

Roles and Processes for Pandemic Preparedness in Infection Control



Jessica I. Abrantes-Figueiredo, MD, David B. Banach, MD, MPH, MS*

KEYWORDS

- Pandemic • Health care epidemiology • Infection preventionist
- Incident management • Ethics

KEY POINTS

- Health care facilities should be adequately prepared for future pandemics. Using an Emergency Management program provides the foundation and guidance to lead through a pandemic response, and use of the Hospital Incident Command System allows for rapid coordination and communication during a crisis.
- It is important to plan for staffing and utilization of space in preparation for a surge of patients to allow continued provision of routine inpatient and ambulatory care. Routine review and revision of such plans is important to adapt to the current state of the pandemic.
- Ethical challenges that are inherent to a pandemic should not only be considered but also addressed in real time, such as the scarcity of resources.
- The psychological health and well-being of health care workers require focus and attention during pandemic preparedness planning. It is common for health care personnel to work under highly stressful conditions requiring difficult treatment decisions while placing their own health at risk.

INTRODUCTION

Infection prevention and control (IPC) programs are an essential piece of a healthcare facility response to a pandemic. It is critical for health care facilities and health systems to have well-established IPC programs, healthcare epidemiologist (HE) expertise, and administrator leadership support to adequately prepare for future rapidly emerging infections that can lead to a pandemic. Ongoing challenges persist in maintaining the health care workforce while simultaneously supporting continued clinical care across different services and effective communication methods, which are critical to avoid a public health emergency transforming into an operational crisis.¹ Here,

Division of Infectious Diseases, Department of Medicine, University of Connecticut School of Medicine, Farmington, CT, USA

* Corresponding author. Division of Infectious Diseases, Department of Medicine, University of Connecticut School of Medicine, 263 Farmington Avenue, Farmington, CT 06030-8076.

E-mail address: dbanach@uchc.edu

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Abbreviations	
CERC	Crises and Emergency Risk
ED	Emergency Department
EMP	Emergency Management Program
HE	Healthcare Epidemiologist
IPC	Infection Prevention and Control
PPE	Personal Protective Equipment

the authors discuss the key roles and processes for pandemic preparedness in infection control to support the health care workforce, clinical care, and research while facing the ethical challenges and need for mental health and wellness support that arise with a crisis.

ROLE OF HEALTH CARE EPIDEMIOLOGIST AND INFECTION PREVENTION AND CONTROL EXPERT DURING A PANDEMIC

Outbreak response and incident management guidance has previously been published to aid HEs in using their skill and expertise to work within an emergency response framework. Incident management phases of preparedness, mitigation, response, and recovery from crisis should be guided by an Emergency Management Program (EMP) within a facility to help devise an emergency operations plan to continue its mission of patient care during outbreaks. The Hospital Incident Command System is responsible for the integration of different response elements identified during incident management while facilitating communication with outside groups and agencies. The National Incident Management System provides standard collaboration and guidance between federal, state, and local governments, as well as nongovernmental organizations to protect and respond against crises, including infectious disease pandemics. Incident management preparedness structures and frameworks are used to organize and coordinate identified functions and responsibilities within management teams in a facility or system (Fig. 1).²

The HE takes on an important administrative leadership role within the Hospital Incident Management Team, generally serving as the medical-technical specialist during an outbreak or pandemic. The HE works alongside the IPC team members to identify risk of emerging infectious diseases as well as mitigation and response to risk. The HE is a subject-matter expert in a variety of areas, including but not limited to infectious diseases, pathogen transmission, IPC as well as quality improvement and regulatory requirements.³ These are essential skills and competencies to possess and maintain an effective health care facility IPC program. A facility’s IPC program is recommended to have a dyad leadership model that combines both physician and infection preventionist leaders.⁴ Together, they form a foundational part of a facility’s operational structure that requires necessary resources and staffing to be an effective program. It is well-known that IPC programs remain underresourced, which is a threat to the safety and quality of care to patients.^{5,6} The COVID-19 pandemic further uncovered multiple challenges faced by infection preventionists, including rapidly changing guidance, lack of personal protective equipment (PPE), and increases in both hospital onset infections and workload.⁷ Over the years, the role of the infection preventionist has continued to expand. The Association for Professionals in Infection Control and Epidemiology competency model for the infection preventionist includes the following 4 critical domains: leadership and program management, performance improvement and implementation, technical, and infection prevention and control.⁸ Overlapping competencies for both HE and infection preventionist include surveillance, quality

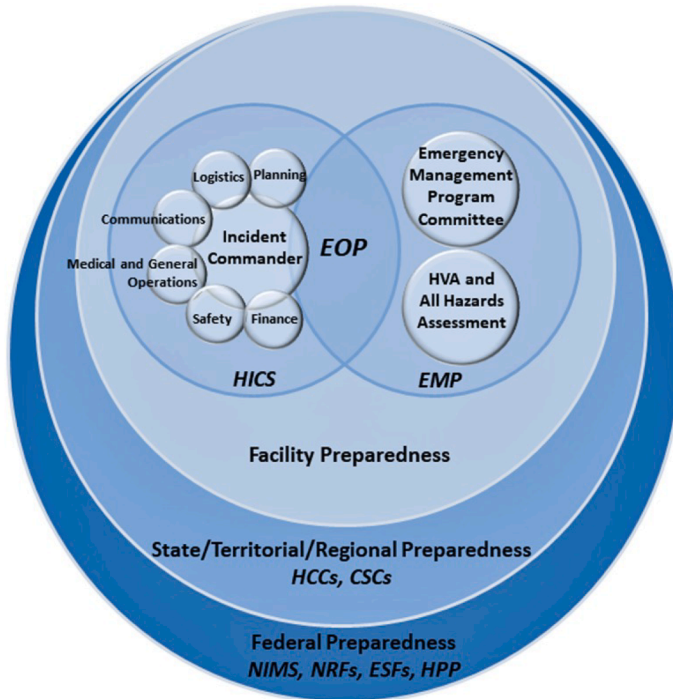


Fig. 1. Incident management preparedness structures and frameworks. This diagram was created by the authors of the Society of Healthcare Epidemiology of America Outbreak Response Training Program expert guidance document to illustrate how US preparedness structures and frameworks relate, starting at the federal level and moving to the facility level. CSC, Crisis Standards of Care; EOP, Emergency Operations Plan; ESF, Emergency Support Function; HCC, Health Care Coalition; HICS, Hospital Incident Command System; HPP, Hospital Preparedness Program; NIMS, National Incident Management System; NRF, National Response Framework. (From Banach DB, Johnston BL, Al-Zubeidi D, et al. Outbreak Response and Incident Management: SHEA Guidance and Resources for Healthcare Epidemiologists in United States Acute-Care Hospitals. *Infect Control Hosp Epidemiol.* 2017;38(12):1393-1419. <https://doi.org/10.1017/ice.2017.212>; with permission.)

improvement, data interpretation and analysis, along with outbreak detection and emergency preparedness.

The HE, within its administrative leadership role, and IPC practitioners collaborate with key stakeholders during pandemic preparedness and response. Input regarding the phases of incident management is provided to the facility's EMP as they relate to infectious diseases and IPC. Additional responsibilities involve monitoring public health alerts of emerging pathogens, maintaining hospital-wide surveillance for rapid detection of exposed patients and health care personnel when faced with an outbreak. There should be continued coordination and communication with facility leadership to guarantee timely sharing of information regarding updates on policies and procedures.² Collaboration occurs closely with multiple services when preparing and responding to a pandemic and can involve all of the following departments: environmental services, occupational health, microbiology and laboratory personnel, industrial hygiene, informatics/information technology, emergency management, supply chain, sterile processing, and device reprocessing.

ROLE OF FACILITY LEADERSHIP DURING A PANDEMIC

Facility leadership plays an important role in ensuring and advocating for the prioritization of an effective IPC program with accessible resources to accomplish core components.^{4,9,10} These core components include combating health care–associated infections, antimicrobial resistance, and preventing and responding to outbreaks. Examples of facility administrative leadership include president/chief executive officer, director of nursing, chief medical officer, chief safety officer, risk manager, vice president of finance, and communications department.² Facility leadership was also at the forefront of the COVID-19 pandemic, and it was evident that key characteristics were essential in supporting not just the surge of patients but also the front-line health care workers. Effective leadership incorporates self-awareness, understanding of others, clinical experience, and adaptability while leading with empathy.^{11,12} It is vital to keep open communication with key stakeholders while aiding in executing operational plans laid out in the multiple phases of incident management. When faced with the uncertainty and adversity of a pandemic, leading and fostering a collaborative environment can help sustain clinical and operational activities during times of crisis.^{13–15}

MAINTAINING THE HEALTH CARE WORKFORCE: PROTECTION, SAFETY, AND STAFFING SHORTAGES DURING A PANDEMIC

The protection of health care personnel during their health care–related activities is a critical component of pandemic preparedness and response. During the early phases of the COVID-19 pandemic and the severe acute respiratory syndrome experience in Hong Kong and Canada as well as the Ebola outbreaks in Africa, health care workers were highly vulnerable to infection in health care settings.^{16–18}

Although the strategies for protecting health care personnel during the delivery of care vary, it depends on the pathogen and the mode of transmission. Fundamentally, the hierarchy of infection controls provides guidance on developing strategies to reduce the risk of infection transmission in health care facilities and thereby protect health care personnel. In infectious diseases response, this includes engineering controls, administrative controls, and PPE (Fig. 2). Frameworks for the application of the hierarchy of controls to emerging infections, including the COVID-19 pandemic, can provide a comprehensive approach to protecting health care personnel.¹⁹ Engineering controls separate the health care worker from the organism source (patient with suspected or confirmed infection) or reduce the time of exposure when separation is not plausible. In the setting of an infection caused by a high-risk pathogen, this may involve segregating patients with suspected or confirmed infection from other patients and health care personnel. This may also include creating a physical environment that reduces the potential for transmission, such as increasing ventilation, negative pressure ventilation, and the use of HEPA filtration.

Administrative controls, notably policies and procedures accompanied by education, are important components in protecting health care personnel during a pandemic or outbreak associated with a high-consequence or novel pathogen. These may include protocols to rapidly identify and isolate potentially infectious patients to “Identify, Isolate and Inform” and perform clinical evaluations and diagnostic testing in a manner that minimizes exposure of personnel.²⁰ Policies and procedures addressing cleaning and disinfection of equipment and the patient care environment are also essential in reducing exposure to the pathogen of concern. The details of these protocols will be organism specific, but ensuring understanding of and adherence to developed protocols are critical to ensure they are most effective in reducing potential exposure. Importantly, staff should be educated on these protocols, including how to

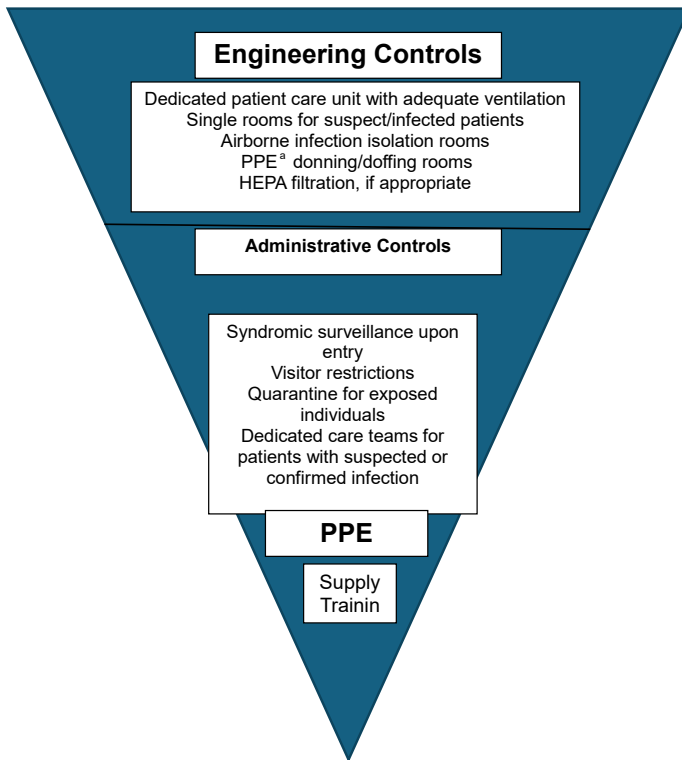


Fig. 2. Hierarchy of infection controls and pandemic preparedness (examples). *Personal protective equipment.

access written protocols and procedures in real time. Unannounced, “mystery patient” drills can be effective in evaluating personnel’s readiness to identify and isolate a patient with a high-consequence infectious disease pathogen.²¹

PPE to create a barrier protecting healthcare personnel from exposure to the infectious agent is an important component of the hierarchy of controls, although remains the most prone to failure. The components of PPE will be specific to the pathogen of concern and may include facemask or a higher level of respiratory protection. PPE is only effective when used correctly and consistently. Ensuring adequate education on donning and doffing PPE and access to a variety of sizes to accommodate all health care personnel are critical components of pandemic preparedness.

As demonstrated during the COVID-19 pandemic, ensuring adequate staffing for health care settings during a pandemic can pose a significant challenge to health care systems. This is especially true when health care personnel face a high risk of infection with the pathogen of concern that is spreading in the community. Retrospective assessments of staffing challenges in the United States during the COVID-19 pandemic have been reviewed, and policy approaches to future preparedness and mitigation have been proposed.²² An approach to addressing staffing challenges, including the development of resilient health care workforce in preparation for an infectious diseases pandemic, encompasses a multifaceted approach.²³ This includes addressing shortages in key components of the health care workforce and expanding the functionality of the existing healthcare workforce, with cross-training of health care personnel to adapt to changing needs during a pandemic. Strengthening relationships

and collaboration between communities, state and local public health departments, and the health care settings they serve will be critical in creating a robust response. In addition, during the COVID-19 pandemic, telemedicine and the remote delivery of health care provided an additional opportunity for the healthcare workforce to adapt and mitigate health care staffing shortages, and opportunities to transition to and support remote methods for health care.²¹

SUPPORTING AND MAINTAINING CLINICAL CARE: INPATIENT, AMBULATORY, AND PREVENTATIVE SERVICES DURING A PANDEMIC

Early during the COVID-19 pandemic, a rapid decline in clinical care across multiple services, both elective and nonelective, occurred. The decrease in utilization led to delays in care for both acute and chronic conditions, and access to preventative care services with subsequent downstream effects of increasing advanced or terminal disease states. A pandemic poses unique challenges in the delivery of patient care to ensure both patient and health care personnel safety with continued ongoing access to care. Facility leadership alongside the HE and infection preventionist team can collaborate to develop protocols and procedures to help maintain ongoing clinical activities while providing and upholding safe work environments during times of pandemic medical surge.^{24–26}

The concept of medical surge is the basis of pandemic preparedness planning. During times of markedly increased patient volumes, surge capacity refers to the ability to care for those patients when normal operating capacity has been exceeded. The US Department of Health and Human Services outlined public health principles and guidelines addressing medical surge capacity and capability.²⁷ The distinction separating capability from capacity is that of having the ability to care for patients that require specialized medical evaluation and care. Maintaining inpatient clinical services at a health care facility during crisis requires sufficient hospital beds, staffing, pharmaceuticals, medical supplies, and equipment to provide the appropriate care needed for patients. Adaptability to the number of patients and infectious risk of the organism also plays a part in determining medical surge planning. For example, expanding hospital beds to outside of the critical care unit or medical ward into areas such as perioperative or operating rooms was done during the COVID-19 pandemic in numerous facilities.^{28,29} With the use of uncommon areas for patient care, it is important to note that additional education with specialized training may be required for staff that are not typically responsible for caring for critically ill patients.

Interdisciplinary collaborations among all disciplines can help to alleviate some of the complexity of a pandemic caused by a novel organism. Although physical space for patients is a requirement during a pandemic to provide medical care, maintaining sufficient qualified health care personnel is just as important. Staffing volumes may require rapid expansion, which typically requires redeploying staff to an area of less experience. Nursing redeployment during the COVID-19 pandemic typically required the move from nonintensive care units to intensive care units. Nursing personnel were one of the more common disciplines redeployed and unfortunately did contribute to high degrees of burnout and risk of psychological harm. Strategies during redeployment should focus on supporting education, role transition, and ongoing competency, but also prevention of burnout and management of staff wellness.³⁰ Redeploying clinical pharmacy staff to work with clinical teams in different settings can be used to proactively assess and optimize pharmacotherapeutics, especially considering newly developed agents with need for ongoing guidance updates.³¹

During a pandemic, the focus for clinical care typically pivots to a surge of patients requiring hospitalization; however, health systems need to also prepare and allow for

the continuation of ambulatory care and preventative services. Deferring care for chronic illness or routine preventative services, such as cancer screening, can lead to the risk of collateral damage with loss of contact with vulnerable groups (elderly, homeless population, pregnant women, and young children).³² With a surge of patients in the hospital, ambulatory care can be used to offload the emergency department (ED) and urgent care settings by treating those with mild to moderate infectious symptoms. The use of telehealth medicine allowed for ongoing continued care in the ambulatory setting, and the technology was leveraged to deliver a variety of services. During the COVID-19 pandemic, institutions with little experience in telehealth were still able to successfully transition to using this technology and perform billable visits using this platform.^{33,34} Routine follow-ups and urgent visits for noninfectious complaints could shift to telehealth visits. More recently, however, the US Department of Health and Human Services has only extended telehealth access options for nonbehavioral/mental health care through September 30, 2025.³⁵

Using primary care as the first line of defense against a pandemic can help reinforce public health messages, manage patient care at home, and recognize those patients who require hospitalization or increased levels of care. Although primary care offices shifted to utilization of virtual care, they also stayed connected with their patients by leveraging the use of registries to identify and reach out to those at higher risk for infection. It allowed outreach to those most vulnerable and those with poorly controlled chronic conditions.³⁶ Increased acute care visits, screening, and diagnostic testing occurred with the implementation of COVID-19 drive-through settings. The use of outdoor locations and distancing ensured increased additional safety for patients and staff by preventing respiratory viral transmission, especially during respiratory specimen collection.³⁷

Offloading the burden of patient surge on the ED can sometimes include deploying outpatient staff from a clinic setting to the ED to provide care for noninfectious emergencies within their specialized field. This may include family and internal medicine physicians as well as advanced practice providers to offload the lower-acuity workload as needed, especially in times of need for surge staffing or filling in for health care providers who are unable to work owing to illness. Surgical specialty physicians may be another pool of providers to use during a pandemic because elective procedures would likely cease for a time or decrease substantially.³⁸

The use of virtual platforms, outdoor screening and testing, along with redeployment efforts is vital to deliver care during a pandemic; however, safety procedures to deliver care in-person are also crucial. Ambulatory offices are sometimes not equipped to safely provide care to allow for separate entrances and exits for patients, sufficient physical space, or even proper ventilation systems.³⁹ To prepare for the next pandemic, outpatient offices must give thought to modifications of both physical space and their workflow in caring for an influx of patients.

EFFECTIVE COMMUNICATION DURING A PANDEMIC—THE ROLE OF HEALTH CARE EPIDEMIOLOGISTS AND INFECTION PREVENTIONISTS

HEs and infection prevention experts frequently have critical roles in communicating to the public during an infectious diseases–related event or outbreak based on valued expertise.⁴⁰ This communication most frequently involves synthesis of guidance from public health and government authorities, incorporating local epidemiology and resources, which may evolve in real time. Communication during a pandemic entails reaching multiple different internal audiences and stakeholders, including those within the health care facility and system, including institutional leadership, health care

personnel, and patients and visitors. Internal communication within a health care facility or system during an infectious diseases event makes health care personnel aware of the situation and provides guidance on how to provide clinical care while protecting themselves from the threat of infectious disease. A centralized stream of communication within the facility can ensure that stakeholders have a consistent source of information. Creating a living document or Web page that is frequently updated with protocols and procedures for staff to use as a daily resource is a way to have all important information that health care workers will reference in a centralized location.³⁸

Effective communication is a critical and fundamental component of pandemic preparedness and response. Communication should be grounded in the science of epidemiology and microbiology, incorporating reliable data as they become available. The Centers for Disease Control and Prevention Crises and Emergency Risk (CERC) framework provides a strategy to promote timely, accurate, and transparent communication fostering trust and promoting active public health response (Table 1).⁴¹ CERC provides an approach that supports ongoing and escalating communication throughout all stages of an event or crisis. Supporting health care epidemiology and infection prevention leadership through providing formal media training, including the CERC framework, can help bolster pandemic response.

During the COVID-19 pandemic, information was communicated to the public through a diverse array of media outlets, including sources that were not traditionally

Table 1 Crisis and emergency response communication—principles and potential pitfalls	
Six Principles of CERC	Potential Pitfalls to Avoid
1. Be First: Crises are time-sensitive. Communicating information quickly is crucial. For members of the public, the first source of information often becomes the preferred source	Mixed messages from multiple experts
2. Be Right: Accuracy establishes credibility. Information can include what is known, what is not known, and what is being done to fill in the gaps	Information released late
3. Be Credible: Honesty and truthfulness should not be compromised during crises	Paternalistic attitudes
4. Express Empathy: Crises create harm, and the suffering should be acknowledged in words. Addressing what people are feeling, and the challenges they face, builds trust and rapport	Not countering rumors and myths in real-time
5. Promote Action: Giving people meaningful things to do calms anxiety, helps restore order, and promotes some sense of control	Public power struggles and confusion
6. Show Respect: Respectful communication is particularly important when people feel vulnerable. Respectful communication promotes cooperation and rapport	

Adapted from Office of Public Health Preparedness and Response (OPHPR). Crisis & Emergency Risk Communication (CERC). Centers for Disease Control and Prevention website. https://www.cdc.gov/cerc/media/pdfs/CERC_Introduction.pdf. Accessed November, 2025.

considered means of communicating infection prevention-related health data and guidance. In many circumstances, inaccurate or misleading data resulted in policy and guidance that had negative downstream consequences, including inconsistent recommendations and guidance, which led to public mistrust.⁴² Different approaches using media communication strategies to overcome challenges associated with inaccurate information have been proposed.⁴³ Addressing inaccurate or misleading information focusing on infection prevention requires collaboration between individuals with content expertise and those with expertise and experience in media communications, including digital and social media. Proactive development and fostering of these relationships can help strengthen communications and support consistency in the development of guidance during an evolving infectious diseases threat.

The mobilization and support of expertise is a critical component of supporting communication in the setting of a pandemic. In the dynamic setting of evolving scientific knowledge resulting in rapidly changing clinical and public health guidelines, groups of individuals with established expertise in infectious diseases and epidemiology have a critical role in reviewing published, and sometimes unpublished, data and formulating best practices and recommendations.⁴⁴ These have generally consisted of groups of experts in medical and public health professional societies and government agencies focused on public health. These groups are needed to formulate and support external communications, particularly as evidence evolves over time. In pandemic preparedness, ensuring the establishment and support of groups with expertise in infectious diseases, public health, and public policy is needed to ensure that communications are adequately supported.

PRESERVING AND CONDUCTING CLINICAL AND PUBLIC HEALTH RESEARCH DURING A PANDEMIC

Dynamic circumstances during a pandemic present unique challenges in conducting research in order to guide clinical and public health practice and policy. Experiences during the COVID-19 pandemic reflected successes and challenges in conducting clinical and public health research activities during the pandemic. Clinical care guidelines and public health policies were designed based on limited and evolving science about the pathogen and proposed countermeasures. Forecasting also became a challenge in the absence of a coordinated, dynamic data collection and surveillance system, which could be readily adapted to changing conditions.⁴⁵

Despite challenging conditions, several clinical research endeavors were successful in supporting COVID-19 research through multicenter collaborations. Two examples include the SOLIDARITY trial conducted by World Health Organization with investigators in 35 countries⁴⁶ and the RECOVERY trial, which was eventually expanded to include several countries across 3 continents to study treatments that may be beneficial to patients with COVID-19 pneumonia.⁴⁷ These collaborative efforts highlight successes in the relatively rapid deployment of multicenter clinical trials in the setting of a pandemic.

There were many challenges in conducting clinical and public health research during the COVID-19 pandemic. These included, but were not limited to, risk of infection and increased workload among research staff, ethical challenges and fears of poor health outcomes among research participants, and challenges with conducting research practices while reducing the risk of infection transmission to participants.⁴⁸ In addition, challenges arise in shifting funding priorities from supporting research toward the provision of clinical care and support of public health infrastructure. This shift, along with patient care demands, resulted in the reassignment of researchers

and research support staff into clinical care roles, away from prepandemic research activities.⁴⁹

Administrative challenges in the conduct of clinical and public health research also arose during the pandemic, including siloed research and the lack of streamlining processes in protocol review and approval, collaborative documentation, and coordination of research activities across hospitals and institutions.^{50,51} The utility of a centralized, national data collection system has been well described⁵² and has been proposed as a critical component of pandemic preparedness. Such a system should balance speed, accuracy, reliability, transparency, and feasibility while ensuring security of data collected. This would include a system that supports rapid deidentification of data sets and includes both qualitative and quantitative data collection. The data systems should be readily accessible by researchers and support data sharing and collaboration between researchers while maintaining subject confidentiality. The prioritization of ensuring an adaptable, sustainable, and adequately supported research infrastructure remains an important part of pandemic preparedness at the local, national, and international levels.

ETHICAL CHALLENGES AND DILEMMAS

Scarcity of resources is a significant ethical issue when dealing with a pandemic. It is not uncommon for certain elements of health care to be stretched beyond capacity, leading to the need to make difficult decisions. Early during the COVID-19 pandemic, testing allocation required thoughtful consideration given shortage of supply.⁵³ The resultant burden of disease and critical illness that a pandemic may bring can outpace the availability of resources, including hospital beds and ventilators, diagnostic, or therapeutic interventions, and health care workforce themselves. Shifting the ethical framework of a hospital from individual patient benefit toward one of working to maximize benefit with the use of limited resources is a necessary component in pandemic preparedness planning.^{54,55} It can certainly be problematic and difficult to maximize public health benefits when that may require taking into consideration the scarcity of therapeutic treatments or life-saving measures, such as a ventilator. Making these determinations brings up not only ethical and legal considerations but also emotional and likely traumatic experiences for all health care workers involved. It is important for hospitals to create and use an ethical framework during times of pandemic-associated scarcity. This may involve rationing limited resources in a manner to maximize benefit, while treating people equally.⁵⁶ The use of clear and consistent protocols for use of limited resources should be drafted well before any pandemic, which will alleviate some of the difficult decisions physicians may have to make when offering life-saving measures. Ultimately, a team with training and expertise in ethics, legal matters, and palliative care should be involved during some of the most critical and ethical decision making that may be required during times of crisis.⁵⁶

SUPPORTING MENTAL HEALTH AND WELLNESS

Healthcare facilities not only need to prepare for the possibility of a pandemic but also require thoughtful preparation for the support that health care workers will need due to the physical and psychological risk that comes with a pandemic. During a pandemic, the task of healthcare workers typically involves putting themselves in harm's way or transitioning out of their normal role to one that may be able to either directly or indirectly help during times of staffing crisis. To prevent burnout, the goal of hospital leadership should focus on prevention of emotional distress and mitigation of causative factors. It is key to promote and support the emotional well-being of

healthcare workers to preserve resilience and maintain ongoing stable health care services.⁵⁷

Strong hospital leadership support can include adequate staffing as well as financial support to help not only prevent burnout but also increase the perception of psychological safety. Departments such as infection prevention were front and center during the COVID-19 pandemic. Not only were they tasked with their normal day-to-day duties but also were forced to deal with the acuity of pandemic-related predicaments. Fostering a culture of open communication and providing tools in which staff feel prepared to face all challenges can decrease the likelihood of mental health crisis.⁵⁸ Stress and burnout can manifest in a variety of manners and may depend on the degree of moral or psychological injury. Enhancing mental health care for frontline medical staff should initially focus on the essential needs of rest and safety. Interventions aimed at bringing staff together for counseling or debrief sessions may allow an outlet for emotions during stressful periods and identifying additional resources that may be useful.⁵⁹

SUMMARY

Emerging and reemerging infectious pathogens are a real threat to the occurrence of future pandemics.⁶⁰ Despite emergency preparedness protocols in place, the COVID-19 pandemic unveiled the fact that many healthcare facilities were indeed unprepared to optimally respond. Reasons such as climate change, inappropriate antibiotic utilization, animal exposure, and the interrelatedness of the world will lead to increasing appearance of novel pathogens to humans with the potential to create a future pandemic. Learning from prior experiences is critical to remain better prepared for another pandemic so that delivery of high-quality patient care continues while maintaining the well-being and safety of the healthcare workforce.

CLINICS CARE POINTS

- Preparation for future pandemics in health care facilities requires an Emergency Management program with rapid coordination and communication through the Hospital Incident Command System.
- Staffing and space utilization planning should be a focal point to allow the continued provision of routine inpatient and ambulatory care during a surge of patients.
- Scarcity of resources poses ethical challenges when trying to maximize public health benefit.

DISCLOSURES

The authors declare that they have no relevant disclosures pertinent to this article.

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