



**ERIE COUNTY DEPARTMENT OF HEALTH
PANDEMIC INFLUENZA PREPAREDNESS AND
RESPONSE PLAN**

(January 2006)

NOTE: This plan is being released with the understanding that some of the supporting plans and guidelines from other organizations are still in draft form (i.e. Pennsylvania Department of Health Pandemic Plan has not been released for publication as of January 2006). Other changes are being made at the local, state, and federal levels by health, public safety, and first responders as the US gears up for a possible pandemic. Questions and comments can be addressed to Rich Knecht, Director, Public Health Preparedness, Erie County Department of Health, 814-451-7867/rknecht@ecdh.org.

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ACRONYMS

ACIP	Advisory Committee on Immunization Practices
BEDP	Bureau of Epidemiology and Disease Prevention
CDC	Centers for Disease Control and Prevention
CERC	Crisis/Emergency Risk Communications
DOH	Division of Health
DMORT	Disaster Mortuary Operations Response Team
ECDH	Erie County Department of Health
EIS	Epidemic Intelligence Service
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESF	Emergency Support Function
ESS	Epidemiological Services Section
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FRED	Facilities Resource Emergency Database
HAN	Health Alert Network
ICP	Infection Control Professional
ICS	Incident Command System
ILI	Influenza-like illness
IND	Investigational New Drug
JIC	Joint Information Center
LHD	Local Health Department
LIN	Laboratory Information Network
LRN	Laboratory Response Network
NIMS	National Incident Management System
NRP	National Response Plan
NREVSS	National Respiratory and Enteric Virus Surveillance System
OIE	World Organization for Animal Health
OLRH	Office of Local and Rural Health
PHIX	Public Health Information Exchange
PIO	Public Information Officer
PPE	Personal Protective Equipment
RCTTF	Regional Counterterrorism Task Force
SEOC	State Emergency Operations Center
SNS	Strategic National Stockpile
VAERS	Vaccine Adverse Events Reporting System
VIS	Vaccine Information Statement
VOAD	Voluntary Organizations Active in Disasters
WHO	World Health Organization

GLOSSARY

Characterization	Identification of the strain of an influenza virus such as A/Panama
DMORT	A coordinated effort of forensic experts and mortuary personnel to effectively handle a mass fatality disaster
Endemic	A disease that is continually present in a community or a region
Enzootic	Affecting or peculiar to animals of a specific geographic area.
Epidemic	The occurrence of a disease in a community or region clearly in excess of normal expectations
Epizootic	Affecting a large number of animals at the same time within a particular region or geographic area.
Health Alert Network	An Internet based program used to communicate health and emergency messages
Influenza-like illness (ILI)	The presence of fever >100° F, with a cough and/or sore throat
JIC	A central location for involved agencies to coordinate public information activities and a forum for news media representatives to receive disaster or emergency information
Novel virus	A virus rarely, or not previously known to infect humans
Pandemic	The occurrence of a disease in excess of normal expectations in extensive regions, countries and continents
Strategic National Stockpile (SNS)	A federal cache of medical supplies and equipment to be used in emergency and disaster situations
Subtype	Identification of influenza A viruses according to the hemagglutinin (H) and neuraminidase (N) components of the virus, such as H1N1 or H3N2
Surveillance	The collection, analysis and dissemination of data
Syndromic	Occurring as part of a complex of signs and symptoms suggesting the existence of an undesirable condition or disease

INTRODUCTION

Influenza viruses are unique in their ability to cause sudden illness among humans in all age groups on a global scale. The importance of influenza viruses as biologic threats is due to a number of factors including the high degree of transmissibility, the presence of a vast reservoir of novel variants (primarily aquatic birds), and the unusual properties of the viral genome. The infamous “Spanish flu” of 1918-19 was responsible for more than 20 million deaths worldwide, primarily among young adults. Mortality rates associated with recent pandemics of 1957 and 1968 were reduced in part by the use of antibiotic therapy for secondary bacterial infections and aggressive supportive care of infected patients. However, these later pandemics were associated with high rates of morbidity and social disruption. The Centers for Disease Control and Prevention (CDC) estimates the economic loss associated with the next pandemic will be in the billions of dollars.

Experts agree, an influenza pandemic is inevitable. To prepare for the next pandemic, the Erie County Department of Health (ECDH), in cooperation with state and local organizations and partners, has developed this ECDH Pandemic Influenza Preparedness and Response Plan which provides an overview of strategies to reduce pandemic influenza-related morbidity, mortality, and social disruption in the county.

Influenza Background

Influenza is an illness caused by viruses that infect the respiratory tract of humans. Signs and symptoms of influenza infection include rapid onset of high fever, chills, sore throat, runny nose, severe headache, nonproductive cough, and intense body aches followed by extreme fatigue. Influenza is a highly contagious illness and can be spread easily from one person to another. It is spread through contact with droplets from the nose and throat of an infected person during coughing and sneezing. The period between exposure to the virus and the onset of illness is usually one to five days. Influenza is not an endemic disease, but in the Northern Hemisphere annual epidemics usually occur from December to April.

There are two types of influenza viruses which cause significant disease in humans: type A and type B. Influenza A viruses are composed of two major antigenic structures essential to the production of influenza vaccines and the induction of immunity: hemagglutinin (H) and neuraminidase (N). These two components define the virus subtype. Influenza A viruses are unique because they can infect both humans and animals and are usually associated with more severe illness than type B influenza viruses. Most influenza A viruses are considered to be avian in origin. Worldwide avian influenza control efforts are coordinated by the World Organization for Animal Health (OIE).

Influenza viruses mutate frequently resulting in an antigenic drift or a shift. Antigenic drift is a minor change caused by mutation that results in the emergence of a new strain within a subtype. Drifts can occur in both type A and B influenza viruses. Antigenic shift is a major change caused by genetic recombination that results in the emergence of a novel virus strain that has not previously infected humans. Antigenic shifts occur only in influenza type A viruses; these changes can lead to an influenza pandemic.

Pandemic Influenza

Pandemic influenza is a unique public health emergency. No one knows when the next influenza pandemic will occur. However, when it does occur it will be with little warning. Since the novel virus may be identified in any region of the world, experts believe that we will have between one to six months from the identification of a novel influenza virus to the time that widespread outbreaks begin to occur in the United States. Outbreaks are expected to occur simultaneously throughout much of the nation, preventing reallocation of human and material resources.

An influenza pandemic will occur in multiple waves. The effect of the initial wave on individual communities will be relatively prolonged (as long as six to eight weeks) when compared to the minutes-to-hours observed in most natural disasters. Due to the prolonged nature of a pandemic influenza event, the World Health Organization (WHO) and the CDC have defined phases of a pandemic in order to facilitate coordinated plans (Appendix A). Phase determination in the United States will be the responsibility of the WHO and the CDC.

The following are assumptions that provide a basis for preparedness activities pertaining to pandemic influenza:

- Influenza pandemics are expected, but unpredictable and arrive with very little warning.
- Outbreaks can be expected to occur simultaneously throughout much of the U.S., preventing shifts in human and material resources that usually occur in the response to other disasters.
 - Localities should be prepared to rely on their own resources to respond.
 - As with many public health emergencies the effect of influenza on individual communities will be relatively prolonged (weeks to months) in comparison with other types of disasters.
- Because of the high degree of infectiousness of pandemic influenza, the number of persons affected in the US will be high, it is estimated that:
 - Up to 200 million persons will become infected
 - Between 38 million and 89 million will be clinically ill
 - Between 18 million and 42 million will require outpatient care
 - Between 314,000 and 733,000 will require hospitalization
 - Between 89,000 and 207,000 will die
- In the county of Erie it is estimated that:
 - Between 60,000 to 80,000 persons will require outpatient care
 - Between 4,000 to 6,000 require hospitalization
 - Between 1,000 to 3,000 individuals will die
- Health care workers and other first responders may be at higher risk of exposure and illness than the general population, further straining the health care system.
- Effective prevention and therapeutic measures, including vaccine and antiviral agents, will be delayed and in short supply.
- Widespread illness in the community could increase the likelihood of sudden and potentially significant shortages of personnel in other sectors that provide critical public safety services.

Federal Roles in Pandemic Influenza Preparedness and Response

- Surveillance in the U.S. and globally.
- Epidemiological investigation in the U.S. and globally.

- Development and use of diagnostic laboratory tests and reagents.
- Development of reference strains and reagents for vaccines.
- Vaccine evaluation and licensure.
- Determination of populations at highest risk and strategies for vaccination and antiviral use.
- Assessment of measures to decrease transmission (such as travel restrictions, isolation and quarantine).
- Deployment of federally purchased vaccine.
- Deployment of antiviral agents in the Strategic National Stockpile.
- Evaluation of the efficacy of response measures.
- Deployment of the Commissioned Corps Readiness Force and Epidemic Intelligence Service officers.
- Medical and public health communications.

State Roles in Pandemic Influenza Preparedness and Response

- Identification of public and private sector partners needed for effective planning and response.
- Development of key components of the pandemic influenza preparedness plan; surveillance, distribution of vaccine and antivirals, and communications.
- Integration of pandemic influenza planning with other planning activities conducted at the state and local levels.
- Coordination with local areas to ensure development of local plans as called for by the state plan and provision of resources, such as templates to assist in the planning process.
- Development of data management systems needed to implement components of the plan.
- Assistance to local areas in exercising plans.
- Participation with local areas in exercising their plans.
- Coordination with adjoining jurisdictions.
- Training state staff on roles and responsibilities identified in this plan.

Local Roles in Pandemic Influenza Preparedness and Response

- Identification of public and private sector partners needed for effective planning and response.
- Coordination with adjoining jurisdictions.
- Maintain and exercise the ESF 8 component of the Local Response Plan and the SNS Standard Operating Guide.
- Continue to emphasize annual influenza vaccine and the use of pneumococcal vaccine during the preparation phases of the pandemic.
- Identify priority groups for vaccination.
- Develop a system to estimate the number of persons in priority groups for vaccination.
- Assure the security of influenza vaccine during storage and delivery when it becomes available. Planning for civil unrest due to pandemic should also be considered.
- Ensure coordination with local emergency management coordinators, hospitals, and special populations in their area.
- Maintain media relations at the local JIC.
- Maintain a 24/7 contact list of key health department staff, local partners, and the media.

Organization of the ECDH Pandemic Influenza Preparedness and Response Plan

This plan was developed using the CDC Planning Guide for State and Local Officials (Draft), which was based on the WHO planning phases that were defined in 1999. The ECDH plan is organized according to the World Health Organization's Pandemic Phases (2005). The following functions are described in each applicable phase: Establish Command, Control, and Management Procedures, Surveillance, Communication, Vaccine Delivery, Emergency Response, and Antivirals.

The World Health Organization recently released the "WHO global influenza preparedness plan" which redefines the phases that were identified in 1999. It is expected that the CDC will also revise the national plan and issue new planning guidance to states in the coming months. The ECDH Pandemic Influenza Preparedness and Response Plan must be considered a "living document" that will be updated when new information and guidelines from the WHO or CDC are available. At any time during the stages, the activities may also be changed or cancelled by the Bioterrorism Medical Director or the Incident Commander.

All state and local governments are required to have an emergency management plan, which addresses all hazards. However, pandemic influenza is likely to pose unique challenges that may not be addressed in current emergency management plans. Because of these challenges that will arise, emergency management plans will incorporate the pandemic influenza elements in the health and medical annexes. Some of the relevant issues that must be addressed in these plans include:

- Medical services and healthcare workers may be overwhelmed during the influenza pandemic.
- Healthcare workers may not be able to provide essential care to all patients in need.
- Unlike the typical disaster, because of increased exposure to the virus, essential community services personnel such as healthcare personnel, police, firefighters, emergency medical technologists, and other first responders, may be more likely to be affected by influenza than the general public.
- Unlike typical natural disasters, during which critical components of the physical infrastructure may be threatened or destroyed, an influenza pandemic may also pose significant threats to the human infrastructure responsible for critical community services. This threat will be due in part to widespread absenteeism in the workforce. Significant decreases in the workforce could impact distribution of food, home meal deliveries, day care, garbage collection and other critical services.
- Work with veterinary and other animal health partners in veterinary components of pandemic planning and response.

The PHP Staff is currently developing local Standard Operating Guides (SOG's) that contain the details regarding how the various plans will be carried out. These details include: contact lists for partner organizations and resource owners, step-by-step operational procedures, Job Action Sheets for key staff, and notification procedures. RCTTFs are currently completing the Strategic National Stockpile SOG, which describes how mass-vaccination and pharmaceutical dispensing clinics will be conducted. Most of the critical pandemic influenza functions are described in these SOG's. Future SOG's that will be completed include: information management, disease investigation, and quarantine.

Interpandemic Period - Phase 1

No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.

Interpandemic Period - Phase 2

No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.

The distinction between phase 1 and 2 is based on the risk of human infection or disease resulting from circulating strains in animals. The distinction depends on various factors and their relative importance according to current scientific knowledge. Factors may include: pathogenicity of the virus in animals and humans; occurrence of influenza in domesticated animals and livestock or only in wildlife; whether the virus is enzootic or epizootic, geographically localized or widespread; other information from the viral genome; and/or other scientific information.

ESTABLISH COMMAND, CONTROL, AND MANAGEMENT PROCEDURES

ECDH has adopted the Incident Command System and the National Incident Management System (NIMS) for responding to disasters and emergencies (Executive Order 05-03). The NIMS was published in March 2004 and the National Response Plan (NRP) became finalized in December 2004. State and local agencies are revising plans to include NIMS-compliant activities and to align with the NRP. This is a challenging process that requires cross-agency and cross-jurisdictional coordination in order to be successful.

The ECDH will use the Medical and Health Incident Management System (MaHIMS) to organize the response to public health and medical emergencies in Erie County. Throughout this plan Incident Command titles are used to identify roles and responsibilities for responding to a pandemic influenza event. Day-to-day position titles are used in the preparation phases of the plan to clearly indicate planning responsibilities.

The Health Department Director will lead the local response to pandemic influenza or any other contagious disease emergency in Erie County.

SURVEILLANCE

Influenza viruses have constantly changing antigenic properties. Surveillance for pandemic influenza must include both virologic surveillance, in which influenza viruses are isolated for antigenic and genetic analysis, and disease surveillance, in which the epidemiologic features and clinical impact of new variants are assessed. The goals of influenza surveillance are to detect the earliest appearance of a novel influenza virus in Erie County and to describe the epidemiologic features of novel virus circulation.

Since most influenza A viruses are avian in origin it is essential that ECDH works with PA Dept. of Agriculture and the United States Department of Agriculture in monitoring circulating animal viruses,

especially highly pathogenic avian influenza.

Virologic Surveillance: Each week, approximately 75 U.S. collaborating laboratories that are part of the World Health Organization's Influenza Surveillance Network and 50 National Respiratory and Enteric Virus Surveillance System laboratories report the number of clinical specimens tested for influenza and the number of positive results by virus type (A or B) and subtype (A/H1, A/H3N2 or not subtyped).

Surveillance for influenza-like illness (ILI): Approximately 1,100 sentinel health care providers/clinics located in 50 states regularly report the number of patient visits for ILI by age group and the total number of patient visits each week during the normal influenza season.

Surveillance for influenza and pneumonia deaths: The Vital Statistics Offices of 122 U.S. cities report each week the percentage of total deaths that may be influenza-related.

State and territorial epidemiologists assess influenza activity levels in their respective states each week and reports it as "widespread", "regional", "local", "sporadic" or "no activity."

During the Inter-Pandemic Phase PADOH will maintain Pennsylvania's' current influenza surveillance activities, which include:

- A state public health laboratory that:
 - Isolates and subtypes influenza viruses during the influenza season
 - Maintains the capability of isolating and sub-typing influenza viruses year-round, and reports these data weekly to CDC.
 - Continues to perform viral culture in the face of increasing use of rapid influenza diagnostic tests and PCR tests.
 - Is transmitting their influenza data (positives and negatives) electronically to CDC via the Public Health Laboratory Information System.
 - Is actively involved in contingency planning for surge capacity (staffing and reporting) and safety issues
- An influenza sentinel provider program with at least the minimum number of health care providers (1 per 250,000 persons or a minimum of 10 providers in states with smaller populations) that report their weekly data to CDC via the Internet year-round. These providers are encouraged to send specimens collected from patients with ILI at the beginning, middle, and end of the normal season to the state laboratory for viral culture at no charge to the provider or patient.
- An active state Influenza Surveillance Coordinator who:
 - Monitors sentinel provider data weekly for completeness and/or errors.
 - Provides feedback and maintains contact with sentinel providers weekly to encourage reporting and follow-up on unusual reports.
 - Contributes to state pandemic planning issues and activities.
 - Maintains a strong working relationship with the ECDH.
 - Encourages sentinel providers to submit specimens for viral culture to the state laboratory.
 - Conducts a weekly assessment of overall influenza activity level in the state during the normal flu season and reports the data to the CDC.

The ECDH is working with the Erie County Emergency Management Agency to implement the FRED system to manage information and resource requests. Enhancements to the current system include collecting the following local data:

- Available (or needed) staffed beds (specifies adult or pediatric):
 - ICU/CCU beds
 - Medical beds
 - Emergency Department (monitored and unmonitored)
- Available or needed number of ventilators
- Available or needed negative-pressure air isolation rooms
- Number of cases (confirmed, suspect, probable)
- Number of cases under investigation
- Number of contacts under investigation
- Number of investigators
- Number of needed investigators
- Number of deceased individuals that met case definitions
- Number of individuals discharged that met case definition
- Number of individuals hospitalized that currently meet case definition
- Number of health care professionals affected
- Morgue capacity
- Available or needed medical supplies, equipment, and personal isolation equipment
- Number of hospitals on Emergency Department Diversion
- Number of patients waiting for inpatient beds (to include average wait time)

The electronic screens used to collect this data will be based on forms that will be available in paper format if the Internet based system fails.

EMERGENCY RESPONSE

Emergency response, including maintenance of critical services and surge capacity issues in the health care system, is addressed in the State and Local Response Plans and internal Standard Operating Guides (SOG's). This plan will not duplicate that planning process.

There are 4 community hospitals in Erie County and the staffed beds in these facilities range from 55 to 450. The average daily census indicates that there are 1,000 available beds in the county on any given day. It is estimated that during a pandemic influenza event approximately 3,500 beds to 5,500 beds would be needed to provide care for influenza victims.

Hospitals in Erie County are currently reviewing a Shared Resources Agreement to prepare for an increase in acutely ill patients, which may occur during a public health emergency. Some of the facets of the agreement:

- Hospitals in the county will cancel non-emergency surgeries and other elective procedures.
- Discharge non-infected patients to other acute care facilities out of the affected geographical area, or to long-term care or home care while assuring that the level of care required by these patients can be met.
- Transfer patients to other hospitals in the region with available beds. Hospitals may need to send patients to several other hospitals (not all patients to one facility), depending on bed availability. Hospitals will start by transferring patients to hospitals in the counties nearest to their own county, then to other hospitals in the region.
- If all hospital beds in the region are at capacity, then hospitals will transfer patients to

hospitals in other regions.

- Finally, if hospitals in other regions are full, the hospital will send patients to alternate locations based upon their partnerships (Long Term Care (LTC) Facilities, schools, etc.).

The RCTTF is identifying overflow locations which may be used for inpatient or outpatient care. Establishing health care facilities in nontraditional sites is a significant task that requires that staffing, equipment, infection control, legal, and other issues be addressed.

Home health care agencies will play an important role, given the potentially high number of ill persons. In the event of a pandemic, the quality of material care (such as nursing, ventilators, nutrition, and hydration) will deteriorate. Family members will be expected and needed to provide care to family members that are unable to be hospitalized. Instructions for home (family) care can be found in Appendix A.

An influenza pandemic may pose significant threats to the human infrastructure responsible for critical community services due to widespread absenteeism and exhaustion in the workforce. Examples of such services (and personnel) in non-health sectors might include highly specialized workers in the public safety, utility, transportation and food service industries, and will likely vary from jurisdiction to jurisdiction. The CDC has formed a work group to further define the possible priority groups that should receive prophylaxis. Once these groups are identified, the ECDH will consult with stakeholders to adapt the CDC recommendations to Erie. Current priority group recommendations, used for pharmaceutical caches, can be found in Appendix C.

Emergency Response Activities during the Inter-Pandemic Phase include:

- Identifying issues specific to pandemic influenza
- Meeting with Public Health Preparedness staff and other emergency planners
- Ensuring that specific challenges posed by an influenza pandemic are addressed in emergency response plans
- Reviewing pertinent legal authorities including:
 - Isolation and quarantine laws
 - Laws and procedures for closing businesses or schools and suspending public meetings during a declared state of emergency
 - Medical volunteer licensure and liability
 - Compensation laws for in state, out of state, and returning retired medical and non-medical volunteers.

COMMUNICATIONS

In an emergency, accurate, consistent and timely messages are key in notifying and educating the public, notifying and facilitating movement of emergency staff to their assigned duties and stations, and in activating the emergency plan as intended. The following delineates communication-related issues that pertain to pandemic influenza:

- Assuring adequate communication systems will be a joint responsibility of federal, state and local agencies.
- During a pandemic the public will likely encounter some unreliable and possibly false information in the media and on the Internet. ECDH will communicate accurate, reliable information regarding the influenza pandemic.
- Mechanisms for communication with the public will vary depending on the phase of the pandemic and its impact on communities.

- ECDH will continually strive to communicate with all essential partners realizing that this will be difficult during the pandemic.

CDC will make a number of materials available before and during an influenza pandemic, including:

- Basic communication materials (such as question and answer sheets and fact sheets) on influenza, influenza vaccine, anti-viral agents, and other relevant topics in various languages.
- General preventive measures such as “do’s and don’ts” for the general public.
- Information and guidelines for health care providers.
- Training modules (Web-based, printed, and video).
- Presentations, slide sets, videos, and documentaries.
- Symposia on surveillance, treatment and prophylaxis.

Because of anticipated shortages of both vaccine and antivirals, planning messages to inform the population about availability, as well as addressing the rationale for priority groups and measures to be taken until such are available will be critical. Other important topics include:

- Basic information about influenza (including symptoms and transmission)
- Information about the course of the pandemic (contagiousness, geographic spread, case counts)
- Information about which symptoms should prompt seeking medical attention and which symptoms should be managed at home
- Information about school and business closures and suspended public meetings
- Information about travel restrictions as well as isolation and quarantine laws.

ECDH will:

- Maintain the Relay FAX to effectively communicate with public health officials, healthcare professionals and other target audiences.
- Establish lines of communication and define ECDH staff roles and responsibilities clearly to facilitate the best possible communication with partners.
- Exercise the Crisis Communications plan.
- Regularly distribute informational updates to all appropriate partners.
- Maintain the list of media spokespersons and contact information from each state agency and the local hospitals.
- Coordinate with the Pennsylvania Emergency Management Agency to provide information to the media via the state Emergency Operations Center/Joint Public Information Center when activated.
- Regularly update and maintain the ECDH Web site with information.
- Develop materials and messages regarding pandemic flu.
- Plan responses to anticipated questions.
- Educate public health officials, elected officials, and the media about what information will and will not be available during a pandemic.
- Review CDC materials and adapt and revise as needed.

VACCINE DELIVERY

Vaccine administration is likely to serve as an important preventive strategy during the next influenza pandemic. Unlike annual production of influenza vaccine, wherein strains are selected in the spring,

leading to vaccine distribution in the late summer, a pandemic strain could be detected at any time. Current manufacturing procedures require six to eight months before large amounts of vaccine are available for distribution.

Contrasts between delivery of pandemic vaccine and the annual influenza vaccine include the following:

- The target population will be modified, possibly to include the entire U.S. population.
- It is impossible to predict how quickly the novel virus would arrive in the U.S. Because of the six to eight month period to produce a vaccine, it is anticipated that demand for vaccine will be greater than the supply early in the course of the pandemic. It is also possible that no vaccine will be available.
- Once vaccine is available, it will need to be distributed as quickly as possible
- Immunologic responses following initial vaccination of serologically negative individuals is poor and represents a priming of the immune system. The emergence of a pandemic strain with new hemagglutinin and or neuraminidase antigens will likely require a second (booster) dose of vaccine two to four weeks after the first dose is given.

A final decision regarding the degree of federal vaccine purchase during a pandemic may not be made until the pandemic vaccine is being produced. The PADOH plan for delivery and administration of vaccine addresses many possible scenarios, including; complete federal purchase and distribution to states, partial federal purchase with distribution to states, and minimal federal purchase (similar to the current annual influenza vaccination program). Currently influenza vaccine is primarily administered through the private sector. Coordination with and education of the private sector is a key aspect of our planning.

Because a relative shortage of vaccine is expected early in the pandemic, vaccine recipients will be prioritized. Recommendations will be made at the national level, which will be adapted by ECDH. ECDH currently has priority prophylaxis recipient groups identified and may follow the same prioritization for pandemic influenza. See Appendix C for the current priority group recommendations for Erie County.

Eventually, it is assumed that sufficient vaccine will be available for mass vaccination of the population. Local health departments have conducted detailed planning activities that have culminated in the creation of the local Strategic National Stockpile Standard Operating Guide (SNS SOG). This guide explains the specific operations of large-scale clinic management and can also be used for developing the Smallpox, Chemo-prophylaxis, and Influenza Vaccination Clinic functions. We will utilize our immunization registry to monitor adverse events related to the pandemic influenza vaccine.

The success of the pandemic influenza vaccination program will be determined in large part by the strength of state and local vaccination programs during the Inter-Pandemic Phase for three main reasons: (1) increased acceptance of and public confidence in the vaccine; (2) stimulation of vaccine production by manufacturers to meet demand; and (3) strengthening of distribution channels.

During the Inter-Pandemic Phase, efforts to increase pneumococcal polysaccharide vaccination (which can reduce the incidence of invasive pneumococcal disease secondary to influenza) is recommended and emphasized. Because large-scale pneumococcal vaccination may not be feasible once a pandemic alert has occurred, the Inter-Pandemic Phase is the ideal time to deliver this preventive measure.

Activities that will be conducted during the Inter-Pandemic Phase include:

- Enhance influenza vaccination coverage levels in traditional high-risk groups, especially subgroups in which coverage levels are particularly low (e.g. minorities and persons younger than 65 years of age with chronic underlying medical conditions). Increasing routine, annual vaccination coverage levels in these groups will further reduce the annual toll of influenza and will facilitate access to these populations when the pandemic occurs.
- Enhance pneumococcal vaccination coverage levels in traditional high-risk groups to reduce the incidence and severity of secondary bacterial pneumonia.
- Continue to review, modify and exercise the SNS SOGs.
- Ensure that state laws continue to allow for important elements of vaccination plans.
- Ensure that contingency plans have been considered for emergency distribution of unlicensed vaccines using emergency Investigational New Drug (IND) provisions.
- Ensure vaccine distribution plans are coordinated with the bordering counties in New York and Ohio.
- Maintain the PA Immunization Registry to track vaccine and facilitate reminder notification to track the administration of two doses per person (if recommended) and to track adverse events.

ANTIVIRALS

Because vaccine will likely not be available when the novel virus first affects communities, antivirals may play an important role in the control of influenza, especially – but not only – during the period before vaccine is available. Existing production capacity for influenza antiviral drugs is less than would be needed to provide prophylaxis or treatment for the entire population and the current supply of antivirals in the Strategic National Stockpile is limited. Similarly to planning for vaccine distribution, it is important to consider planning for different scenarios, including:

- Federal purchase of the existing supply and distribution to states.
- State purchase of antivirals using emergency funds.
- Federal stockpile with distribution to states.
- Status quo (majority of drugs available in private sector).

Prophylaxis

The amantadanes, amantadine and rimantadine, are best suited for prophylaxis (preventive care) because of the high potential for viral resistance to emerge during treatment, the potential supply, and their cost. However, studies have shown an increased resistance to amantadine in circulating strains of highly pathogenic avian influenza. In addition, the central nervous system side effects, although substantially less with rimantadine than amantadine, may preclude the use of these drugs for certain target groups (e.g. commercial airline pilots). The neuraminidase inhibitor oseltamivir is an alternative.

Identification of influenza within a community (based upon either isolation of the pandemic strain or an increase in ILI) will be the trigger for initiating prophylaxis. In order to be effective, prophylaxis must be continued until the exposure has ceased. Use of antivirals for prophylaxis would only be indicated if the outbreak was very limited in scope.

As with decisions about vaccine use, recommendations for priority groups for antivirals will be established at the national level and ECDH will review these recommendations and revise them as needed based upon local factors.

Therapy

Neuraminidase inhibitors (oseltamivir and zanamivir) should be used for therapy because of the potential for viral resistance when adamantines are used for therapy. Therapy is effective at decreasing severe complications and reducing hospitalizations only if offered within two days of developing symptoms. Distribution of drugs for therapy is a challenge given the limited amount available, the large number of points of care, and the need to initiate the course of treatment within 48 hours of onset of symptoms.

Antivirals from the SNS will be distributed to points of care utilizing the distribution system that is detailed in the PA SNS plan. The PADOH will determine whether controls for dispensing (such as positive rapid test) will be required. They will also provide guidelines on appropriate use of antivirals that are distributed. Public education will be very important given the scarcity of this resource.

Prioritizing within priority groups will be necessary given the limited supply. For antivirals purchased with public funds, the state will be responsible for local distribution of the antivirals in collaborations with the private sector. If there is no state or federal purchase, the state's role will largely be one of public and provider education regarding appropriate use of antivirals. As with vaccine, it will be critical to clearly communicate with the public about the rationale for priority groups. Coordination with and education of the private sector is a key component of the plan.

During the Inter-Pandemic Phase, ECDH will continue to:

- Quantify high-priority populations for therapy, and develop drug distribution contingency plans for the different possible scenarios
- Educate the medical community and the public regarding appropriate prescribing information during a pandemic event.
- Continue to coordinate with bordering states
- Continue to maintain the Immunization Registry to track antiviral supplies, distribution, use, and adverse event tracking.

Pandemic Alert Period– Phase 3 and Phase 4

Phase 3 – Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.

Phase 4 – Small cluster(s) with limited human-to-human transmission, but spread is highly localized, suggesting that the virus is not well adapted to humans.

The distinction between phase 3, phase 4 and phase 5 is based on an assessment of the risk of a pandemic. Various factors and their relative importance according to current scientific knowledge must be considered. Factors may include: rate of transmission; geographical location and spread; severity of illness; presence of genes from human strains (if derived from an animal strain); other information from the viral genome; and/or other scientific information.

ESTABLISH COMMAND, CONTROL, AND MANAGEMENT PROCEDURES

The ECDH Director will meet with the management staff and appropriate stakeholders to review major elements of the plan and assess and evaluate the state and local levels of preparedness. Changes

to the plan will be made as needed. Coordination with border states will be initiated.

SURVEILLANCE

The Centers for Disease Control and Prevention (CDC) continuously monitors surveillance data reported nationally and frequently communicates with public health colleagues around the world so that novel viruses are detected and investigated as quickly as possible. If PADOH is notified by CDC that a novel influenza virus has been identified, but efficient transmission of the virus from person-to-person is not yet established (that is, a novel virus alert), PADOH will enhance our inter-pandemic surveillance activities by:

- Increasing case detection among persons who recently traveled to the outbreak area and present with clinical illness possibly caused by influenza including pneumonia, acute respiratory distress syndrome, or other severe respiratory illness. Appropriate specimens will be collected to diagnose influenza infection. In some situations, if the novel influenza virus is a highly pathogenic avian strain, such as with the 2004 H5N1 influenza virus in Asia, local hospital laboratories should not attempt viral isolation because of the potential risk that the strain could spread. Specimens will be sent to the PA State lab or to CDC where isolation and subtyping can be done under more stringent bio-safety conditions. Influenza infection can be diagnosed locally using antigen detection, immunofluorescence, or PCR. CDC will provide guidance appropriate to each specific novel virus alert.
- Ensuring that all inter-pandemic influenza surveillance activities are underway regardless of the time of year and that all participating laboratories and sentinel providers are reporting data to CDC each week.
- Subtyping all influenza A viruses identified in clinical specimens and, as always, reporting any influenza A viruses that cannot be subtyped to CDC immediately. CDC will provide instructions on the safe handling of a potential novel influenza virus.
- Obtaining reagents from CDC (when they become available) to detect and identify the novel strain.
- Monitoring and instituting recommendations from CDC for any additional surveillance activities that should be undertaken given the specific circumstances.
- Review contingency plans for further enhancing influenza surveillance if efficient person-to-person transmission of the novel virus is confirmed.

EMERGENCY RESPONSE

The RCTTF Medical Committee will meet with appropriate partners to review this plan and the corresponding Standard Operating Guides.

COMMUNICATIONS

The Erie County Director of Administration serves as the Public Information Officer (PIO) under the Incident Command System. The PIO and his or her staff maintain a system to effectively communicate with the public, healthcare professionals and other targeted audiences. This system is described in the ECDH Crisis Communications Plan and describes the following activities that would be conducted by the PIO and his or her staff:

- Review materials and revise as needed.
- Activate public hotline.
- Disseminate information to public and partners on an ongoing basis.
- Educate health partners, elected officials, community leaders, and the media about what information will and will not be available during a pandemic.

- Prepare spokespersons.
- Coordinate with bordering jurisdictions.

VACCINE DELIVERY

State and local health authorities will meet with appropriate partners and stakeholders and review major elements of the state and local SNS plans and operating guides. Plans will be modified as needed to account for updates, if any, on recommended target groups, projected vaccine supply, and human resources available.

ANTIVIRALS

Once a novel virus has been identified, ECDH staff will review the distribution and priority prophylaxis and treatment plans to ensure they are updated. The medical community will be notified of the status of the plans and the availability of antivirals. ECDH will distribute guidelines to the medical community and conduct training for public health staff involved in antiviral distribution protocols and procedures.

Pandemic Alert Period – Phase 5

Phase 5 – Larger cluster(s) but human-to-human spread is still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).

ESTABLISH COMMAND, CONTROL, AND MANAGEMENT PROCEDURES

- The ECDH Director will convene the management staff and partners and review the plan and corresponding Standard Operating Guides.
- Active surveillance will be initiated.
- The Crisis Communications Plan will be activated.
- Begin vaccine and antiviral distribution (if available).
- Notify emergency management of the need for additional resources.
- Activate Standard Operating Guides for operational priorities.
- Arrange for facilities use.
- Document expenses of pandemic response.

SURVEILLANCE

If efficient person-to-person transmission of a novel influenza virus is confirmed, the following additional surveillance enhancements will be made:

- Assess the need to screen travelers arriving in the U.S. from affected countries.
- Investigate the epidemiology of all early cases either originating in the U.S. or that are imported into the country.
- At hospitals and emergency departments, increase laboratory diagnosis of influenza, including use of rapid antigen detection tests, for persons with compatible clinical syndromes, particularly those who may have had recent exposure at the site of an outbreak. PADOH and the Laboratory Response Network (LRN) have plans in place to test substantially more specimens than usual. CDC will provide guidance to assist with triage of specimens for testing

and for choosing which isolates to send to CDC.

- The completeness and timeliness of reports from all participating laboratories and sentinel providers will be assessed, and non-reporters will be contacted to improve their performance as necessary.

EMERGENCY RESPONSE

Procedures and equipment in the ECDH Response Room will be tested to ensure operational readiness.

COMMUNICATIONS

Once sustained human-to-human transmission is confirmed anywhere in the world, the Public Information staff will:

- Review major elements of the communications plan with partners and stakeholders.
- Disseminate information to public, partners and the media on an ongoing basis.
- Monitor media coverage and address misinformation.
- Coordinate with bordering jurisdictions.

VACCINE DELIVERY

Once human transmission is confirmed, ECDH will ensure that human resources and logistics are in place to begin vaccination, taking into account the need for additional staff due to illness and relief for workers. Refresher training will be provided to relevant agencies and partner groups regarding vaccine delivery protocols and procedures. Activities will be coordinated with border-states and cities.

ANTIVIRALS

Same actions as stated in Vaccine Delivery Section.

Pandemic Period – Phase 6

Phase 6 – Pandemic phase: increased and sustained transmission in general population.

ESTABLISH COMMAND, CONTROL AND MANAGEMENT PROCEDURES

Once a pandemic alert has been issued, the ECDH Director or his or her designee will activate the ECDH Response Room.

Key activities that will be conducted include:

- Fully activate the response plan.
- Monitor staffing needs and recruit additional staff, if necessary.
- Ensure activities are coordinated with the bordering states of Ohio and New York
- Ensure that PADOH is briefed on the actions occurring in Erie County.
- Document the expenses related to responding to a pandemic influenza outbreak.
- Ensure coordination of PADOH Lab response activities with those of ECDH and the medical community.
- Monitor staffing needs at ECDH and within the Response Room, and reassign staff or request additional assistance as necessary.

SURVEILLANCE

PADOH will:

- Conduct enhanced monitoring for antiviral resistance.
- Ensure that studies are in place to monitor vaccine effectiveness.
- Monitor health impacts including deaths and hospitalizations from influenza. Absenteeism will be measured in key industries.
- Assess the quality of surveillance and make recommendations for improvement during the period between pandemic waves and after the pandemic.
- Track adverse events to vaccine and treatment.

EMERGENCY RESPONSE

PADOH will implement generic elements of the response plans and specific plans for identified pandemic influenza issues, including continuous collection of data concerning medical and material supplies and their allocation to rapidly identify changing patterns of need and modify or redirect policy.

COMMUNICATIONS

- Using the communication systems identified in the Inter-Pandemic Phase, public information staff will update appropriate agencies and the public at least weekly and as needed regarding any new information regarding the novel virus and its impact.
- Materials and messages will be reviewed and modified as needed.
- When the State EOC is activated, the Joint Information Center (JIC) will also be activated. JIC activities will be coordinated with bordering states.

VACCINE DELIVERY

PADOH will activate the Emergency Operations Center, fully staff the logistics section and:

- When available, distribute vaccine and supplies (e.g., needles, syringes) necessary for influenza vaccine administration through a centralized distribution system to local health departments using SNS infrastructure.
- Distribute a specified number of doses of vaccine and medical supplies to local health departments based upon population and distribution of prioritized essential services personnel. Supplies may be shipped separately from vaccine.
- Consult with ECDH to coordinate assistance in the storage, security, and transportation of vaccine and supplies, as appropriate.
- Implement vaccination of those government officials and state and federal personnel deemed as a priority to maintain essential services.
- Monitor adverse reactions to influenza vaccine using the PA Immunization Registry.
- Distribute pneumococcal vaccine for high-risk individuals to be administered by healthcare providers, home health agencies, local health departments, and others.

ANTIVIRALS

Once the onset of a pandemic is confirmed, PADOH will fully activate the antiviral drug distribution plan.

Postpandemic Period

Return to interpandemic period activities.

APPENDIX A: COMMUNITY CONTAINMENT MEASURES INCLUDING NON-HOSPITAL ISOLATION AND QUARANTINE AND HOME CARE

Introduction

Pandemic influenza is a unique public health emergency and community disaster. It is considered a highly probable, if not inevitable event but no one can predict when it will occur. There may be little warning, but most experts agree that there will be one to six months between identification of a novel virus and widespread outbreaks in the U.S. Outbreaks will occur simultaneously throughout the U.S., and the effect on individual communities will last from six to eight weeks or more.

Pandemic influenza has the potential of affecting all elements of society. A large number of cases will add burden to hospitals and other health care systems already stressed with the normal day to day crises. Mortality is usually markedly increased. Health and medical personnel as well as other infrastructure workers, i.e. law enforcement, fire, public works, will not be immune. The effects on our communities could be staggering.

Immunization and respiratory hygiene are the best control measures available for influenza. Because no vaccine against a novel influenza strain will be available initially, and, it is likely that when vaccine becomes available, it will be in short supply, there are few community control measures available in a pandemic influenza event.

Non Hospital Isolation and Quarantine

Major Points:

1. Influenza is now included in the federal list of communicable diseases for which federal isolation and quarantine are authorized (Amendment to EO 13295).
2. States generally have authority to declare and enforce quarantine within their borders.
3. Quarantine is medically very effective in protecting the public from disease.
4. People in isolation may be cared for in their homes, in hospitals, or in designated healthcare facilities.
5. The Governor in PA may choose to utilize "snow-days".
6. Non-hospital isolation and quarantine is a non-issue in pandemic influenza due to a novel virus.

CDC Fact Sheet on Isolation and Quarantine January 20, 2004:

To contain the spread of a contagious illness, public health authorities rely on many strategies. Two of these strategies are isolation and quarantine. Both are common practices in public health, and both aim to control exposure to infected or potentially infected persons. Both may be undertaken voluntarily or compelled by public health authorities. The two strategies differ in that isolation applies to persons who are known to have an illness, and quarantine applies to those who have been exposed to an illness but who may or may not become ill.

ISOLATION: FOR PEOPLE WHO ARE ILL

Isolation refers to the separation of persons who have a specific infectious illness from those who are healthy and the restriction of their movement to stop the spread of that illness. Isolation allows for the focused delivery of specialized health care to people who are ill, and it protects healthy people from

getting sick. People in isolation may be cared for in their homes, in hospitals, or in designated healthcare facilities. Isolation is a standard procedure used in hospitals today for patients with tuberculosis (TB) and certain other infectious diseases. In most cases, isolation is voluntary; however, many levels of government (federal, state, and local) have basic authority to compel isolation of sick people to protect the public.

QUARANTINE: FOR PEOPLE WHO HAVE BEEN EXPOSED BUT ARE NOT ILL

Quarantine refers to the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent and therefore may become infectious. Quarantine of exposed persons is a public health strategy, like isolation, that is intended to stop the spread of infectious disease. Quarantine is medically very effective in protecting the public from disease.

States generally have authority to declare and enforce quarantine within their borders. This authority varies widely from state to state, depending on state laws. The Centers for Disease Control and Prevention (CDC), through its Division of Global Migration and Quarantine, also is empowered to detain, medically examine, or conditionally release persons suspected of carrying certain communicable diseases. This authority derives from section 361 of the Public Health Service Act (42 U.S.C. 264), as amended.

Whereas isolation and contact management strategies such as active monitoring are directed to individuals, broader *community containment measures* may be applied to groups of persons or to communities during outbreaks characterized by extensive transmission. These interventions range from *measures to increase social distance* among community members (e.g., cancellation of public gatherings, use of masks, implementation of community-wide “snow days”) to *community-wide quarantine*.

Although all of these interventions are designed to prevent transmission by limiting social interactions and preventing inadvertent exposures, the less stringent actions may be easier to implement on a large scale. For example, in the “snow day” approach, community members are asked to stay home as they would during a major snowstorm. Schools are closed, work sites are closed or restricted, large public gatherings are cancelled, and public transportation is halted or scaled back. Implementation requires fewer resources than are needed to activate and maintain community-level quarantine. In addition, as snow days are a familiar concept in most communities, implementation can occur quickly. Implementation of quarantine, on the other hand, can be resource intensive, requiring mechanisms for enforcement and provision of necessities. Snow days and other measures to increase social distance are therefore the preferred community-level responses, with quarantine reserved for situations in which less drastic measures have not been successful in containing an outbreak.

Home Care

Home care will be the predominant mode of care for most people infected with influenza. During the Pandemic Alert Period, individuals should discuss with their health care provider specific recommendations for both vaccination and chemoprophylaxis.

The single best way to prevent influenza is to get vaccinated each fall. In the absence of vaccine, however, there are other ways to protect against influenza. Four antiviral drugs (amantidine, rimantidine, oseltamivir and zanamivir) are approved and commercially available for use in treating influenza. Three of them (amantidine, rimantidine, and oseltamivir) are approved for prevention (chemoprophylaxis) against influenza. All of these drugs are prescription drugs, and a doctor should be consulted before their use.

The public should receive frequent and repetitive health communications that emphasize the simple steps that individuals and families may take to prevent the spread of respiratory illnesses like influenza:

1. Avoid close contact with people who are sick.
2. Wash hands often (hourly). If sick, stay at home and keep at least 3 feet away from others.
3. Cover mouth and nose with a tissue when coughing or sneezing.
4. Dispose of used tissue in appropriate waste receptacle.

Individuals who are cared for at home should:

1. Get plenty of rest.
2. Drink a lot of fluids.
3. Avoid using alcohol and tobacco.
4. Consider taking over-the-counter medications to relieve the symptoms of influenza (but never give aspirin to children or teenagers who have influenza-like symptoms).
5. Stay home and avoid contact with other people.
6. Cover nose and mouth with a tissue when you coughing or sneezing.
7. Dispose of used tissue in appropriate waste receptacle.

In a pandemic influenza event, some individuals who are cared for at home may develop complications. Should complications develop, these individuals should seek medical care immediately, either by calling the doctor or going to an emergency room. Upon arrival, the receptionist or nurse should be told about the symptoms so that precautions can be taken (providing a mask and or separate area for triage and evaluation).

Warning Signs to seek urgent medical care:

In children, these include:

1. High or prolonged fever
2. Fast breathing or trouble breathing
3. Bluish skin color
4. Not drinking enough fluids
5. Changes in mental status, somnolence, irritability
6. Seizures
7. Influenza-like symptoms improve but then return with fever and worse cough
8. Worsening of underlying chronic medical conditions (for example, heart or lung disease, diabetes)

In adults, these include:

1. High or prolonged fever
2. Difficulty breathing or shortness of breath
3. Pain or pressure in the chest
4. Near-fainting or fainting
5. Confusion
6. Severe or persistent vomiting

Pandemic Influenza and Schools

CDC Guidance: *Preventing the Spread of Influenza (the Flu) in Schools: Interim Guidance for School Administrators, Teachers and Staff, January 12, 2004*. Available at <http://www.cdc.gov/flu/school/>

Remind students and staff to clean their hands, and make sure they have the supplies to do so.

Frequent hand washing with soap and water will help protect students and staff from viruses. Wash hands for 15- 20 seconds (long enough to sing the "Happy Birthday" song twice.) Alcohol-based hand rubs may be used as an alternative. Students and staff should be advised to rub their hands thoroughly until dry. Work with your school's janitorial staff to ensure that restrooms are stocked with soap and paper towels or working hand dryers. Work with teachers to have a supply of alcohol-based hand-rub in each classroom.

Remind students and staff to cover noses and mouths when coughing or sneezing, and have tissues readily available.

Advise students and staff to cover their noses and mouths with a tissue when coughing or sneezing, and to dispose of used tissues in appropriate waste receptacles. Make sure that tissues are available in all classrooms and common areas, such as libraries or lunchrooms. If hands become contaminated with respiratory secretions while coughing or sneezing, perform hand hygiene as soon as possible.

Encourage sick students and staff to stay at home.

Sick students and staff should stay home from school until they have been without fever for 24 hours to help prevent spreading illness to others.

Work closely with your local health department if making plans regarding school closure.

Any decisions about closing a school due to increased influenza activity should be made in consultation with local and state health departments. It is unknown whether school closings are beneficial in controlling the spread of influenza.

In a pandemic influenza event, it may be necessary to close schools for administrative reasons (insufficient staff to meet the instructional and safety needs of students).

APPENDIX B: – Internet Sites Referenced

CDC FluAid

FluAid is a test version of software created by programmers at the Centers for Disease Control and Prevention (CDC). It is designed to assist state and local level planners in preparing for the next influenza pandemic by providing estimates of potential impact specific to their locality.

<http://www2.cdc.gov/od/fluaid/default.htm>

CDC (Pandemic) Planning Guide for State and Local Officials (Draft 3.0)

<http://www.hhs.gov/nvpo/pandemicplan/index.html>

World Health Organization Pandemic Preparedness

<http://www.who.int/csr/disease/influenza/pandemic/en/>

PADOH Influenza Pandemic Response Plan

A link to the plan will be posted on the ECDH website upon completion.

Mass Clinic (SNS) Standard Operating Guide Template for Local Health Departments

Under Development

APPENDIX C: – ECDH Priority Prophylactic Treatment Recommendations

ECDH Priority Prophylactic Treatment Recommendations		
<ul style="list-style-type: none">• Hospital, health department staff and household members, community health providers• Hospital and health department clinic volunteers (would include all personnel assisting with clinic operations).• Emergency Medical Service personnel and household members.• Law Enforcement.• Fire Departments.• Public Works.• Identified contacts.• General public.		
The groups listed below have been identified as possible priority recipients by various entities. It is anticipated that the CDC Workgroup may recommend some of these groups in the guidance that should be ready in the summer of 2005.		
Persons necessary to provide legal authority to initiate activities not governed by current state laws including: <ul style="list-style-type: none">• The County Executive• The individuals identified by statute to take charge of county functions in the event of the loss or incapacitation of the County Executive.• Persons essential to maintain basic community infrastructure contingent on the epidemiology of the pandemic and the quantity of influenza vaccine available. (See options below)		
Medical laboratory workers	Emergency management personnel	National Guard members that have been called into state service by the

		governor
Long term care facility staff	Utility field workers (gas, electric, water, sewer, etc.)	Communications personnel
Fuel suppliers	Food suppliers	Waste management workers (general and medical)
Public transportation drivers	Air travel personnel (pilots, air traffic controllers, etc.)	Corrections workers
Morticians/Coroners/Medical Examiners	Pharmacists	Red Cross field workers
U.S. Postal Service workers	Contracted persons involved in the transportation of vaccine	

APPENDIX D: Local Pandemic Influenza Response Checklist

ACTION	
Interpandemic Period – Phase 1 <i>Goal: Strengthen influenza pandemic preparedness</i>	
Establish a local health care task force as a focus for planning, preparedness, and coordinated response. The task force should include representatives from hospitals, physician and nursing organizations, home health care, long-term care facilities, pharmacists, EMS and local public health officials.	
Develop strategies to increase the demand for influenza vaccine among your county’s residents and especially healthcare workers.	
Continue to develop and refine the Local Strategic National Stockpile (SNS) Standard Operating Guide (SOG).	
Work with the local chamber of commerce and large employers to increase awareness in the community.	

<p>Interpandemic Period – Phase 2</p> <p><i>Goal: Minimize the risk of transmission to humans; detect and report such transmission rapidly if it occurs</i></p>	
Conduct training and exercises to ensure the Local SNS SOG is operational.	
Educate Health Department staff and health care providers about Pandemic Influenza.	
Estimate target populations (priority groups) of essential personnel, including health care workers, first responders and public safety workers.	
<p>Pandemic Alert Period – Phase 3</p> <p><i>Goal: Ensure rapid characterization of the new virus subtype and early detection, notification and response to additional cases.</i></p>	
Review Local Response Plan, Emergency Support Function 8 – Health and Medical Annex.	
Review SNS SOG, ensure contacts are updated and potential vaccination clinic facilities are available.	
Review County Point of Dispensing sites and update, if necessary.	
Convene local health task force and brief on the status of the Pandemic alert and local preparedness efforts.	
Review message maps relating to Pandemic Influenza and make sure they are current.	
Review priority group estimates.	
Ensure SNS SOG addresses vaccine distribution to tribal entities, military installations, and correctional facilities, if applicable.	
<p>Pandemic Alert Period – Phase 4</p> <p><i>Goal: Contain the new virus within limited foci or delay spread to gain time to implement preparedness measures, including vaccine development</i></p>	
Repeat actions undertaken in Phase 3	
Ensure city police departments and the county sheriff’s offices are aware of the potential for civil unrest to occur in the event of a pandemic.	
<p>Pandemic Alert Period – Phase 5</p> <p><i>Goal: Maximize efforts to contain or delay spread, to possibly avert a pandemic, and to gain time to implement pandemic response measures</i></p>	

Repeat actions undertaken in previous phases.	
Meet with adjoining jurisdictions to ensure actions will be coordinated in Phase 6. Special considerations include: priority group recommendations, vaccination clinic operations (hours of operation, locations, policies, and forms).	
Local health task force reviews the priority group recommendation of the State Health Officer and provides guidance to local health officer on any changes.	
Once priority groups are identified, estimate the number of local citizens in each group.	
Health Department ensures that all agencies and volunteers tasked in the plan are aware of the Pandemic Alert Phase and the potential for escalation.	
Ensure all personnel who may have contact with the media are trained on the message maps.	
Ensure all media contacts are up to date.	
Review security component of the SNS SOG and ensure security assets are available and briefed.	
Special Populations?	
Pandemic Alert Period – Phase 6 <i>Goal: Minimize the impact of the pandemic</i>	
Activate Local Response Plan (LRP), Emergency Support Function 8.	
Activate Local Emergency Operations Center and the local Joint Information Center.	
Administer influenza vaccine as it becomes available. Ensure a second dose of vaccine is administered if necessary.	
Assist PADOH with obtaining data to determine age-specific attack rates, morbidity and mortality.	
Work with PADOH to determine vaccine efficacy.	