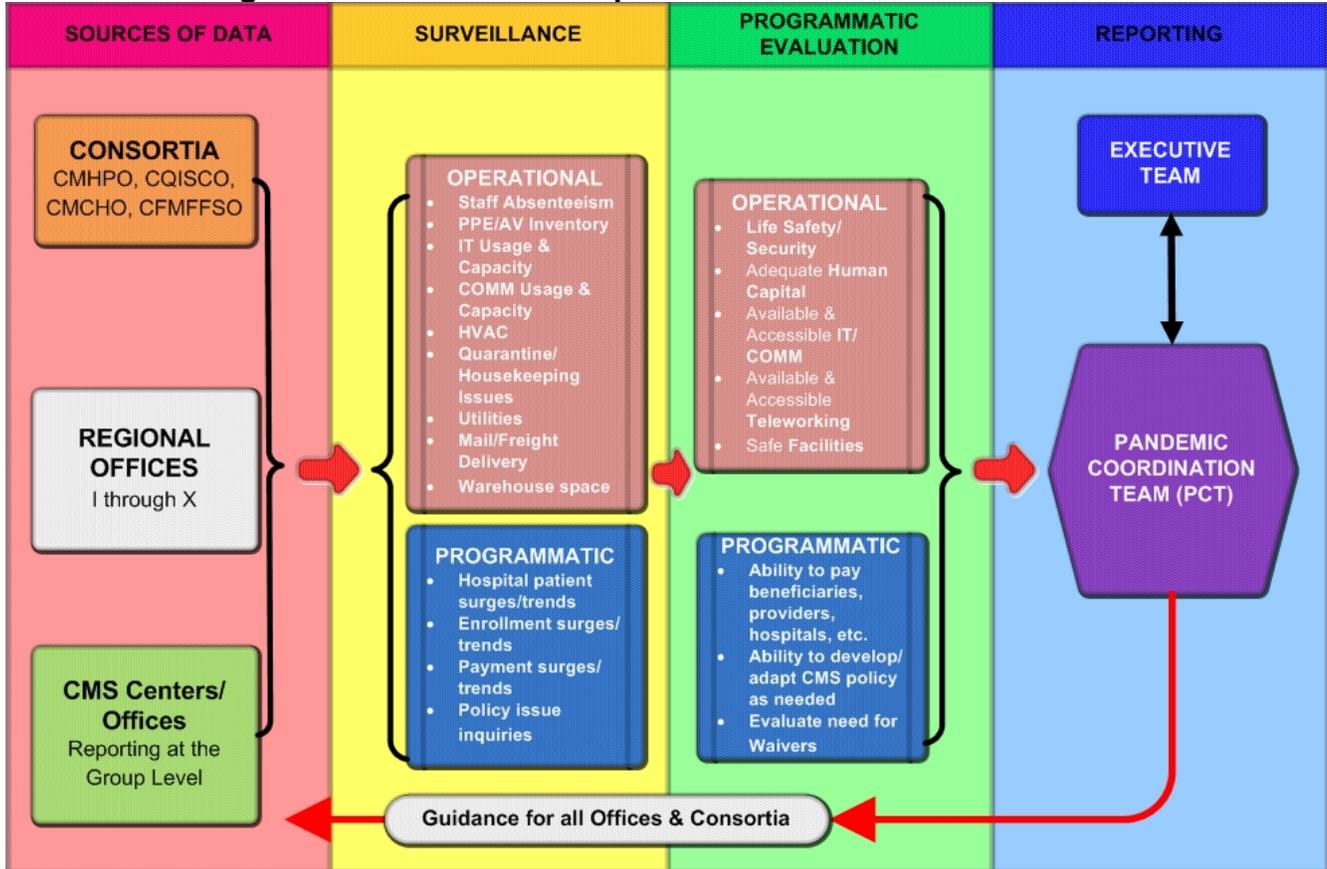
9.1   Sources of Data

During a pandemic, CMS utilizes multiple assessment tools to capture data from four major sources: Consortia, Regional Offices, CO Operational Offices and CO Program Offices. This data is captured from each office's line of business. For instance, OBIS can collect pandemic-related inquiries through 1-800 Medicare or the Consortia/Regional Offices can track the results of survey and certification activities impacted by the pandemic.

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10.0 CMS PROGRAM RESPONSE

10.1 Pandemic Program Evaluation

CMS' Pandemic Coordination Team (PCT) receives surveillance data from all sources and coordinates with the Executive Team to provide responses to various triggers.

Table 10.1 – Pandemic Program Evaluation Examples

Element	Issue	Trigger Value	Recommended Action
CMS program requirements	Pandemic results in a significant increase in public inquiries and/or services requiring CMS involvement	Volume of inquiries increases of 20% or higher	Implement necessary response procedures (increased survey and certification activities, as needed coordination teleconferences, etc)
Number of A&B claims processed	Number of claims increases.	Number of claims increase 30-40% from pervious measures	Identify any budgetary issues, and mitigate as necessary
Payment Surges	Number of payments may increase dramatically or is at significant level	Payment surges projected to exceed appropriated amounts	Identify any budgetary issues, and mitigate as necessary
Number of enrollments	Enrollments significantly increase	Number of enrollments increase 150% from last recorded measurement	Identify any budgetary issues, and mitigate as necessary. Determine capability/risks in inclusion of additional enrollments.

Element	Issue	Trigger Value	Recommended Action
Quality of Services	Service decrease to a low satisfaction level	Survey service satisfaction rating decreases to "very low"	Prioritize and address complaints based upon amount receive for individual services
Quantity of Pandemic related Inquires to the 1-800 Medicare	Quantity of Inquires increase	1-800 Medicare calls exceed 35% of normal call volume	Increase Contractor /CMS staff capabilities as necessary, identify trends in inquiries.
Number of Pandemic Inquires to CMS.GOV/ MEDICARE.GOV	Number of inquires increase	Inquires exceed 35% of normal response	Increase Contractor /CMS staff capabilities as necessary, identify trends in inquiries.

10.2 Program Response

CMS' program response is coordinated and implemented by each Center/Office and Consortia/Regional Office. Each office maintains its own standard operating procedures and policy documents related to the implementation of necessary corrective and mitigative actions. Generally, these plans involve the identification and mitigation of risks and threats to CMS' beneficiaries. Some examples of these policies include:
- Implementing 1135 Waivers through the affected Regional Offices.
- Issuing revised enrollment policy to affected pandemic populations.
- Issuing revised coverage policies to affected pandemic populations.
- Issuing revised policy related to payment.
- Issuing provider and beneficiary communications.

Standard Operating Procedures shall be maintained by each component in implementing the processes and protocols outlined in this Pandemic Plan. Additionally, these documented procedures will be submitted to OSORA for capture into CMS' vital records.

10.3 Communications Response

CMS' role in public health communication and outreach to beneficiary populations cannot be understated during a pandemic response effort. Two of the five responsibilities delegated by the HHS Pandemic Plan include reference to CMS' role in communications. Additionally, communicating policy changes to the provider population

will enforce accurate claims submission and quality care of beneficiaries during CMS' pandemic response. This response is a highly coordinated effort between HHS HQ, CDC, CMS Centers/Offices, and CMS Consortia/Regional Offices. The CMS Communications Response can be characterized into two categories: communicating preparedness information and communicating policy changes.

OEA retains the lead role in development and maintenance of CMS pandemic communications plans. The OEA managed CMS Pandemic Flu Communications Plan shall be updated on a minimum annual basis and be consistent with the policy and direction of this agency-wide pandemic plan. Additionally, the CMS Pandemic Flu Communications Plan will be made available to the CMS workforce and all key partners.

The CMS Pandemic Flu Communications Plan can be accessed through CMM or the CMS Emergency Response Coordinator.

10.4 Emergency Response

In addition to the program and communications response, CMS carries a significant role in emergency response as well. The CMS Emergency Response Procedures Manual provides CMS Regional Offices with a standardized protocol for interacting with State Agencies and health care providers in response to operational issues that they may experience in preparation for or in the wake of natural or man-made disasters or emergency situations. It clarifies the role that CMS plays in such circumstances relative to the U.S. Department of Health and Human Services and to Federal Disaster Declarations as issued by the President.

The manual addresses procedural preparedness for emergency situations as well as actions that CMS can take both without and with temporary waivers or modifications of certain Medicare, Medicaid and CHIP requirements in order to ensure sufficiency of health care service delivery in affected areas. Further, the manual complements established policies as promulgated by CMS Central Office and consists of a step-by-step process for policy implementation through the Regional Offices. Finally, it anticipates a transitional period between responses to disasters or emergency situations and an active period of recovery from them.

The CMS Emergency Response Procedures Manual can be accessed through contacting the CQISCO or CMS Emergency Response Coordinator.

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11.0 PANDEMIC READINESS

To ensure that the CMS Pandemic Influenza Operations and Response Plan is current and effective, a number of readiness activities are built into annual programmatic activities. Table 11.0 describes these activities, the tasks that must be completed to accomplish them, and the frequency with which they will be carried out.

Table 11.0 – Readiness Activities

Activity	Tasks	Frequency
Plan update and certification	Review entire plan for accuracy. Incorporate lessons learned and changes in policy and philosophy. Manage distribution of plan updates.	Annually (Send to components for review and update NLT July 15th, Comments due August 1st, Final due September 1st
Update checklists	Update and revise checklists. Ensure annual update/validation.	As needed Annually
Conduct quarterly baseline assessment of CMS absenteeism	Follow "manual" process for collecting absenteeism information Query ITAS for additional absenteeism information	Quarterly
Conduct training	Provide training/informational materials on the CMS pandemic response and operational continuity actions to key senior leadership and other necessary CMS personnel	Annually
Orient new policy officials and senior management	Brief officials on Pandemic Plan. Brief each official on his/her responsibilities under the Pandemic Plan.	Within 30 days of appointment
Plan and conduct exercises	Conduct internal exercises. Conduct joint exercises with Regions. Support and participate in interagency exercises.	Semi-annually Annually Annually or as needed

11.1 After Action Reports (AAR)

Testing, Exercising, and responding to a real-time pandemic can offer insight into the effectiveness of the CMS pandemic processes and procedures. It is critical to capture the lessons learned by conducting an AAR to identify to those areas that require corrective action. This review will include the following:

- Creating an Incident Report that identifies lessons learned and creates a corrective action plan.
- Compile an AAR with lessons learned and corrective actions for submission to the Administrator, Deputy Administrator, and Chief Operations Officer.
- Informing office components of relevant corrective actions identified in the AAR.

12.0 APPENDICES

Appendix A – CMS Mission Impact Report
Appendix B – VPN Connection Guidance
Appendix C – Checklist for Individuals and Families
Appendix D – Sample Phone Tree
Appendix E – Glossary

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Appendix A – CMS Mission Impact Reporting

PANDEMIC IMPACT REPORT - EXAMPLE				DATE	
CO/CONSORTIUM/REGION	**OFFICE**	**DIVISION**		**NAME**	
SAMPLE	SAMPLE	SAMPLE		SAMPLE	

	Absenteeism	**Actual**	**% Change (Actual over Previous)**			
	Total Employees	**5000**	**0.0%**			
	Total Employees who are Absent	**222**	**64.4%**			
	% of Total Employees who are Absent	**4.4%**	**64.4%**			
	Absentees plus Travel Employees	**285**	**74.8%**			
	% of Total Employees who are Absent or on Travel Duty	**5.7%**	**74.8%**			
		Actual	**% Change (Actual over Previous)**	**Comments**		
	Sick Leave	600	**20.0%**			
	Family Leave	500	**25.0%**			
	Short Term Disability Leave	50	**11.1%**			
	Emergency Care Leave	100	**-4.8%**			
	TOTAL EMPLOYEES ON LEAVE	**1250**	**19.0%**			
		Actual	**% Change (Actual over Previous)**	**Comments**		
	Total Tier I CMS Employees	500	**0.0%**			
	Absent Tier I CMS Employees	17	**13.3%**			
	Total Tier II CMS Employees	1000	**-4.8%**			
	Absent Tier II CMS Employees	25	**0.0%**			
	Total Tier III CMS Employees	2000	**1.3%**			

		Actual		Comments		
	Absent Tier III CMS Employees	70	40.0%			
	Total Remaining CMS Employees	1500	1.7%			
	Absent Remaining CMS Employees	110	144.4%			

Travel		**Actual**	**% Change (Actual over Previous)**	**Comments**		
	Total Employees on Approved Travel	**63**	125.0%			
	NCR	50	400.0%			
	Regional	10	-33.3%			
	Inside US	2	0.0%			
	Outside US	1	0.0%			

Telework		**Actual**	**% Change (Actual over Previous)**	**Comments**		
	Number of Teleworkers	**187**	59.8%			
	% of Employees who Telework	**3.7%**	59.8%			
	At least 3 days/week	10	-23.1%			
	1-2 days/week	31	675.0%			
	< 1 day/week but at least 1 day/month	146	46.0%			

HR Flexibilities		**Actual**	**% Change (Actual over Previous)**	**Comments**		
	Number of Alternate Schedules	75	0.0%			
	Number of Pandemic Hires	2	100.0%			

Protective Measures		**Actual**	**% Change (Actual over Previous)**	**Comments**		
	Packages of Masks	100	0.0%			

Boxes of Gloves	100	**25.0%**	
Doses of Vaccines	200	**-11.1%**	
Doses of Antivirals	43	**-14.0%**	

Day-to-Day Operations Impact		**Current**	**Previous**	**Previous Value**	**Comments**		
VALUES None-Trace=**10%**; Few=**25%**; Several=**50%**; Many=**75%**; Nearly All=**100%**	Priority Changes due to Pandemic Response	Several	Few	25.0%			
	Projects impacted due to Absenteeism	Few	Few	25.0%			
	Projects impacted due to Infrastructure issues	None to Trace	None to Trace	10.0%			

MEF #1--Cash Flow Impact		**Current**	**Previous**	**Previous Value**	**Comments**		
VALUES None-Trace=**10%**; Mild=**25%**; Moderate=**50%**; Significant=**75%**; Severe=**100%**	SF #1--Medicare FFS Payments	Significant	Mild	25.0%			
	SF #2--Medicaid/CHIP Grants	Moderate	Moderate	50.0%			
	SF #3--Medicare C & D payments	None to Trace	Mild	25.0%			
	SF #4--Critical Payments & Authorizations	Moderate	Mild	25.0%			

MEF #2--Communications Impact		**Current**	**Previous**	**Previous Value**	**Comments**		
VALUES None-Trace=**10%**; Mild=**25%**;	SF #1--Health & Policy Information	Moderate	None to Trace	10.0%			
	SF #2--Survey & Regulatory Information	Mild	Mild	25.0%			

			None to Trace	None to Trace				
Moderate=**5 0%**; Significant=**7 5%**; Severe=**100%**	SF #3--Internal Stakeholders		None to Trace	None to Trace	10.0%			
	SF #4--General Support		None to Trace	None to Trace	10.0%			
MEF #3--Enrollment Impact			**Current**	**Previous**	**Previous Value**	**Comments**		
VALUES None-Trace=**10%**; Mild=**25%**; Moderate=**5 0%**; Significant=**7 5%**; Severe=**100%**	SF #1--Medicare A & B Enrollment		Mild	Mild	25.0%			
	SF #2--Medicare C & D Enrollment		None to Trace	None to Trace	10.0%			
	SF #3--Low-Income Medicare Beneficiary Enrollment		Mild	None to Trace	10.0%			
MEF #4--ESRD Impact			**Current**	**Previous**	**Previous Value**	**Comments**		
VALUES None-Trace=**10%**; Mild=**25%**; Moderate=**5 0%**; Significant=**7 5%**; Severe=**100%**	SF #1--Facility & Patient		None to Trace	None to Trace	10.0%			
MEF #5--Quality Care Impact			**Current**	**Previous**	**Previous Value**	**Comments**		

VALUES None-Trace=**10%**; Mild=**25%**; Moderate=**50%**; Significant=**75%**; Severe=**100%**	SF #1--Fast-Track Appeals	None to Trace	None to Trace	10.0%			

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Appendix B – VPN Connection Guidance

INTRODUCTION

This document will assist you with remotely accessing the Centers for Medicare and Medicaid Services (CMS) network infrastructure via wired or wireless connectivity through a VPN (Virtual Private Network). If you have any issues connecting to the CMS network, please contact the CMS IT Service Desk at (410) 786-2580 or 1-800-562-1963.

The CMS Network and all resources including internet, mainframe, Microsoft Outlook and any network drives will be available when you have successfully logged into the CMS Network via the VPN.

If you have been issued a PIV card, this should be used to access the network remotely. The RSA Token should only be used if your PIV card has not been issued yet.

PREREQUISITES:

To access the CMS Network remotely, you must have the following items:
CMS-furnished laptop.
Cisco VPN software (installed on all CMS-provided laptops).
PIV Card (Personal Identity Verification), PIV PIN (Personal Identity Number), or RSA Token "fob".
High speed Internet access from a remote location.

REMOTE ACCESS VIA A WIRED CONNECTION (Network cable connector)

Remote access can be accomplished by establishing connectivity via a wired connection from a remote network to the Dell E6400 laptop. You will need to have a network cable with one end plugged into a network router and the other connected to the back of your laptop.

Plug in the network cable into your machine.
Boot up your machine.
Wait for the machine to completely boot up.
Log in using your CMS UserID and Password. (Ignore the VPN Client window which will appear in the lower left corner of the screen.).
Proceed to *Connecting to the VPN* section in this document. Select one of the **VPN Connectivity** steps for using either your **PIV** card or an **RSA Token.**
To ensure connectivity to the Ethernet, right-click the **AirDefense Personal icon** on your system tray.
Click Enable and then click **Intel ® 82567 LM Gigabit Network Connection**.
Note: There is a ten minute window for you to establish a VPN connection. Once ten minutes has elapsed, the Ethernet will automatically disable. Repeat Steps 4 through 7 to reconnect.

REMOTE ACCESS VIA A WIRELESS CONNECTION

Remote access via a wireless connection is managed by the **AirDefense Personal** software installed on your laptop. The **AirDefense Personal icon** is found in the lower right corner of your system tray next to the system time.
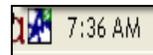
To gain a wireless connection to the network you will need to turn on wireless for the Dell laptop, activate the **AirDefense** Wireless card and then activate the wireless adapter on the computer. Please follow these steps:

*Note**:** You will need to know the name of the wireless network and the **Wireless Encryption Password (WEP)** for the wireless network you are connecting to for this procedure. The **WEP** and the name of your network are provided by the **Internet Service Provider (ISP)** supplying the wireless service.*

Select the wireless switch on the right side of the laptop and move it towards you so that the slot does not show red.

Boot up your machine. Wait for the machine to completely boot up.

Log in using your **CMS UserID and Password**. (For now, ignore the **VPN Client** window which appears in the lower left corner of the screen.)

Right click on the **AirDefense Personal** icon on your system tray.

Click **Enable** and then click *Intel WiFi 5100 AGN* to enable the **AirDefense WiFi** card.

Next, enable your **Wireless Adapter** by right clicking on the **AirDefense Personal** icon in the right side of your system tray**.**

Configure your WiFi by double-clicking on the **WiFi adapter** icon. **(**configuring WiFi is required for each new wireless remote access site**).**

After a list of available WiFi networks displays, select **your named network** in the list.

Click the **Connect** button to display the Connect window.

If requested, enter the **Wireless Security Password** for your network. Click Ok. If you typed the password in correctly your Wireless Adapter should turn green.

Note: There is a ten minute window for you to establish a VPN connection. Once ten minutes has elapsed, the Wireless Adapter will automatically disable. Repeat Steps 5 through 10 to reconnect.

ABOUT WIRELESS HOTSPOTS:

Wireless hotspots often require a "terms and conditions" agreement be accepted before allowing connectivity to the internet. Many providers will automatically redirect you to this agreement page as soon as you open Internet Explorer. If you are not automatically redirected you will receive an error page. This is normal as your default homepage can only be accessed after the VPN tunnel has been created. You will need to manually type in the address of the agreement page if you are not redirected automatically (this address will need to be provided by the hotspot provider). After you have agreed to the provider's terms and conditions you should be granted internet access.

Check your Network Connectivity. Network connectivity means you have access to the internet and can browse to https://webmail.hhs.gov. If you cannot reach this site you do not have connectivity and the VPN connection will fail.
 Once you have verified that you have internet connectivity you may proceed to the "Connecting to the VPN" section in this document. Select one of the VPN connectivity steps for using either your **PIV** card or an **RSA Token.**
CONNECTING TO THE VPN
Once you have established network connectivity either through a wired or wireless connection, you are now ready to access the CMS Network via the VPN. Remember, CMS network resources are not available until a VPN connection has been established. Connecting to the VPN is achieved by clicking on the VPN Client icon and using either your PIV card or RSA Token. Please follow these steps:

USING A PIV CARD TO CONNECT TO THE VPN

Insert and leave your PIV card in the card reader (located at the front left side of the CMS issued laptop).
Click on the VPN Client Icon on the desktop
Select **CMS Internal PIV Card** from the   Network drop down field in
the VPN Client screen.
Click **Connect**. The ActivClient Login window
displays.
Type in your PIN (the PIN established when your PIV card was
issued), then click **OK**.
The system will show a number of screens indicating progress while connecting to the network.
The Cisco Clean Access agent scans the system for patch updates before it connects you to the CMS network. If updates are required, you must install the updates and reboot your system before continuing.
Once established, a notification will confirm that you are successfully connected via the VPN.
Click on the VPN Drive Mappings icon on your desktop to map your
network drives.
If you lose VPN or network connectivity, insert your PIV card again and
repeat steps 2-10.
You may remove your PIV card at any time once successfully connected.

USING THE RSA TOKEN (FOB) TO CONNECT TO THE VPN

Note: *You will only need to set up your 4-8 digit PIN (Personal Identification Number) the first time you connect using the RSA Token.*
When you get your new laptop, you will be given an RSA SecureID Token. **If you have been issued a PIV card, it should be used instead of the RSA Token**.

FIRST TIME LOG IN TO THE VPN WITH THE RSA TOKEN

Connect to the Network using either a wireless or wired connection (See Remote Access via a Wired Connection or Remote Access via a Wireless Connection in the previous section).
Once you have internet connectivity – click on the VPN Client icon on the desktop.
Select CMS Internal Network from the drop down menu.
Click "Connect".
Enter your four alpha-numeric CMS User ID and the 6-digit number displayed on your RSA Token, then click the **OK** button (see Page 8 – Your RSA Token for more information).
In the Response field, type a new 4-8-digit Personal Identification Number (PIN), then click the **OK** button.
In the Response field, re-type the PIN established in # 6 above, then click the **OK** button.
Wait for the 6-digit number displayed on the RSA Token to change, then enter the new number.
Click **OK**.
The Cisco Clean Access agent scans the system for patch updates before it connects you to the CMS network. If updates are required, you must install the updates by following the prompt instructions. Then reboot your system before continuing.
Once you receive the "You are Successfully Logged in" message, you are now ready to work on the CMS network.
Click on the VPN Drive Mappings icon on your desktop to map your network drives.
*Note**: *If you continue to get a window requesting your PIN once you have entered it three times incorrectly, your PIN account may be locked and needs to be reset. Please contact the CMS IT Service Desk for assistance at 410-786-2580 or 1-800-562-1963.*

SUBSEQUENT LOG IN TO THE VPN WITH THE RSA TOKEN

Connect to the Network using either a wireless or wired connection (See Remote Access via a Wired Connection or Remote Access via A Wireless Connection in the previous section).
Once you have internet connectivity – click on the VPN Client icon on the desktop.
Select CMS Internal Network from the drop down menu.
Click "Connect".
Enter your CMS UserID in the Username field
Enter the combination (no spaces) of your pin and the 6 digit number on the RSA token.
Click **OK**.
The Cisco Clean Access agent scans the system for patch updates before it connects you to the CMS network. If updates are required, you must install the updates by following the prompt instructions. Then reboot your system before continuing.
Once you receive the "You are Successfully Logged in" message, you are now ready to work on the CMS network.

Click on the VPN Drive Mappings icon on your desktop to map your network drives.

USING THE RSA USB TOKEN TO CONNECT TO THE VPN

*Note***:** *You will only need to set up your PIN the first time you connect using the RSA Token.*

Remove the cap from the end of the RSA Token (fob).

Insert the RSA Token into one of the USB slots on the laptop.

Click on the VPN Client Icon on the desktop.

From the drop-down field in the connection window, select CMS Internal Network:USB, then click the **Connect** button.

Enter your four alpha-numeric CMS User ID and PIN then click the **OK** button (see Page 8 – Your RSA Token for more information).

In the Response field, type a new 4-8-digit Personal Identification Number (PIN), then click the **OK** button.

In the Response field, re-type the PIN established in # 6 above then click the **OK** button.

Wait for the window which tells you that you are successfully connected to the Network to begin using CMS resources.

The Cisco Clean Access agent scans the system for patch updates and connects before it connects you to CMS network. If updates are required, you must install the updates and reboot your system before continuing.

Click on the VPN Drive Mappings icon on your desktop to map your network drives.

ADDITIONAL INFORMATION CONCERNING YOUR WIRELESS CONNECTION

When connecting via Wireless, remember:

You must make a VPN connection within 5 minutes of starting your computer, or the wireless card will be disabled.

One reminder message displays before the card is disabled.

If the card is disabled, you may re-enable it by right-clicking the AirDefense icon to display a popup menu, then click the Enable option, and click *Intel WiFi 5100 AGN.*

You cannot establish simultaneous wired and wireless connections. If you plug into a wired connection (e.g., by connecting your laptop to the Ethernet connection at home or at work), the wireless card will be disabled.

TERMINATING YOUR REMOTE ACCESS CONNECTION

In the System Tray on your desktop, right-click the yellow **VPN Connection** icon. A popup menu displays.

Click the **Disconnect** menu option. The VPN connection is terminated if you turn off your machine.

If you get disconnected while working, click on the VPN Client icon again and connect using your PIV Card or RSA Token.

YOUR RSA TOKEN

Note: *The RSA Token number resets every 60 seconds, and will change when the countdown timer reaches zero bars. If the countdown is close to finishing, wait until the RSA Token number resets before you begin entering password information.*
Choose a PIN number between 4 and 8 digits. This PIN number will always be a part of your VPN password. Enter your PIN number in the Response field, and click **OK**.
Re-enter your pin number in the Response field and click **OK**
Wait until the RSA Token number resets at least once. In the Response field, enter your PIN number followed by the RSA Token number. Click **OK** to log in.

CLEAN ACCESS AGENT

The Clean Access Agent ensures that your laptop computer is protected and up to date when you log into the VPN. If the Clean Access Agent detects no problems, click **OK** to begin working.

To update your laptop: In the CISCO **Clean Access Agent** window, click Continue for each component that needs to be updated, click Update. When there are no more updates to be applied, click **OK** to begin working. Some updates may require you to restart your computer.

AUTOMATIC DISCONNECTION

To remain in compliance with Federal Security Requirements, effective August 10, 2009, network connectivity must be disabled after thirty (30) minutes of user inactivity. This means that laptops that are connected remotely to the CMS network via the VPN will be automatically disconnected from the network if keystrokes or mouse clicks are not detected by the system for a period of thirty (30) minutes. To reconnect, simply use the instructions you used for connecting initially.

Appendix C – Checklist for Individuals and Families

You can prepare for an influenza pandemic now. You should know both the magnitude of what can happen during a pandemic outbreak and what actions you can take to help lessen the impact of an influenza pandemic on you and your family. This checklist will help you gather the information and resources you may need in case of a flu pandemic.

1. To plan for a pandemic:

    - Store a supply of water and food. During a pandemic, if you cannot get to a store, or if stores are out of supplies, it will be important for you to have extra supplies on hand. This can be useful in other types of emergencies, such as power outages and disasters.

    - Have any nonprescription drugs and other health supplies on hand, including pain relievers, stomach remedies, cough and cold medicines, fluids with electrolytes, and vitamins.

    - Talk with family members and loved ones about how they would be cared for if they got sick, or what will be needed to care for them in your home.

    - Volunteer with local groups to prepare and assist with emergency response.

    - Get involved in your community as it works to prepare for an influenza pandemic.

2. To limit the spread of germs and prevent infection:

    - Teach your children to wash hands frequently with soap and water, and model the correct behavior.

    - Teach your children to cover coughs and sneezes with tissues, and be sure to model that behavior.

    - Teach your children to stay away from others as much as possible if they are sick.

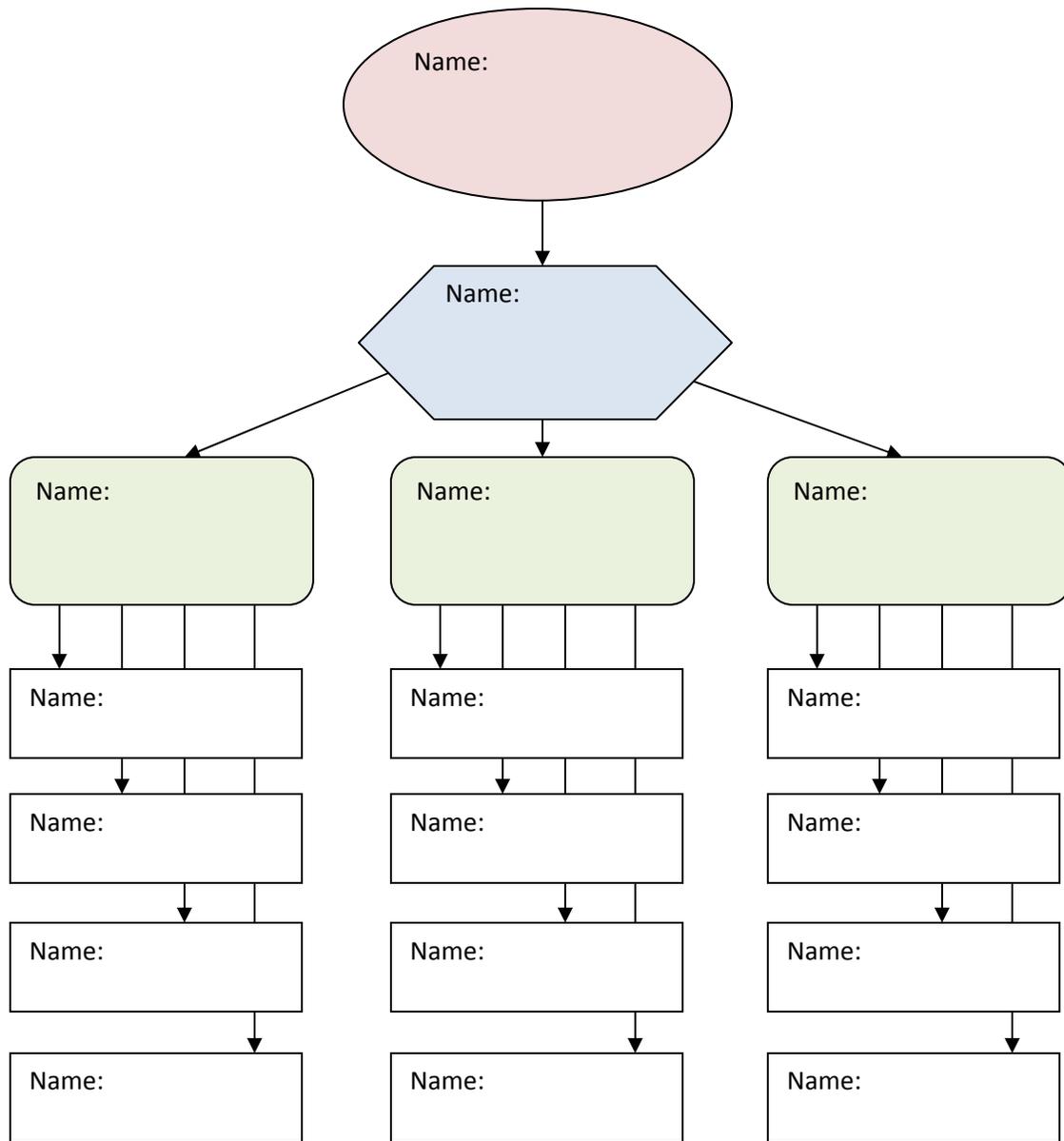   - Stay home from work and school if sick.

3. Items to have on hand for an extended stay at home:

    - Food and non-perishables
    - Ready-to-eat canned meats, fruits, vegetables, and soups
    - Protein or fruit bars
    - Dry cereal or granola
    - Peanut butter or nuts
    - Dried fruit
    - Crackers
    - Canned juices
    - Bottled water
    - Canned or jarred baby food and formula
    - Pet food

4. Examples of medical, health, and emergency supplies:

- Prescribed medical supplies such as glucose and blood-pressure monitoring equipment
- Soap and water, or alcohol-based hand wash
- Medicines for fever, such as acetaminophen or ibuprofen
- Thermometer
- Anti-diarrhea medication
- Vitamins
- Fluids with electrolytes
- Cleansing agent/soap
- Flashlight
- Batteries
- Portable radio
- Manual can opener
- Garbage bags
- Tissues, toilet paper, disposable diapers

Appendix D – Sample Phone Tree

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Appendix E – Glossary

Antibiotic: A substance that is either artificially synthesized or naturally produced by bacteria or fungi that destroys or prevents the growth of other bacteria. Antibiotics are generally not useful for viral infections.

Antiviral: Drug that is used to prevent or cure a disease caused by a virus, by interfering with the ability of the virus to multiply in number or spread from cell to cell. Antivirals are generally not useful for bacterial infections

Avian flu: A highly contagious viral disease with up to 100% mortality in domestic fowl caused by Influenza A virus subtypes H5 and H7. All types of birds are susceptible to the virus but outbreaks occur most often in chickens and turkeys. The infection may be carried by migratory wild birds, which can carry the virus but show no signs of disease. Humans are only rarely affected.

CDC: Centers for Disease Control and Prevention, the U.S. government agency at the forefront of public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities, and environmental health threats. CDC is one of 13 major operating components of the Department of Health and Human Services.

Contagious: A contagious disease is easily spread from one person to another by contact with or exposure to the infectious agent that causes the disease. Contagious viral diseases are often spread within droplets of liquid particles made by coughing or sneezing. These droplets can directly transmit disease if other persons reinhale the droplets from midair. The droplets can also indirectly transmit the disease if they land upon a surface (the cougher's hands, a table, a utensil, another person's skin, in water/food, etc.) and are later touched and transferred through a new victim's eyes, nose, or other mucous membranes.

Epidemic: A disease occurring suddenly in humans in a community, region, or country in numbers clearly in excess of normal. See also: **pandemic**.

FDA: U.S. Food and Drug Administration, the government agency responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. FDA is one of 13 major operating components of the Department of Health and Human Services.

H1N1: A species of influenza virus that has been isolated from pigs (which originally led many persons to name it "swine flu"), and has currently varied to where it also causes influenza in humans. The worldwide spread of the current H1N1 variant among humans has been sufficient enough for the World Health Organization to declare a pandemic. See also: **pandemic** and **swine flu**.

H5N1: A variant of avian influenza, which is a type of influenza virulent in birds. It was first identified in Italy in the early 1900s and is now known to exist worldwide.

Immune system: The cells, tissues and organs that help the body to resist infection and disease by producing antibodies and/or altered cells that inhibit the multiplication of the infectious agent.

Influenza: A serious disease caused by viruses that infect the respiratory tract.

Isolation: A state of separation between persons or groups to prevent the spread of disease. The first published recommendations for isolation precautions in United States hospitals appeared as early as 1877, when a handbook recommended placing patients with infectious diseases in separate facilities. Isolation measures can be undertaken in hospitals or homes, as well as in alternative facilities.

Mutation: Any alteration in a gene from its natural state. This change may be disease-causing or a benign, normal variant. Specific mutations and evolution in influenza viruses cannot be predicted, making it difficult if not impossible to know if or when a virus such as H5N1 might acquire the properties needed to spread easily among humans.

Pandemic: The worldwide outbreak of a disease in humans in numbers, clearly in excess of normal, to the point where many large clusters of affected humans are present in many communities, regions, and countries. See **epidemic**.

Pathogen: Any organism—bacteria, virus, yeast, fungus, mold, or parasite—that is capable of causing disease. A pathogen will cause disease only if *all four* of the following conditions are met: it must (1) have disease-causing potential, (2) be of sufficient quantity, (3) enter a human who is sensitive, ***and*** (4) penetrate a correct entry site of that human.

Quarantine: The period of isolation decreed to control the spread of disease. Before the era of antibiotics, quarantine was one of the few available means of halting the spread of infectious disease. It is still employed today as needed. The list of quarantinable diseases in the U.S. is established by Executive Order of the President, on recommendation of the Secretary of the Department of Health and Human Services, and includes cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, and viral hemorrhagic fevers (such as Marburg, Ebola, and Congo-Crimean disease). In 2003, SARS (severe acute respiratory syndrome) was added as a quarantinable disease. In 2005 another disease category was added to the list, influenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic.

Recovery Time Objective (RTO): The amount of time a function can be disrupted before the consequences become irrecoverable.

Seasonal flu: A respiratory illness that can be transmitted person to person. Most people have some immunity, and a vaccine is available. This is also known as the common flu or winter flu.

Sign: An observable, objective indicator that an individual carries a disease or illness. An example of a sign of influenza would be active coughing. A carrier who has signs is much easier to recognize as being potentially contagious than one who has only symptoms or is asymptomatic. See also: **symptom**.

Social Distancing: A protective measure enacted by local, state, and federal agencies to limit the likelihood of spreading a virus among their workforce or community. These measures are typically implemented through use of personal protective equipment, telework, staggered shifts, and liberal work/leave policies.

Swine flu: A generic term given to any virus species that normally affects pigs. The term was originally used as a public designation for the current H1N1 influenza virus that also affects humans, but has since been replaced by the more accurate term, "H1N1 influenza," to avoid public misunderstanding. According to the website www.flu.gov, the four most common viruses isolated from pigs are: H1N1, H1N2, H3N2, and H3N1. However, most of the recently isolated influenza viruses from pigs have been H1N1 viruses. See also: **H1N1**.

Symptom: A non-observable, subjective indicator that an individual carries a disease or illness. An example of a symptom of influenza would be muscle aches. A carrier who only has symptoms of influenza could look and act normal, but still be contagious. See also: **sign**.

Vaccine: A preparation consisting of antigens of a disease-causing organism which, when introduced into the body, stimulates the production of specific antibodies or altered cells. This produces a form of immunity to the disease-causing organism. The antigen in the preparation can be whole disease-causing organisms (killed or weakened) or parts of these organisms.

Virulent: Highly infectious and/or highly lethal; causing severe illness or death. The more virulent an organism is, the more likely it is to cause disease.

Virus: Any of various simple submicroscopic parasites of plants, animals, and bacteria that often cause disease and that consist essentially of a core of RNA or DNA surrounded by a protein coat. Unable to replicate without a host cell, viruses are typically not considered living organisms.

WHO: World Health Organization, an agency of the United Nations established in 1948 to further international cooperation in improving health conditions.