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Pandemic Influenza Workshop
June 23, 2005

Meeting Summary Report
and
Meeting Evaluation Report

Virginia Department of Health
Office of Epidemiology and Emergency Preparedness

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VDH PANDEMIC INFLUENZA WORKSHOP
RICHMOND, VA
JUNE 23, 2005
9:00 AM – 3:30 PM

MEETING SUMMARY

Introduction

On June 23, 2005, the Virginia Department of Health (VDH), Office of Epidemiology and Emergency Preparedness and Response (EPR) Programs convened a workshop on pandemic influenza. Held in the Sheraton Richmond West Hotel in Richmond, VA, the meeting brought together representatives of diverse groups, both healthcare and non-healthcare related, to discuss the implications of a worldwide influenza epidemic in Virginia.

An influenza epidemic would impact all parts of society with large numbers of individuals ill with influenza and an increased number of deaths, with enormous healthcare, economic, and societal implications. The Pandemic Influenza Workshop had three primary goals:

1) To identify the essential factors of a pandemic response;
2) To identify the key policy decisions that are needed for an effective response; and
3) To identify the prospective role of each organization in the response to a pandemic.

The workshop brought together public and private sector representatives from Virginia (and representatives from the District of Columbia (DC) Department of Public Health). The following organizations and groups were represented:

- Centers for Disease Control and Prevention's Quarantine Division
- Virginia Department of Health Leadership
- Local Health Districts
- VDH Office of Epidemiology
- Academic and Non-academic Hospitals
- State Laboratory
- Department of Emergency Management
- VDH EPR Programs
- VDH Office of Emergency Medical Services
- VDH Office of the Chief Medical Examiner
- VDH EPR Regional Offices
- Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)
- Department of Agriculture and Consumer Services
- Department of Fire Programs
- State Police
- Office of the Attorney General
- DC Department of Public Health
- Emergency Medical Services

- University of Virginia Institute for Practical Ethics
- Langley Air Force Base
- Portsmouth Naval Base
- Representatives of the Legal Profession
- Medical Society of Virginia
- Virginia Nurses Association
- Virginia Primary Care Association
- Virginia Health Care Association
- Virginia Hospital and Healthcare Association
- Virginia Pharmacy Association
- Virginia Health Quality Center
- Virginia Dominion Power
- DuPont
- Honeywell

Workshop attendees were organized into two groups: participants who were directly involved in discussions; and observers who were given specific opportunities to provide comments throughout the day, both orally and in writing.

Dr. Lisa Kaplowitz, Deputy Commissioner for Emergency Preparedness and Response at the Virginia Department of Health began the workshop with a brief welcome. The welcome was followed by a 15-minute presentation given by Dr. Diane Woolard, Director of the Division of Surveillance and Investigation at the Virginia Department of Health. This presentation provided participants with background information on influenza, criteria for a pandemic, and information on key issues in dealing with a pandemic.

The bulk of the workshop focused on gaining participants' comments on issues related to and challenges with addressing pandemic influenza and recommendations on how to respond in such a situation. In order to fully discuss potential roles for agencies during the various stages of a pandemic, the workshop was organized around discussions of six scenarios, each designed to allow participants explore the impact of a pandemic at different stages. A facilitator from the Academy for Educational Development (AED) described each scenario and led workshop participants through discussions about each to gain their input on how their respective agencies could respond in each situation. Discussions were facilitated in a manner designed to help participants identify what could be done given existing resources, what could be done if additional resources were available, and what could be done to modify the existing response plan.

This report is divided into two sections, the Meeting Summary and the Evaluation Report. The Meeting Summary summarizes discussions and written comments about each of the six scenarios discussed at the meeting. Specifically, the summary, which is organized by scenario, includes for each scenario, a description of the scenario, key points and issues from discussions, general comments, and written comments submitted by participants and observers. Following the Meeting Summary is the Evaluation Report which summarizes the evaluation results of the Workshop.

A list of acronyms used in this report is included at the end of the document in Appendix A.

Scenario One: Emergence of a Novel Influenza Strain

Background

In this scenario the public health community is alerted in February 2006 about multiple cases of severe respiratory disease outside of Beijing, China. A novel influenza virus (H8N4) is isolated in two children and the World Health Organization (WHO) is working to confirm reports. Mid-month, H8N4 is isolated from two travelers returning to Taiwan from mainland China. Later that month, there is a hospital-associated outbreak in Taiwan and preliminary reports suggest increased morbidity and mortality associated with the strain. In March 2006, a WHO team travels to China to investigate and confirms H8N4 in China in addition to two hospital outbreaks in Beijing. Travel advisories are issued by both WHO and the Centers for Disease Control and Prevention (CDC).

Following are key discussion points, general comments shared by participants, and written comments shared by participants and observers.

Key Discussion Points

The key discussion points for this scenario focus on actions that agencies would take during this situation. The list of actions is organized by agency.

- **State and Local Health Departments**
  - Focus on communications and remain in contact with CDC, which would be in contact with WHO.
  - Increase communications with neighboring states.
  - Conduct additional surveillance for influenza.
  - Gather information for local health departments and information for the public.
  - Alert physicians and hospitals.
  - Instruct public about traveling overseas and possible travel restrictions.

- **CDC Quarantine Office**
  - Communication and Notification – with incoming passengers at port authorities, customs, and border protection; with state and local public health authorities; and with hospitals for transportation of sick individuals arriving from overseas.
  - Response – when alerted of a sick passenger arriving from an affected area an emergency response team will meet the passenger at port of entry to assess his/her health and to assess the epidemiologic risk factors to others who came into contact with that person.

- **State Laboratory**
  - Relay to CDC questions regarding various issues including: biosafety levels, test protocols, serum supplies for identifying the virus, instructions on how to test samples, etc.

- **Office of the Chief Medical Examiner**
  - Alert medical examiners about the situation so that they are on the lookout for possible deaths due to influenza, especially pandemic strain. Screen hospital deaths for infectious disease. Heighten MedEx surveillance programs.
  - Identify suspect deaths and enter their information into the system (this is especially important for initial cases).

- **Hospitals and Health Care Associations**
  - Expect direct contact from the local and state health department concerning medical information on the situation in South Asia.
  - Coordinate with other hospitals to establish standard level of assessment for incoming patients (recording travel history, symptoms, etc.).
  - Hospitals should share information by reporting diseases to health departments so that information flows both ways.
  - Alert provider networks to inform and educate them on gathering travel history, isolating patients, and informing authorities of infected patients.
  - Refer to past memoranda of understanding (MOUs) with CDC's Quarantine Division in order to prepare for transport of suspected cases to hospitals.

- **Military**
  - Re-emphasize respiratory etiquette (hand washing, masks, etc.).

- **University of Virginia Institute for Practical Ethics**
  - In addition to communicating with hospitals and physicians, also communicate with the public. Since the media will be involved, accurate information is critical. We want to avoid panic, but in order to gain the public's trust, honesty is important.
  - Need to identify how to build trust with the community before this scenario occurs, so that trust and partnership already exists when issues of allocation arise.

- **Business**
  - Due to the number of employees who travel overseas, the company would continuously monitor the situation based on information from the CDC; prepare both internal and external talking points about the situation; and begin discussions about prohibiting work-related travel (essential only, business critical, etc.).

Written Comments

Following are the written comments received from both participants and observers. The comments are organized into three topics: partners, surveillance, and communication.

- **Partners**
  - Why isn't the Metropolitan Medical Response System (MMRS) a participant at the center table?
  - It's important to have established relationships. Groups that need to be brought into the discussion include:
    - social services – child day care
    - small businesses, minority businesses, Hispanic Chamber of Commerce
    - private outpatient medical facilities (e.g. Patient First)
    - Office of Family Health Services in Virginia Department of Health

- **Surveillance**
  - Syndromic surveillance, i.e., how rapidly would health departments be alerted to problems/symptoms?
  - Surveillance – include active surveillance; hospitals, businesses that send staff overseas.
  - Verify airports have infectious traveler/Isolation and Quarantine (I-Q) response planning, ditto for the airlines. How would they deplane passengers, obtain passenger contact information, interface with public health, etc.?
  - If we are going to limit gatherings, etc. are we now recommending that people keep a 30-day supply of food at home, as stores would be closed?

- **Communication**
  - Regarding lack of early information from China or other countries (not willing to communicate early, as in SARS experience)—what is being done to ensure open communication with countries (i.e., early surveillance) will be available to WHO, etc.?
  - At this stage, shouldn't the CDC consider providing a basic information card to all incoming travelers from suspect areas (for those possibly incubating but not yet symptomatic) that would instruct them to be aware and on what to do?
  - The Virginia Department of Health should communicate with state agencies so that all are saying the same thing. Messages need to convey what the public can do to help protect themselves.
  - Need for information/guidance to public: pro-active, to prevent/allay fears, and to facilitate preventive actions/precautions.

Scenario Two: WHO Declares Onset of Influenza Pandemic

Background

In this scenario WHO confirms outbreaks throughout mainland China and localized outbreaks in Taiwan, Thailand, Singapore, and Australia in April 2006. The overall case fatality rate is 25 percent and severe disease is identified in multiple groups (children, elderly, and immunocompromised). In the U.S., surveillance is intensified and the CDC begins predicting the impact. People arriving from affected areas and native populations already living in the U.S. encounter hostility and racism. The public demands that persons from abroad should not be allowed into the US. In contrast, business groups protest isolationist sentiment and express concern about international trade and travel. To try to slow the spread of the disease, ill persons arriving to the U.S. from affected areas are isolated. There are intense efforts on the part of the U.S. Department of Health and Human Services (HHS) to obtain a seed virus for vaccine production, but estimates are that it will take four to five months before the first batch of vaccine becomes available. There is growing concern amongst individuals that the government is not doing enough.

Following are key discussion points, general comments shared by participants, and written comments shared by participants and observers.

Key Discussion Points

The key discussion points for this scenario are disease predictions and actions that agencies would take during this situation. The list of actions is organized by agency.

- **Pandemic disease predictions for Virginia based on a 25 percent attack rate, over a 12-week period**
  - Outpatient visits: 1 million
  - Hospitalizations: 20,000
  - Deaths: 4,500

- **State and Local Health Departments**
  - Refer to the pandemic influenza plan.
  - Distribute information to all local health departments and healthcare providers via the Health Alert Network.
  - Work with epidemiologists to ensure accuracy of information.
  - Continue syndromic surveillance.
  - Confer with DC area officials and contiguous states due to proximity to Virginia.
  - Ensure consistent messages. Coordinate messages among government organizations so that similar information is conveyed to the public.
  - Schedule press conferences to control information.
  - Engage in regular communication with local hospitals.
  - Convey severity of message without creating panic.

- Engage important decision makers within the state (for example, legislators) because they will be making future decisions regarding dealing with the pandemic.
- Review lessons learned from the SARS situation, especially with regards to implementing quarantine.
- Work with CDC and legal counselors to implement quarantine.
- Emphasize good personal hygiene, washing hands, staying at home if sick, etc. Increase individual understanding of how to stay healthy.
- Communicate with local government officials.
- Begin preparing for surge capacity at medical facilities, including staffing, etc.

General Comments

The following comments, arranged by agency, were made in response to these questions: What could be done given existing resources? What could be done if additional resources were available? What could be done to modify the existing response plan?

➢ **State Laboratory**

- We would need more information regarding availability of antiserum to test samples, availability of supplies for a direct influenza test, availability of samples to test, testing capacity, staff to run lab, decisions regarding testing H8N4 if it is already identified, biosafety 3 capacity, etc.

➢ **Hospitals and Health Care Associations**

- Even with a modest 25 percent attack rate, 20,000 extra hospitalizations would strain service capabilities.
- Currently the Infection Control Department at our hospital is not receiving reports from the health department on planning for a pandemic, which prevents us from appropriately allocating resources.
- With a 25 percent attack rate our hospital should be able to manage a surge, but it would be difficult and it would not be sustainable. It would require intra-facility augmentation of staffing resources, coordination with health departments, and volunteer services.
- On a good day, there are no beds available in our hospital. The wait is 36- to 48-hours in the ER for a bed. During the last influenza season a “code black” was issued. We had no way to increase capacity, except to cancel elective surgeries. In an urban area there is very little surge capacity.
- There are a finite number of surge beds, so planning needs to start now [during this phase of the pandemic]. It would be even better if planning started before this scenario. Surge capacity is not just a hospital issue, but requires caretakers, etc.
- Suggest using Medical Reserve Corps (MRC), a volunteer backup surge capacity for surge staff.

- **Quality Improvement Organization (QIO) (Virginia Health Quality Center (VHQC))**
  - Ensure good consistent messaging.

- **Military**
  - The Department of Defense has some surge capacity in Virginia and can take some civilian patients.

- **CDC**
  - As the epidemic becomes more widespread the CDC would:
    - look for resources both within and outside CDC
    - look to increase staffing
    - conduct screenings
    - distribute health alert notices
    - post Web-based educational notices
    - decide case definitions
    - define endemic areas
    - disseminate travel advisories
  - CDC would meet passengers at up to 3 stops from the endemic area to provide them with health information, screen them, and advise them on where to go if symptoms developed. If a case is identified, all the contacts of that person are noted and the local health department is involved for health care and diagnostics.

- **Business**
  - Educate employees of the signs and symptoms of influenza. Encourage employees to stay home if they are sick. Overseas travelers have a 24-hour hotline to ease their minds and help determine if self-quarantine is necessary. Encourage employees to not feel guilty if they stay home.

- **Representative of the Legal Profession**
  - Playing in the background of all of this will be the issue of liability in meeting surge. At issue is, how to manage expectation of public health authorities and their ability to meet surge, with the conflicting messages of state, local and national media and the expectations of the public.

Comments regarding legality of detaining and quarantining travelers

- Does the state have the authority to quarantine?
- Issues surrounding logistics of quarantine (location to hold passengers, etc.).

Written Comments

Following are the written comments received from both participants and observers. The comments are organized into four topics: partners, surveillance, antivirals and vaccine, and communication.

- **Partners**
  - Involvement of small businesses—while it may be easier for large businesses to tell employees to stay home, this will be a challenge for small businesses. We need to include them in this discussion.

- **Surveillance**
  - How will we isolate or locate illegal migrants who may be ill and entering the country?
  - Since the first outbreaks in China were in hospitals, what would be happening differently in hospitals in Virginia to protect staff while they are dealing with increased care needs? Would all returning travelers from certain areas be asked to self-isolate for three to four days?

- **Antivirals and Vaccine**
  - Scenario assumes that a new strain grows readily in eggs to make vaccine—what if it grows poorly?
  - Make Tamiflu® available now to get it disseminated and stimulate new production and more supply.
  - There is a need for pre-positioning/stock piling of antivirals. There is a need for pro-active steps to avoid playing "catch-up"—for example, anticipatory guidance to public. For example, if new vaccine is initiated, distribution/priority plans will be needed to increase public acceptance and logistic organizations.

- **Communication**
  - District should begin "table topping" response protocols/actions.
  - Suggest communications with the public should include what we "can do" as was stated, but also what we should not be doing especially with regard to over the counter (OTC) medicines and antibiotics.
  - Messages to health care providers might be distributed in part through professional organizations—if later, need to involve nurses not in current workforce, some mechanisms to provide information to them (outside employer channels) is important.
  - Public information messages should already be prescripted! Establish public inquiry hotline.
  - Local public health could and should reach out to the local Asian community, discussing travel issues, family concerns, and two-way communication.
  - Can Virginia Department of Health try to put extra emphasis on providing information for health care providers to communities, such as Chinese, who are most likely to be traveling in heavily impacted countries? They need to provide anti-racial messages to public.

Scenario Three: The Pandemic Arrives in Virginia

Background

In May 2006, sporadic infections in the U.S. are reported in travelers returning from Asia. Outbreak of influenza is reported among a group of 60 soldiers returning to Norfolk and is later confirmed as H8N4. Upon arrival, many soldiers depart for leave or for reassignment to other states. Local health department and hospital resources are stretched thin in response to the outbreak. Other states report similar localized outbreaks. In Virginia there are 32 confirmed cases and eight deaths. Concern is rampant in the media about vaccine availability, antiviral availability, and the likely impending shortage of health services (for example, Intensive Care Unit beds, ventilators, etc.).

Following are key discussion points, comments shared by participants on several topics related to this scenario, and written comments shared by participants and observers.

Key Discussion Points

The key discussion points for this scenario include: actions that agencies would take, antivirals, communicating with the public and employees, transmission by health care workers, decreasing transmission within hospital settings, state of emergency, and special needs populations.

Actions

- **Office of the Chief Medical Examiner (OCME)**
  - Military cases do not fall within the jurisdiction of the OCME. Therefore, if these were military cases, the OCME would need permission from the military to enter the Base and help.
  - If these were cases throughout the state, the OCME would take cultures to verify the disease in those locations.

- **Departments of Health**
  - Report disease information between communities. Establish a disease surveillance system across the region.
  - Recognize the challenge of creating and maintaining consistency among disease reporting measures across states.
  - Increase communications within the state and with neighboring states.
  - With respect to canceling large events, the department of health would try to maintain the delicate balance between raising concern in the public and creating panic. Recommend avoiding large crowds and, if possible, avoiding public transportation. Although recommending people avoid public transportation raises many difficult issues, this is an issue that would need to be considered at this point in the scenario.

➢ Anitvirals

The discussion on antivirals (AVs) focused on priority groups and stockpiling.

Priority groups

- If there were plenty of AVs for everyone, then they would be used prophylactically (e.g., with health care workers). If there were not enough AVs to use prophylactically, then they would be used as treatment for those already infected with influenza. AVs only decrease the duration of illness, therefore people would still become ill.
- At the moment, the Virginia Department of Health does not have the answer, nor a list, on how to rank priority groups.
- Priority groups that are under consideration include:
    - Ill patients who are hospitalized with onset of illness within 48 hours
    - Health care workers (yet to be defined)
    - Essential service providers (which could include transportation, public health workers, water supply, food delivery, etc.)
- Persons in these groups are to be treated as soon as possible after the onset of illness for antivirals to be most effective.
- Priority will be given to the use of antivirals for treatment rather than prophylaxis because of the large amount of medication that would be required for prophylaxis.
- VDH has no input yet on prioritizing groups from the national level and is relying on this meeting to help answer these questions.
- It's important to remember there may be limitations in production and distribution from the national level. The national plan is being updated now.
- The military has increased supplies of AVs and suggested that the department of health could recommend that hospitals increase their supply of AVs in advance of a pandemic.
- VDH Office of Emergency Preparedness and Response (EPR) indicated that there are HRSA funds for stockpiling antiviral medication within hospitals and for other healthcare providers. (For example, as with the Tamiflu® stockpile for the country). The decision on how to distribute antivirals from the Strategic National Stockpile (SNS) nationwide will probably be based on population. Once the state receives the supply, the AVs must then be distributed at the state level. The national plan on prioritization for AVs and vaccine is vague and is being revised now. The guidelines are also vague in determining whether to use AVs prophylactically or as treatment.

Personal caches or stockpiles of antivirals

- There are groups in the community advocating for personal stockpiles of the antivirals. There is concern about how this would affect prioritization.
- It is not the policy of the Virginia Department of Health to recommend personal stockpiles because it creates further issues and complications related to fairness of distribution and the need to target limited supplies to priority populations. Due to the fact that most of the supply of AVs is in the private sector the health

department has little control over how they are distributed because they are prescribed by physicians.
- The importance of informing the public about what they should and shouldn't take needs to be stressed. It was noted that it is hard for physicians to refuse patients requests for multiple supplies of anti-infective agents (for example, Cipro®). There needs to be information for families on what to do.

➢ Communication Challenges

The discussion on communication challenges focused on communicating with the general public and employees.

Communicating with the general public

- It is important to target efforts with providers that serve populations that originate from the countries that are affected by the pandemic. To be alert for discrimination and to inform and educate the public that not all Asians carry influenza.
- People need to be given something to do, other than worry, and so information on how they can protect their families is important (hand washing, personal hygiene, when to go to the doctor, when to stay home, etc.).
- Disseminate messages about the effectiveness of AVs (that they are only partly effective) and promote personal hygiene.
- Need to consider messages informing people that they, their children or other family members are not eligible for AVs due to age or not falling into a priority group.
- Consider pharmacies as a national means of communication. They are a natural point of contact for people, especially sick people.

Communicating with employees

- Communicating with employees who are anxious about entering facilities housing ill patients that need their services to continue functioning (e.g., utility workers).

➢ Transmission by Health Care Workers and within Hospitals

The discussion on transmission focused on transmission by health care workers and decreasing transmission within hospital facilitates.

Transmission by health care workers

- Health care workers could transmit influenza from location to location.
- The need for including long-term care in the State Pandemic Influenza Plan.
- A hospital representative commented that personal protective equipment is more available and that with proper training it could become more accepted and used.

Suggestions for decreasing transmission within hospital facilities include:

- Barrier protection
- Surveillance of symptomatic employees
- Acquiring travel history of patients
- Visitor restrictions
- Utilizing long term care
- Communicating in regional structure to stay informed

➢ **State of Emergency**

When asked if this scenario would be considered a state of emergency, representatives from hospitals, the military and local health departments responded as follows:

- Hospitals: No.
- Military: Would be moving in that direction—yes.
- Local health departments: Look at incident command and set up emergency center, know the number of ill people within the community.

➢ **Special Needs Populations**

- Prior to this stage of the pandemic, we would need to have discussions to identify the special needs populations and how to address their needs.
- There are also special needs in terms of health care needs, not just special needs populations.

Written Comments

Following are the written comments received from both participants and observers. The comments are organized into three topics: antivirals and vaccine; staffing, employment, and economic impact; and communication.

➢ **Antivirals and Vaccine**

- At what point would a decision be made requiring allocation of vaccine and antivirals? The later in the pandemic, the greater the amount of anxiety, fear, and suspicion around the issue—and concerns and accusations of unfairness.
    - Who will make this decision? Will CDC issue guidelines to be adopted or modified by state or local health departments or will each local health department decide separately?
- Are there any studies of resistance to long-term use of antivirals during an epidemic situation? Wouldn't the addition of a young-adult, high-risk group tax vaccine availability? For example, children versus elderly versus "the most productive members of society?"
- At this stage, would there be any control over availability of antivirals or would it still be open to market forces with hoarding, runs on pharmacies, etc.? It has been suggested that private stockpiling NOW [before the onset of the pandemic] will stimulate more production. Is that feasible, or are the companies already close to peak production?

- **Staffing, Employer Leave Policies, and Economic Impact**
  - Would organizations consider adding to number of sick leave days that an employee can take?
  - Recommend businesses evaluate long term minimum staffing levels and associated staffing plans, revisit sickness policies, training, and education.
  - Economic impact analysis—what are the insurance companies going to do—if they foresee future mass deaths and therefore policy payouts, what pressures will they apply?
  - ICS with minimum staff needed at this time. Provisions for long-term expansion should be planned. Contrary to the hospital comment (indicating ICS not needed yet), the hospitals need to plan for:
    - Long term staffing
    - Supply chain movement
    - Limiting visitor access, etc.
    - Surge provisions, beds
    - Maintenance
  - Manage public health staffing issues—mandate time off for percent of staff to maintain services through time.

- **Communication**
  - Issues that relate to communication and surveillance and were not addressed include: Geographic Information Systems (GIS)—need to include grocery stores, pharmacies, churches, schools, long-term care as well as, to extent possible, location of those ill (via hospital admission addresses etc.)—will then enable more rapid picture of disease/epidemic and also ability to pull labels for rapid information dissemination not only to public but public places.
  - Talk to essential services agencies regarding staffing issues should employees get sick—offer guidance/education to employees about when to stay home
  - Talk to essential services agencies about staffing issues—offer guidance in discussion—mention of staying home—what happens when whole family is sick (which is often the case with influenza)?
  - It is extremely important to maintain communication with surrounding states.
  - Need for public guidance, e.g., guidelines/algorithms for when to go to a doctor/ or the emergency room and when not to go (to contain spread, conserve resources, and allay fears).
  - Reverse 911—excellent mode for rapid notification via recorded message to those with phones. Public's need to feel they can have some control in protecting themselves, not dependent solely on government, is a factor in advising that although scientific data can't confirm benefit of mask, use of a mask may help and it does no harm. Public service entities (groceries, pharmacies, Dollar tree, etc.) may consider masks for employees and/or patrons.
  - Communicate with Medical Reserve Corps (MRC) and other volunteer organizations—inform, gear up, identify roles.
  - Work with media to clearly explain isolation and quarantine (voluntary and involuntary).
    - Reassure public regarding quality of life issues during quarantine.

Scenario Four: Widespread Outbreaks and Critical Shortages Occur Across the U.S.

Background

In June and July 2006, outpatient visits for respiratory disease have tripled in hospitals and clinics, facilities are filled beyond capacity, and high schools and community centers are being used as alternate care centers. There are severe staff shortages due to personal illness and absenteeism in order to care for family members. In addition, there are many employees who do not want to come to work due to fear of being exposed. Essential services continue to degrade due to the impact of the disease. Most hospitals are on diversion status. About 80 percent of the country is affected and the emerging problem is deciding what to do with the bodies of expired patients. In addition, public demand for a vaccine grows and there are demonstrations about the need for vaccine and concern over priority groups. AVs are exhausted. States are requesting federal assistance, but federal resources are not sufficient enough to meet the requests. Shortages of personal protective equipment occur. The estimated impact of the epidemic in Virginia over the last three months is: over 1.3 million outpatient visits; over 28,000 excess hospitalizations; and over 6,200 deaths.

Following are key discussion points and written comments shared by participants and observers.

Key Discussion Points

The key discussion points for this scenario are mental health needs, business-related issues, hospitals which have reached full capacity, expired bodies, and crowd control and public safety.

- **Mental Health Needs of Citizens, Health Care Workers, Emergency Responders and Others**
  - Consider health care workers and others who need stress reduction interventions.
  - Risk communication with the public.
  - Information sharing with other state agencies (health department lead).
  - Use federal funds for crisis counseling (such as after the September 11th terrorist attacks) to increase mental health capacity.
  - Consider who delivers the message—use speakers that represent the minority populations and media that target the minority population.
  - The health department should take the lead, but if the health department involves the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) early on, then DMHMRSAS can assist with creating messages.
  - The challenge is to continue the flow of information without creating media distrust.

- **Business-related Issues**
  - There is a need for information on when employees can return to work and determining when someone is again ready to return to work (case definition of resolution of illness).
  - Identify what corporate resources can be given to the community. Ensure there are appropriate staffing levels so supplies will be available to the responders who need them.
  - Encourage employees to use the employee assistance program for mental health needs.

- **Hospital Capacity and Related Issues**
  - Alternate care facilities need planning efforts and resources, and need to be discussed in order to set them up. Since the September 11th terrorist attacks there have been discussions, but no forward progress has been made.
  - Responding to a pandemic is a resource issue. Responding to a surge must be done at the community level.
  - Ensuring adequate staffing levels is an issue.
  - Suggestion that people embrace home care—that the ill be cared for at home by family with specific guidelines for when to get higher levels of care.
  - If promoting home care, the health department should create basic messages for the public on seeking higher levels of care (when it is necessary to go to the hospital and who needs to seek higher levels of care).
  - The issue of home care versus hospital care is complicated due to hospital liability. Hospitals have a federal obligation to screen and stabilize any patient who enters the hospital (even if the patient panicked and is not infected).
  - A possible resource for strengthening future discussions on pandemic planning is the report from the University of Pittsburgh and the Society for Critical Care Medicine on the panel that was convened to discuss rationing critical care. This report could be used as a starting point for a broader discussion—it can be used as a template on how to apply uniformity to ethical discussions.

- **Expired Bodies**
  - The doctor who attended the patient should sign the certificate of death.
  - The hospital makes arrangements for the proper bagging, labeling, and funeral home pick up.
  - Hospitals must identify an area where the bodies can be kept cool (morgue, basement, refrigerated trailers, etc.)
  - Funeral directors and their national organizations need to be working with state organizations and agencies to develop plans for retrieving bodies.

- **Crowd Control and Public Safety**
  - State police are trained for crowd control. Plans already exist and are ready to be implemented. When working on public safety to prevent infection, police need some consideration in the supply of the vaccine. Police would have to enforce orders for quarantine, secure stockpiles of vaccines, provide site and scene security, and work with the Disease Mortuary Operational Response Team (DMORT). If the police are infected with the virus there would be staff shortages and this would be a problem.
  - Hospitals will need additional security.
  - Emergency Medical Services (EMS) personnel would require thorough training to prepare for the kind of situation presented in this scenario.

Written Comments

Following are the written comments received from both participants and observers. The comments are organized into four topics: surge, antivirals and vaccines, public safety, and miscellaneous issues.

- **Surge Issues**
  - Surge continues to be an issue, particularly for rural areas. Not only facility and personnel, but equipment.
  - How many workers, i.e., hospital, public health, emergency medical services, medical reserve corps would report to work versus sheltering in place so as not to "expose" their family?
  - Solutions to personnel in hospitals—like using medical and nursing students and public health nurses to provide care weren't suggested or addressed. Also, looking at counties that have limited resources in order to prioritize who should get the limited resources wasn't suggested.
  - What about appeals to businesses to defer some routine work and pay staff to fill some needed public service roles? There should also be a review of laws and plans for how they would be invoked (and others revoked) in widespread shortages.
  - Involve parish nursing organizations for staffing (also cancel classes and use students). Cancellation of public events—compare to "sniper" in numbers and probability of death by attendance—cancel NASCAR. We cancelled school, football games, parades, etc. for sniper.

- **Antivirals and Vaccine**
  - Wouldn't allowing personal caches of antivirals likewise prompt an increase in supply and as supply volume grows, costs could go down?
  - What about antibiotic supplies for secondary infections? Acute Respiratory Distress Syndrome (ARDS) has high mortality even under best of circumstances —need ventilators, supportive care—how will this be handled?

- **Public Safety**
  - Could an influenza epidemic represent a target of opportunity for bioterrorism? It would seem that detection of agents would be difficult to identify in the background of ill/dying influenza patients.
  - Great time for an insurgent to inject a terrorist situation, or incite fear/panic.
  - Discussion on food supply chain integrity needed; public stockpiling of non-perishables needed?
  - What are hospitals doing to address crowd control? Local law enforcement will be overwhelmed and not necessarily available.

- **Miscellaneous issues**
  - It's important to provide good information to natural support systems such as primary care physicians and clergy.
  - Issues that need to be addressed:
    - Situation is a paradigm shift: "usual rules" do not apply
    - Triage
    - Rationing of resources and associated ethical issues (in this scenario, resources will be inadequate and must be allocated/prioritized).
  - Plan A: Most plans call for setting up a dispensing site for meds. I'm concerned that most people will not leave their homes for fear of becoming infected. What about Plan B for those not coming to sites?

Scenario Five: The First Batch of Vaccine Becomes Available

Background

In August and September 2006, the first doses of vaccine become available and are distributed to the priority groups. Doses are available for 1 percent of the population per week. There is not enough vaccine for everyone. Many are outraged that they are not included in the priority groups. Media reports focus on personal interest stories of those not in priority groups. Public demonstrations occur at vaccine plants and at public health clinics. There are security concerns at facilities with vaccine and antiviral supplies. Localities are demanding that the National Guard assist them with security. As the academic year begins in September, there are concerns about whether or not to open schools and universities. Many feel that it is impractical to keep schools closed for the duration of the pandemic. Yet, many parents refuse to send their children to school. In addition, there is concern among teachers and staff about being exposed at school.

Following are key discussion points and written comments shared by participants and observers.

Key Discussion Points

The key discussion topics included a comparison of priority groups identified in the current Virginia Strategic Plan for Pandemic Influenza to those identified in the plan created by the Canadian government, determining and communicating about vaccine priority groups, distributing a limited supply of vaccine, and public safety at vaccination sites.

- **Priority Groups Not Yet Identified in the Current Virginia Strategic Plan for Pandemic Influenza**
  - The discussion addressed these possibilities:
    - 1st tier: Health care workers and persons involved in direct medical care or transportation of ill patients. Persons at high risk of mortality and morbidity.
    - 2nd tier: Emergency personnel, security personnel, etc.
  - The Virginia Department of Health stated it needs assistance in determining priority groups.

- **Priority Groups in the Canadian Pandemic Influenza Strategic Plan**
  - 1st tier: Health care workers (labs, physicians, nurses, pharmacists, EMS, etc.)
    - 2nd tier: Essential service providers – armed forces, police, elected officials, etc.
    - 3rd tier: High risk patients

- **Determining and Communicating about Vaccine Priority Groups**
  - Develop criteria for determining priority groups prior to reaching this scenario.
  - Include public opinion so that the process is perceived as fair. The process of explaining the reasons for the policy must also be clear.
  - The issue of whether the vaccine will be delivered through the public sector or the private sector remains.
  - Last year with the shortage of vaccine for the influenza season, CDC did not want to decide priority populations due to differences among states. However, when the vaccine was distributed, if the state was distributing the vaccine and distributed the first wave of vaccine to long-term care facilities, then the state received less of the vaccine distributed in the second wave.
  - The Department of Fire Programs expressed concern over the current prioritizing of groups because first responders were identified as health care workers. This participant made the argument that people dial 911 when they are sick and therefore firefighting volunteers, who also serve as EMS personnel, are those who have initial contact with sick individuals. In addition, there was concern that if firefighters did not receive vaccine, then firefighters would no longer respond to 911 calls for sick individuals.
  - Important to be clear and specific when identifying priority groups from the start. In the past people had to be turned away because their definition for the priority group was not specific enough, and people that hadn't been considered for that group showed up for vaccine. For example, if saying direct patient contact makes one eligible for vaccine, be sure to be more specific (e.g., indicate the number of minutes spent with the patient).
  - It was noted that there may be other emergencies that the state and the country are dealing with at the time of the pandemic and that the discussion assumed the pandemic was the only emergency.

- **Distributing a Limited Supply of Vaccine**
  - Logistically the department of health will need assistance. One percent of the Virginia population is 70,000 people. The department of health would need assistance vaccinating people if one percent of the population were being vaccinated per week.
  - With priority groups it is easy to verify someone's age, but it is considerably more difficult to verify someone's medical condition if they don't have their medical records. Need to identify a way to verify medical conditions that make individuals eligible for vaccine.
  - Need to be careful about messages for the public because the vaccine is delivered in waves. You don't want to have vaccine left over if people get discouraged from limited supplies.
  - Consider that the traditional influenza season may coincide with the pandemic.

- **Security at Vaccination Sites**
  - Dispensing sites for mass vaccines have already been identified.

- If the vaccine is distributed via the private sector, the security concerns will need to be addressed at the community level.

Written Comments

Following are the written comments received from both participants and observers. The comments are organized into three topics: vaccine priority groups, communication and policy, and miscellaneous issues.

➢ Vaccine Priority Groups

- Take action now to develop vaccine priority groups.
- How much say will the state or locals have with earliest vaccine supplies or will it really be directed by federal government? Perhaps state should prioritize to localities and let each locality decide how to allocate locally, which will give the most incentive to plan ahead.
- Vaccine priorities—may need to be geographically based—i.e., rather than vaccinate all health care workers in the state you may have to focus on the geographical areas of greatest risk.

➢ Communication and Policy

- Should have addressed/educated the public regarding the issue of vaccine priority groups at Scenario 3 or earlier (know this issue will arise; need to strive for public acceptance in advance). Need to pre-qualify/pre-register persons in high risk groups.
- What about getting across information on what does NOT work—e.g., homeopathy, herbal, often alternative needs (was an issue in 1918 also!).
- Establish concise policy decisions and stay the course. Consistent messages will be needed.

➢ Miscellaneous Issues

- In absence of good data and guidance, allocate resources based on efficiency.
- We really need to look at maintaining infrastructure—water, electricity, 911.

Scenario Six: Additional Vaccine Arrives in Virginia; Preparation for Second Wave

Background

From October to December 2006, Virginia continues to receive about 71,000 doses of vaccine per week. Vaccination of priority groups continues. In November CDC releases a study that indicates two doses of vaccine are needed for complete protection against illness. First dose provides some reduction in serious complications. The state faces decisions about how to allocate vaccine, given the study findings. In December, the first wave of the pandemic appears to be ending. In Virginia there have been nearly 12,000 deaths over the last six months. The CDC is predicting that the second wave will cause more morbidity and mortality than the first wave.

Following are key discussion points and written comments shared by participants and observers.

Key Discussion Points

Key points focus on vaccine doses and preparing for a second wave of the pandemic.

- **Vaccine Doses**
  - The Virginia Pandemic Influenza Plan does not indicate if priority groups receive a second dose of vaccine before the general population receives a first dose.
  - If only 10 to 20 percent of those who received a first dose are protected, then it makes no sense to give a first dose to the second priority group, but would be better to give a second dose to those who have already received a dose. However, if 80 percent of those who received a first dose are protected then it makes sense to give a second priority group a first dose instead of giving a second dose to those who already have received a dose.

- **Preparing for a Second Wave of the Pandemic**
  - Ensure there is ongoing communication with the public. Need to communicate anticipation of second wave of vaccine so that people continue getting vaccinated and there are no leftover vaccines.
  - Involve elected officials because they will be making difficult decisions about prioritization and distribution and will also be the ones to relay their decisions to the public.

Written Comments

Following are the written comments received from both participants and observers. The comments are organized into two topics: vaccine priority groups and dosage and miscellaneous issues.

- **Vaccine Priority Groups and Dosage**
  - The decision of one or two doses should be made at the time based on the data available at the time.
  - Need to determine objectives of vaccination (e.g., decrease demand on health care system, prevent death, preserve vital infrastructure capacity, maximize years of productive life, etc.) and frame priority groups accordingly.
  - Vaccinate more with one dose; future ramifications of government action will be heavily scrutinized.

- **Miscellaneous Issues**
  - Education of the public regarding options to vaccinate children to protect the elderly, should be emphasized before a critical decision is needed. To wait until crisis, will spread the opinion that "the government is trying to get rid of the elderly."
  - Pregnant women are particularly affected, as are their fetuses. What special considerations will address this issue as well as premature births, impacts on Neonatal Intensive Care Unit (NICU), etc.? Pregnant women are also more susceptible to mental health needs—concerns for baby, etc.
  - Economic and transportation infrastructure impact issues need to be evaluated.

Additional Written Comments

- We need to recognize that pandemic does not equal a typical influenza season; that it is more severe; and qualitatively different. Avoid “fighting the last war” (i.e., don’t base planning on experience prior to influenza season).
- Written materials in diverse languages and accurate translation for understanding should be available to insert vital information.
- Cultural diversity and how medical advice/instructions from governmental resources should be considered/studied and an action plan will be required.
- A collaborative effort across all levels of governmental organizations and the media to communicate vital messages for public action in diverse languages (i.e., Spanish, Asian dialects, etc.) for accuracy and understanding should be implemented. Racial and ethnic minority groups make up 30 percent of Virginia’s 7.3 million population.
    - The 30 percent is merely an approximate assessment. The numbers are larger when illegal residency is addressed. The migration of workers (migrant farmers) throughout the state must be considered in vital health communication and action steps must reach the man-camps with the correct translated communication and the authority to see that actions are implemented.

VDH PANDEMIC INFLUENZA WORKSHOP
RICHMOND, VA
JUNE 23, 2005
9:00 AM – 3:30 PM

EVALUATION REPORT

Introduction

This section of the report summarizes evaluation results from the Workshop.

One hundred evaluation forms were completed. Approximately 30 percent of the evaluations were received from participants; the remaining 70 percent were received from observers. Overall evaluation results — both ratings and written comments — were very positive.

The evaluation was divided into two parts. The first part of the form evaluated the participant's opinions on each of the six scenarios. The questions were designed to capture the participants' perceptions of how realistic each scenario was, whether the discussions of each scenario was productive, and whether key issues around pandemic planning for each scenario were identified. Participants were also given the opportunity to provide written comments for each scenario. During the meeting, participants were asked to complete the scenario-based evaluation questions after each scenario discussion.

The second part of the evaluation form was designed to capture meeting attendees' opinions about the overall meeting and to determine if meeting objectives were achieved.

The following Evaluation Report outlines the evaluation results and is organized in the same manner as the evaluation form. Section one provides the results of the assessment of the six pandemic scenarios and the full list of comments. Section two provides the results of the meeting assessment.

SECTION ONE: SCENARIO EVALUATIONS

SCENARIO ONE: EMERGENCE OF A NOVEL INFLUENZA STRAIN

Scale: 1 to 4 (1 = strongly agree, 4 = strongly disagree)

TO WHAT EXTENT DO YOU AGREE THAT…	AVERAGE RATING	NUMBER OF RESPONDENTS
THIS SCENARIO WAS REALISTIC?	**1.54**	**98**
THE DISCUSSION OF THIS SCENARIO WAS PRODUCTIVE?	**1.77**	**98**
THE DISCUSSION OF THIS SCENARIO IDENTIFIED KEY ISSUES FOR PANDEMIC PLANNING?	**1.77**	**98**

COMMENTS:

➢ ***Issues of Concern***

- Communicating to diverse residents throughout the Commonwealth is a concern that was not addressed.
- Need to address existence (or not) of airport and airline infectious traveler plans: passenger information, notification to public health, passenger manifest, destination, and contact numbers.
- Business views are important—little recognition by VDH to work with business on economic impact and planning with them to protect workforce and nation.
- Need more medical examiner investigators to provide better MED-X surveillance and capture of suspect deaths.
- The months chosen for the beginning of an influenza virus are not realistic. Because there's a *novel* strain identified, a lot of concerns will be raised.

➢ ***Helpful Tips***

- A copy of *all* scenarios to reference would have been very helpful.
- It would have been beneficial to know what actions are in place now to address these issues prior to a pandemic and identify issues to work/develop situations.
- Not sure that specific lessons learned were shared. Recommend second laptop projection that catalogues key points of discussion.

➢ ***Other Comments***

- Agree that planning gets "carried away" too early during "exercises." Realistically, we may not move forward so quickly.
- Improve communication; Public information needs; One voice. What's the message?
- Highlighted the need for communication between stakeholders and for pre-planning scenarios and understanding the actions to be taken when, by whom and how.

SCENARIO TWO: WHO DECLARES ONSET OF INFLUENZA PANDEMIC
Scale: 1 to 4 (1 = strongly agree, 4 = strongly disagree)

TO WHAT EXTENT DO YOU AGREE THAT…	AVERAGE RATING	NUMBER OF RESPONDENTS
THIS SCENARIO WAS REALISTIC?	**1.50**	**98**
THE DISCUSSION OF THIS SCENARIO WAS PRODUCTIVE?	**1.62**	**98**
THE DISCUSSION OF THIS SCENARIO IDENTIFIED KEY ISSUES FOR PANDEMIC PLANNING?	**1.62**	**99**

COMMENTS:

➢ ***Surge Capacity***

- After several years, we still have not solved the problem of surge capacity.
- Isolation and quarantine issues are key. Realistic scenario that hospital surge capacity will probably be nonexistent was a very interesting comment.
- Hospital surge issue was a very important issue to discuss.
- I don't think that issues such as "surge" were actually solved.
- Surge capacity seems to be an area that needs more consideration. Also highlights need to emphasize staffing and hospitalization shortfalls.
- Triage and surge capacity and possibility of care outside of hospital setting were not addressed.
- Additional graphics which reinforce numbers of patients (attack rate) would be useful to demonstrate the points related to surge capacity. Also, reference to state regulations and documents suggests these would be useful to review/make available.
- Surge is everyone's issue—other medical facility care areas need to be planned for (sheltering in home, etc.).
- Need to be more proactive on initiating community surge planning/provisions at this point with all partner agencies at the local level, as well as hospitals. Make Tamivir® available early on for personal stockpiles. This will stimulate production of more supply based on the demand.

➢ ***Issues of Concern***

- Didn't come up that the CDC would probably be issuing guidance and the federal level would likely be controlling such issues as international travel, etc. Travel advisories would also likely be issued regarding travel to and from Asia, etc.
- Only the what, not the how—lack of practical plans. Still only thinking in theory.
- Department of Corrections (DOC) numbers expected based on information provided: 7,500 sick calls; 150 hospitalizations; 37 deaths.

➢ ***General Comments***

- Believe it would be beneficial to have representation from the media present.
- Need more issues identified.
- More time needed to hit more issues.
- People have a tendency to escalate their responses beyond this point in the scenario.
- Need to keep discussion focused on the relevant scenario—tended to stray into the next stage.

SCENARIO THREE: THE PANDEMIC ARRIVES IN VIRGINIA
Scale: 1 to 4 (1 = strongly agree, 4 = strongly disagree)

TO WHAT EXTENT DO YOU AGREE THAT…	AVERAGE RATING	NUMBER OF RESPONDENTS
THIS SCENARIO WAS REALISTIC?	**1.56**	**99**
THE DISCUSSION OF THIS SCENARIO WAS PRODUCTIVE?	**1.66**	**99**
THE DISCUSSION OF THIS SCENARIO IDENTIFIED KEY ISSUES FOR PANDEMIC PLANNING?	**1.67**	**99**

COMMENTS:

➢ ***Premature Discussion***

- I am not convinced that many of the stated activities would have begun with 32 cases.
- Discussion seemed to get ahead of current status in scenario (only 32 patients). We were already into pandemic status.
- Scenario discussions were premature for the incidence described in the scenario description.

➢ ***Issues of Concern***

Roles and Responsibilities

- Great point in conversation. Role of private sector versus government and the resources needed (public wants government protection, but resources tied up in private sector) needs to be addressed.
- Excellent plans and processes at the administrative, policy and executive levels, but weak at the level of actual communication to the public in rural and remote areas of the state.
- Liability issues.

Antivirals

- What are methods/means to provide or "drive/require" increased production/supply of antiviral medications? (So not "caught" with shortage of supply.)
- Can local pharmacy and hospital resources for antivirals be surveyed and quantified, so public health is aware where they are in the state.
- More interaction/comment from business and insurance sector is needed. Resolve national policy on antiviral use. Hospitals need to move towards an ICS structure at this point!

Additional Discussion Points

- Should have reported not just Virginia statistics but national/international to have understanding (age, mortality rates, impact of treatments, etc.). Should give out more scientific or capacity baseline information to assist discussion (more on morbidity of cases, current capacity for more antivirals, etc.).
- Families exposed to members of the military may not show symptoms; however, carriers could be exposing others in child day care settings and/or schools. What measures will be taken to protect child care providers, teachers, and the children? Where do these persons fall in the priority groups?
- This segment raised several questions which need to be addressed. I don't think that we worked well on discussing prioritization, recommendation to Governor.
- Instead of speaking about confirmed influenza, we should speak to the number of people flooding the healthcare system and complaints of influenza or influenza-like illness. Resources would not be available in every jurisdiction and education of the public is key for hygiene and voluntary isolation.

- Discussion about limiting visitors to long-term care facilities. Also think limiting visitors at hospitals, mental health facilities, correctional centers, etc. would help lessen the spread of disease.
- In the Department of Corrections the issue of rationing care versus value of life is political. As media presents to public, offenders may not get community standard of care.
- The interplay of three different entities in the Capital region was an important topic that deserves further discussion.
- A reminder of the necessity to adopt infection control procedures (hand washing, etc.) was important.
- Solutions were not being discussed. Identification of issues discussed.
- Very valuable side bar discussions. Very thought provoking ethical issues raised.
- Regional Hospital Coordinating Centers.

SCENARIO FOUR: WIDESPREAD OUTBREAKS AND CRITICAL SHORTAGES OCCUR ACROSS THE U.S.

Scale: 1 to 4 (1 = strongly agree, 4 = strongly disagree)

TO WHAT EXTENT DO YOU AGREE THAT…	AVERAGE RATING	NUMBER OF RESPONDENTS
THIS SCENARIO WAS REALISTIC?	**1.51**	**95**
THE DISCUSSION OF THIS SCENARIO WAS PRODUCTIVE?	**1.63**	**96**
THE DISCUSSION OF THIS SCENARIO IDENTIFIED KEY ISSUES FOR PANDEMIC PLANNING?	**1.59**	**96**

COMMENTS:

➢ ***Partners***

- I am not clear if home health/personal care agencies are represented today. If not, shouldn't they be?
- Inclusion of faith-based education as well as community targeted media campaign of a unified message of how to protect oneself and family. What degree will law enforcement enforce quarantine? Telecommuting may offer some relief. A combination of efforts would aid in reducing exposure and transmission.
- Communities not mentioned, but should be part of discussion: faith based, churches, jails/corrections.

➢ ***Issues for Further Discussion***

- Telemedicine may be considered when hospital capacity is an issue and how to access this service for alternate care (possibly in the home).
- Not too much discussion on alternate non-traditional medical care, treatments, and prevention of spread of influenza.
- It all comes back to surge capacity—both facility and manpower. The other issue is the uninsured; they will flood the emergency department.
- Public will need guidance on stockpiling non-perishable foods. Food supply chain will be degrading quickly. This is now a prime opportunity for an insurgent organization to incite fear and panic and possibly inject additional hazard challenges! Hospitals need stand-alone crowd control measures.

➢ ***Other Comments***

- This level scenario is too overwhelming for good effective all purpose discussion. Subgroups focused on only part of the problem would be better.
- State level emergency powers issues particularly interesting.
- Mental health aspect of discussion interesting, especially regarding strategies to target different cultural group.
- In DOC, healthcare of more than 30,000 offenders will be at the mercy of state officials and employees. It becomes a politically charged issue to provide healthcare to offenders at the expense of the general public. Media (TV/newspaper/radio) create interference and friction. Include media representatives in future discussions. Call resources—vaccine, antivirals and healthcare workers. Healthcare staffing is huge issue in already stretched system where security is important.
- VDH appears to be very willing to get bogged down in public relations concerns. Public health has to make (or provide leadership to make) the hard ethical decisions for worst case scenarios and hopefully adjust up when this occurs. Public health model versus medical

model.

➢ *Areas of Concern*

- Did not address possible solutions to the shortage issues.
- It, the discussion, identified key issues but didn't address ways that we could solve the problems.
- Problems!
- Lots of questions were raised but few answers provided or even much consensus on what answer or who provides answer.
- May be most challenging aspect of the pandemic.
- Many unanswered questions.
- More questions than answers!

SCENARIO FIVE: THE FIRST BATCH OF VACCINE BECOMES AVAILABLE
Scale: 1 to 4 (1 = strongly agree, 4 = strongly disagree)

TO WHAT EXTENT DO YOU AGREE THAT…	AVERAGE RATING	NUMBER OF RESPONDENTS
THIS SCENARIO WAS REALISTIC?	**1.49**	**92**
THE DISCUSSION OF THIS SCENARIO WAS PRODUCTIVE?	**1.63**	**92**
THE DISCUSSION OF THIS SCENARIO IDENTIFIED KEY ISSUES FOR PANDEMIC PLANNING?	**1.59**	**92**

COMMENTS:

➢ ***Prioritization and Distribution***

- Prioritizing vaccine recipients needs to be done before. Maybe start a state-wide committee now and send recommendations to higher officials. Public education needs to start *now*.
- Prioritizing those who get limited vaccine must be worked out and the reason for the decision must be communicated to the public. The decision must be fair and acceptable. Therefore, in developing the process for deciding, include the lay person(s) in that activity along with the other disciplines (ethicist, medical, nursing, emergency management, local/State Government, etc.).
- Priority groups need much discussion before final decision is written into a plan. Verification of medical need must be addressed in a pandemic, and locations must be identified. If schools and day cares are closed, care for children becomes an issue, particularly if the primary caregiver is a healthcare professional or other worker responding to pandemic.
- Need a process *now* for making resource allocation decisions. Now or later. A national goal of prioritizing needs to be articulated for guidance.
- Good discussions about *carefully* defining "those eligible for vaccine" prior to pandemic. Can learn from past vaccine shortages. However, this will be more severe and concerning. People will panic.
- A plan for who gets vaccine first needs to be codified for the state of Virginia. Also, specific groups within first responders/health professionals need to have a plan within their group that prioritizes who gets vaccine.
- Why would we not want to let the public know now the priority groups, especially with the fall 2006 being highly speculative?
- Agree that a *process* for prioritization should be a follow-on responsibility of the advisory group.
- Needed to discuss more planning of how to identify the priority groups.
- Need to identify possible solutions to distribution issues.
- Too much emphasis on vaccine allocation without consideration of ongoing epidemic, shortages, chaos, etc.
- Unrealistic expectations of local, state law enforcement capability. Ramp up Virginia National Guard earlier! It's a fallacy to think Virginia has the capability to staff as many dispensing sites 24/7 as was inferred!

➢ ***Other Comments***

- The "hottest topics" so far. This is where the populace might be really fired up emotionally.
- Need to include private citizens in this discussion.
- A lot of unanswered questions not decided upon.
- My overall question/concern now is with the questions that have been raised. What is the format

for developing responses? How will this plan then be communicated going forward?

- Concern about the responsibility of healthcare administrators when front-line workers refuse to take the vaccine in the event it will "give them the flu."
- People aren't going to quit calling 911 and having other life threatening conditions. These first responders are important. We really need to look at infrastructure and essential functions. No electricity and water means poorer hygiene and less hand washing and more disease.
- Virginia DOC currently provides influenza vaccine to healthcare workers (HCW). Need to work to assure HCWs take advantage of immunization. DOC needs to consider providing vaccine to correctional officers. Need to find ways to avoid DOC hospitalizations because of strains on security.

SCENARIO SIX: ADDITIONAL VACCINE ARRIVES IN VIRGINIA: PREPARATION FOR SECOND WAVE

Scale: 1 to 4 (1 = strongly agree, 4 = strongly disagree)

TO WHAT EXTENT DO YOU AGREE THAT…	AVERAGE RATING	NUMBER OF RESPONDENTS
THIS SCENARIO WAS REALISTIC?	**1.63**	**76**
THE DISCUSSION OF THIS SCENARIO WAS PRODUCTIVE?	**1.81**	**75**
THE DISCUSSION OF THIS SCENARIO IDENTIFIED KEY ISSUES FOR PANDEMIC PLANNING?	**1.78**	**74**

COMMENTS:

➢ ***Dosage Issues***

- Protect more with one dose instead of two dose series—future ramifications and trust of government. Look back at Tuskegee.
- Discussion of second vaccine needed. Think giving one vaccine dose per person more beneficial than giving two doses to only half the people. *Some* is better than *none*.
- Issue of one of two doses is a good one but ultimate choice should be based on data available at the time. This is one decision that can wait.

➢ ***Other Comments***

- To educate public better, more elected officials should be involved in decision-making process.
- Nice job, in getting the information on the table, but where does it go from here? Some of the representatives needed from state, federal, and local. What will the priority *roles* be for local, state and federal? 1. Infrastructure 2. Essential services 3. Roles: expectations
- Very difficult decisions with this scenario. The group seemed a little more reluctant to address them.
- I think everyone was winding down.
- Group began to wear out.
- Fatigue left many issues unstated.
- People were tired and issues had already been covered.

OTHER COMMENTS ON THE SIX SCENARIOS:

- The discussion points to a need for a very well planned communication system to disseminate information at every stage of a pandemic. It is not clear that such a comprehensive plan is in place to keep all affected groups informed. This is a significant issue.
- Reduce exposure and transmission:
  - o Hand hygiene
  - o Cough and sneeze etiquette
  - o Stay at home when ill, unless severity reaches a particular criteria (i.e. fever greater or equal to 103 degrees Fahrenheit, difficulty breathing, etc.) requiring hospitalization
    - Self-care when possible
    - Telecommuting
  - o Widespread media campaign with a unified message that is racially/culturally appropriate
    - Television, radio, billboards, flyers
    - Faith-based leaders
  - o Educate community/public of self-care, reduce transmission and exposure
  - o Large scale vaccination program prior to the influenza season for priority groups (whatever the group is defined as)
  - o Appropriate messages should be developed now and modified to fit specific situations
- Oversight, coordination responsibility unclear. Clear what must be done in a pandemic; not so clear who has responsibility to do it.
- Still needs flushing out and practical procedures. Reassuring that a plan is in progress.
- Need more planning meetings. Too many issues to be discussed/clarified in one day.
- The role of observer was clearly explained, yet expanded to include them which is good. For question about if the location of meeting was convenient—I came from out of town, but obviously regional so had to be centrally located. Facilitator—excellent job!
- Great discussion! I am new to this topic, but overall the approach to the solution was still assuming traditional approaches. Good, but if the resource issues were easy to solve, it would have been done already. Would like to see some brainstorming session on less traditional approaches, perhaps centered on prevention, home care, etc.
- Too long a morning session without a break.
- Seating for observers was uncomfortable and vision was blocked.
- Unable to stay entire day, so unable to respond to number 2 completely [Section 2, Number 2].
- Overall, I think that the questions were very good at encouraging discussion.
- Excellent! Comprehensive!

SECTION TWO: MEETING EVALUATION

STATEMENTS ABOUT THE MEETING

This section of the evaluation form included a series of questions about the meeting. Specifically, meeting attendees were instructed to answer statements about the meeting by indicating if they strongly agree, agree, disagree, or strongly disagree with each statement. They were also instructed to choose N/A for questions that are not applicable.

Following are the average assessments for each statement along with the number of meeting attendees who responded to each question. The assessments are based on a scale of one to four, with one representing strongly agree and four representing strongly disagree.

Scale: 1 to 4 (1 = strongly agree, 4 = strongly disagree)

STATEMENTS ABOUT THE MEETING	AVERAGE ASSESSMENT	NUMBER OF RESPONDENTS
The purpose of the meeting was clear.	**1.61**	**85**
The meeting met my expectations.	**1.79**	**85**
The framework for participant discussion in the meeting was clearly explained.	**1.55**	**85**
The role of observer was clearly explained.	**1.61**	**84**
The facilitator was effective at engaging participants in discussions around the six scenarios.	**1.40**	**86**
The facilitator was attentive to participant concerns and needs.	**1.44**	**85**
The meeting facilities were satisfactory.	**1.61**	**85**
The location of the meeting was convenient.	**1.60**	**85**

MEETING OBJECTIVES

This section of the evaluation form was designed to assess the extent to which attendees agreed that the meeting objectives were met. Meeting attendees were instructed to indicate whether they strongly agree, agree, disagree, or strongly disagree that the following meeting objectives were achieved.

The assessments are based on a scale of one to four, with one representing strongly agree and four representing strongly disagree.

Scale: 1 to 4 (1 = strongly agree, 4 = strongly disagree)

MEETING OBJECTIVES	AVERAGE ASSESSMENT	NUMBER OF RESPONDENTS
The essential factors of a pandemic response were identified.	**1.52**	**84**
Key policy decisions that are needed for an effective response were identified.	**1.76**	**84**
The prospective role of each organization in response to a pandemic was identified.	**2.05**	**84**

OPEN ENDED QUESTIONS

Following are responses to the seven open ended questions that were included on the meeting evaluation form.

WHAT RESOURCES WOULD BE USEFUL TO YOUR AGENCY OR ORGANIZATION TO ASSIST WITH PLANNING FOR PANDEMIC INFLUENZA?

- ***Priority Groups and Vaccine Distribution***

- In corrections — set priorities for healthcare workers, correctional officers, and high risk offenders prior to pandemic to prevent political implications for providing healthcare to offenders over general population.
- Need to develop more specific policies on priority groups and dispensing.
- Prioritization for vaccine and antivirals.
- Knowing how vaccine will be distributed. Knowing who we can rely on for assistance.
- Consensus prioritization of resources across the state, i.e., antiviral medicines and respiratory protective equipment. Sharing of syndromic surveillance data with key stakeholders.

- ***Guidance/Guidelines***

- Federal guidance.
- National guidance.
- Guidelines.
- *Clear guidelines*: (1) for prioritization of vaccine (2) contact/case influenza (3) case definition (4) diagnosing lab guideline. Communication of guidelines for lab work and case definition to private providers. State hotline as opposed to district managed hotline for citizen calls. Rather than distribute all vaccine through local health department, route vaccine for long-term care center/hospitals through Virginia Health Care Association to private providers through Medical Society, to local Emergency Management Services (EMS) through Virginia Department of Fire Programs; etc.
- Clear and early policies from CDC.
- CDC priorities.
- Role definition.
- Clear guidelines from state and federal level. Folks were hesitant to take responsibility.
- Clear guidelines are needed from the health department and CDC.
- Surge guidance.

- ***Access to State Plan***

- Copies of VDH Pandemic Influenza Plan, either paper or electronic, that we can share with all pharmacists in Virginia. Accurate, current information on a true potential pandemic. Knowledge as to whether or not pharmacists would be used to administer vaccine in a pandemic.
- Updated state plan.
- Comprehensive state plan.
- State plan.
- An updated plan to share with our local public safety partners.

- Basic knowledge of VDH planning process.
- State (central office) issue pandemic influenza plan.

➢ ***Templates***

- Templates.
- Templates.
- Template/example plans from other jurisdictions/organizations and/or higher level plans (e.g. national level).
- Template for a generic plan for health agencies and if possible, all types of agencies to help bring consistency.
- Scenario planning and techniques for getting citizens involved in planning (including at the state level).

➢ ***Leadership/Responsibilities***

- Leadership from VDH. Partner with the media, universities.
- Know extent of decisions from above. For example, the Federal Government needs to decide how far they will go so states know where they start and then same for locals.
- More advance decisions or at least decision support matrices to help move the process along when needed.
- We need to be sure that responsibilities are imposed on agencies/organizations with necessary authority over responding agencies/organizations. For example, surge capacity must be managed by agency (state or local?) with authority to direct respond. Hospitals can't coordinate or manage it.
- ACF—will there be these and who will be responsible?

➢ ***Communication***

- GIS-based statewide alert network. Interoperable with local system.
- PIO messages starting now.
- Direct and frequent communication with "higher" levels.
- Risk communication resources.
- Public awareness campaign in general, stressing public health messages, such as hand washing and when and how to report.
- Will need communications that we can help to disseminate information on the pandemic; steps to take at home and/or work; how prioritization was done.
- Prefabricated risk communication messages. More training on risk communication to the public.
- Educational materials to distribute to the public.
- Teaching tools to explain the pandemic influenza plan and issues to public safety partners.
- Improved communications capability, such as computerized dialers/broadcast capability.

➢ ***Additional Resources***

- Staff!
- Vaccine, prescriptions, other supplies.
- Additional disaster staff.

- Resources. Staffing.
- More staff resources! (State level planners.)
- More staff, especially nurses.
- Data on production of some of the resources anticipated to be needed in a pandemic. If the pandemic would last for months, it would be good to have "triggers" established to increase manufacturing of non-drug/vaccine resources such as (1) masks (2) respirators (3) negative air flow rooms or spaces. How long, how much money to increase production?
- Twelve medical examiner investigator full time employees for surveillance, fulfill implementation of MED-EX.

➢ ***More Information***

- More information on body disposal. Putting in place Memoranda of Understanding (MOU's) for providers to handle routine clinic services.
- The meeting minutes or a report would be helpful.
- Case definition. Resolution state. MM. Transmission state. Travel advisories. Vaccine availability. Antiviral guidelines.
- For family physicians, who to call for information (local health department, state, etc.)?

➢ ***Other Comments***

- To work with the regional team/private sector to plan for entire community.
- Volunteer and first responders who will assist us. Better cooperation from the local schools in our community.
- None, if the pandemic follows the scenarios discussed in this session. However, there are potential zoonotic implications for the pork and poultry industries.
- Who gets immunized/prophylactic medicines first with city government, workers, etc.?
- Poor people are well-known to Departments of Social Services (DSS). Almost any situation affecting their lives will become known to DSS. DSS offices are open to walk-ins who bring into a facility/work place whatever diseases, infections, etc. they may have. As such, DSS buildings and staff become vulnerable to exposure. Your expertise and suggestions for carrying out our essential functions during a pandemic would be appreciated. Closing our offices probably won't happen, therefore, our staff remains vulnerable.

HOW WILL YOU APPLY THE INFORMATION GAINED FROM THE MEETING TO YOUR CURRENT AND FUTURE WORK?

➢ ***Share Information from Meeting with Organization and Staff***

- Share information with fellow employees.
- This will enable my work site to be more enhanced by my sharing this information.
- Will share information with Virginia pharmacists through our Web site, journal articles, meetings, etc.
- Relay information to our medical director. Staff and employee education. Remain current in influenza issues.
- To facilitate discussion in my office toward addressing unmet needs.
- Copies of handouts will go to my district offices.
- Use at local organizational level.
- Meet with local staff regarding our local response.
- Recommend changes in DOC's policies, particularly immunization of officers. Find way to involve juvenile justice and local jails to cover their patient populations.

➢ ***Update Plans and Training Efforts***

- Continue to update our plans for POD's.
- Will help in planning/development for future efforts.
- Review local plan for component that may not have been already addressed.
- Will help shape our local planning. Will help me craft issues discussions in the community.
- Plan will be revised.
- Local health department planning process.
- Use of scenarios in planning emergency preparedness.
- Identify issues to plan for.
- Upgrading plans. Standard Operating Procedures (SOPs), job action sheets.
- Into emergency plans.
- Planning and response at local level.
- Planning. Talking to community partners.
- Take back to our district and continue to work on plans.
- Incorporate in existing plans. Bring issues back locally to discuss and come up with ways to work on the local issues. Identify locally how to deal with fatalities. Communicate more with community partners.
- Will help in our planning process.
- Food for thought for planning.
- More proactive planning.
- Planning, pre-training now.
- All stakeholders need specific steps that should/must be taken to implement a plan. Also need

clarity about how pandemic influenza plan intersects with other disaster plans so we don't "reinvent wheel." We seem to be discussing this in a vacuum.

- It will be used on an ongoing basis and will help direct training efforts.
- Coordinate similar multi-dimensional/multi-agency workshops.
- Helpful for planning for events, discussing mock scenarios.
- Additional planning of scenario as we do with our other emergency scenarios.

➢ ***Improving partnerships***

- Engaging additional external partners in the planning effort.
- Continue partnership activities, which will make eventual response smoother.
- Planning. Talking to community partners.
- Work with other groups better by thinking about their issues.
- Incorporate in existing plans. Bring issues back locally to discuss and come up with ways to work on the local issues. Identify locally how to deal with fatalities. Communicate more with community partners.
- Include other stakeholders.
- Will bring up with city government.
- This meeting allowed me to see what other organizations are thinking and what their priorities/questions are in regards to the pandemic influenza and even other situations.
- Helpful to know the perspectives of all the stakeholders.
- Open dialogue with public safety partners.
- In planning and organizing public health activities and communications.
- Development of local plans.
- Stimulate more local discussions.
- Will address with Centers for Medicare/Medicaid Services in regard to EMTALA.
- Will share information with Virginia pharmacists through our Web site, journal articles, meetings, etc.

➢ ***Other Comments***

- As personal education to help me think of likely future scenarios.
- We still have lots of work to do. Continue your efforts.
- In many cases, already still not clear who will get vaccine.
- Better sense of issues and how Virginia is affected.
- Await directions from national and state agencies.
- Continue to monitor the status of H5N1 in Asia. Continue to provide information to staff about H5N1 in Asia. Continue to monitor the status of review and update of plans for prevention and rapid response to low pathogenic avian influenza in poultry.

HOW COULD THE MEETING BE IMPROVED?

➢ ***Participation of other stakeholders***

- Better participation from missing stakeholders.
- To include policy and decision makers at the legislative level if you can get them to come.
- Broader representation at the table. Time after each scenario for observer comment.
- Allow an observer feedback segment at the end. The observers had many comments that could have improved the participant/decision-maker perspective.
- At the end of each scenario allowing 5 to 10 minutes for the observers to make comments on the questions.
- More incorporation of observers.
- Include the observers in the direct discussions.
- More involvement of observers.
- More input from audience.
- Have a real life reporter next time to participate.

➢ ***Unresolved Issues/Questions Remaining to be Answered***

- Presentation of the plan as a basis so we are not addressing issues that have already been worked on. Presentation of scientific basis of control of influenza.
- Reinforce priorities already in VDH pandemic plan rather than always rehashing old issues. Need to move forward in this process.
- Bring out existing plans (VDH, CDC, WHO, etc.) and determine if each organization is ready/capable of meeting its "obligations" as stated in the plan.
- Instead of asking, "What would you (your agency) do now?" it would be more useful to ask "What are your (your agencies) concerns/questions at this point?" This would identify new issues (instead of addressing same old stuff) and encourage non-health department participation.
- Make a list of unresolved issues and assign responsibility for drafting a solution that could be refined at future meetings, or used as guidance if the pandemic arrives before the next meeting.
- Process where we understand *how* decisions will be made based on comments made today.
- Need more discussion on possible solutions to the issues identified.
- We will actually have to make some of these decisions at some point. Still no answers to really hard decisions.
- Increase time on suggested solutions, issues to be investigated, questions to be answered. Rather pedestrian and predictable; found the initial advisory committee meeting more intriguing and thought provoking.
- Thought it was a good forum but disappointed that there are not many answers about what to do and how to handle the taxed resources.

➢ ***Logistical Issues***

- Useful format, but would have been better if we had scenario facts before us in writing before and during discussion. Hard to recall key points in hypotheticals. Facilitator should have done

all mike delivery among speakers.

- Have the scenarios available before meeting for observers. That way, questions for the panel could be brought before the meeting.
- Circulate the plan before the meeting.
- Materials available regarding questions for "players and observers" in advance of meeting for consideration and responding during sessions.
- Please make slides/handouts available with each discussion. Some people learn better by having the visuals and the opportunity to add notes to those visuals at the time of discussion.
- Collect written questions and go over some of them. More time to address questions from observers; more mini breaks.
- Start on time. Tables for observers; larger room with better visibility and layout (for example, no pillars). Electronic interaction (such as via LAN) so more persons can interact/participate. Advance e-mailing of agenda and PowerPoint slides (background) more than one day in advance. Microphones for each/every participant. Add another response to 3 standard questions for each scenario (between "agree" and "disagree," such as "neutral").
- Can understand time restraints/constraints, but a break or two in the morning session would have been helpful. Too much sitting, too much distraction with many coming and going. Content, participation—all very good!
- Have a few more breaks and more time for discussion.
- Break midmorning. Opportunity to network more. Invite Governor and health commissioner. Provide a more substantial lunch (chicken salad warm—not cold, hope no one gets sick).
- Morning break.
- A morning break would be useful in terms of folks being able to get up and stretch without disturbing others.
- Schedule breaks.
- Breaks! Tables for all to write on (chairs and writing in lap is very uncomfortable, especially for all day).
- More comfortable chairs!
- Better chairs.
- More microphones to share so we didn't have to wait between persons.
- Not so cold in the meeting room!

➢ ***Other Issues for Discussion***

- Add some component focus on prevention. For example, immunization efforts for key personnel working with bird, chickens, turkeys, possibly swine.

➢ ***Other Comments***

- Help us as state employees. Identify how these measures can be budgeted and paid for.
- Ongoing facilitated dialogue at local regional levels.
- By the end (last 3 scenarios) it seemed like we'd already discussed most issues.
- Continue working on the issues.
- Actually well done.

- I think a very good job was done.
- I thought it was well done and well represented—lots of perspectives/expertise!

WHAT WOULD YOU LIKE DONE AT FUTURE MEETINGS OR WORKSHOPS ADDRESSING PANDEMIC INFLUENZA?

➢ ***Partners***

- Perhaps more federal participation to give insight into what they are doing to prepare/guidance, etc.
- Involve politicians in key areas of discussion.
- Transportation, airport/port authority presence needed. U.S. National Guard representation needed.
- Include Metropolitan Medical Response System (MMRS) as a participant and see what options are available to include pandemic influenza response with their developing terrorist response to a Bioterrorism (BT) or chemical terrorism (CT) attack.
- A little more local involvement or allowing some local staff who will deal with or have dealt with some of the planning concerns share their experiences. What to do with people who die at home?
- Better participation from missing stakeholders—more non-health in particular.
- Re-invite entities that did not attend such as education, home health association, citizen input (civic organizations/secular).
- Vaccine and antiviral manufacturers represented. Media allies needed in newspapers/TV/radio. Politicians must be present and willing to support decisions of healthcare providers. Solicit insurance companies participation to partner in cost/expenses.
- Representatives from pharmaceutical manufacturing industries.
- Get citizens and media involved in planning. Also private healthcare sector.
- Permit more input from other speakers.

➢ ***Meeting Format***

- POLYCOM (video conferencing system)—videoconference meetings for district participation/observation.
- Steve Gravely aptly put out my thoughts.
- Similar to this.
- This was a good format.

➢ ***Exercises/Planning Steps/Working Groups***

- Actual planning for what we will do in a pandemic. There was too much discussion about roles and not enough planning.
- Actually conduct an exercise. Have media types here to challenge us. Make sure one or two elected officials attend.
- Breakout into some subgroups and also for some specific problems. Focus on this disease within the midst of the very real community disruption by bringing more balance of representatives to the table (real community with only one percent public health, not 50 percent as in this scenario).
- Practice creating communications messages for public and the media.
- Small workgroup sessions.

- Small group discussions.
- Breakdown the problems into specific workgroups and get smaller groups to work on making decisions to be included in the VDH pandemic plan.
- Possibly divide up the issues and address one issue per meeting. Spend more time on one issue at a time.

➢ ***Making Decisions***

- Bring out existing plans (VDH, CDC, WHO, etc.) and determine if each organization is ready/capable of meeting its "obligations" as stated in the plan.
- Make a list of unresolved issues and assign responsibility for drafting a solution that could be refined at future meetings, or used as guidance if the pandemic arrives before the next meeting.
- A summary of objectives met, gaps identified and then a real plan for improvement.
- If possible, 1-2-3 list, when pandemic occurs, of "to dos."
- Address the authority the commissioner and the Governor would have to implement the necessary policies. Need to think of solutions and discuss how and if those solutions would work.
- Addressing some of the issues that were brought up today such as staff shortage and distribution of antivirals and vaccine.
- Specific decisions to be made. Food for thought: Should kids be top priority for receiving vaccine as soon as it's available? Should borders be closed as soon as person-to-person transmission is confirmed to wait for vaccine availability?
- Determine what the priorities are!
- Specifically address resource identification, prioritization, allocation and management.
- Need to come up with some useful recommendations for State Government and agencies to take.
- Some process for decisions. Better defined *roles* and partnership.
- Who will make decision; what decisions will they be?
- Agreement on key public messages.
- Decision making!
- Questions need to be answered *soon*.

➢ ***Review and Understand Current Plan***

- More prepatory materials and planning.
- I think a basic understanding of what the current plan is should be established. I need understanding of whether thoughts/concerns raised will be addressed and in what format. Process for prioritizing. Communications of how.
- Scenarios based in revised influenza plan.
- Drill. Meet again with the revised draft document. (Send out prior for review.)
- Review of changes in plan and updates of plan progress—details of implementation.
- Review draft developed plan. Local and State Government in attendance.
- Try to identify what is not currently in place.

➢ ***Other Comments***

- More scientifically based.
- Updates needed.
- Discuss also how local health departments will handle an influenza pandemic with limited staff. Will other services be discontinued during this time?
- We raised a lot of questions today, and I'd like to know what some of the answers are. I believe they will be in VDH's revised plan.

WHAT OTHER COMMENTS OR SUGGESTIONS DO YOU HAVE ABOUT THE MEETING?

➢ ***Remaining Concerns and Unresolved Issues***

- Regarding the prospective role of each organization: oversight, coordination, responsibility, unclear. Clear what must be done in a pandemic; not so clear who has responsibility to do it.
- The purpose of the meeting was not clearly communicated so that appropriate decisions could be made regarding who should attend. Hearing the private sector concerns and suggestions and impression of public health role was valuable.
- Seem to focus on short-term and avoid long-term decisions. Public policy ought to be built around near-term, mid-term and long-term issues so we are not always dealing with short-term emergencies.
- This looked *only* at the influenza issues, but what if another event occurs at the same time? Several critical infrastructures exist in Virginia (and specifically the Richmond area) and other crises could be occurring (opportunistically) simultaneously.
- There are still a lot of issues that need to be addressed.

➢ ***Logistical Issues***

- More substantial luncheon, less reliance on cookies to fill us up.
- A vegetarian lunch option was not available.
- Poor quality/inadequate lunch.
- Can understand time restraints/constraints, but a break or two in the morning session would have been helpful. Too much sitting, too much distraction with many coming and going.
- Chairs too close together!
- Ten minute break in the morning
- Need breaks.
- More breaks
- More microphones.
- Would have liked to hear more from private sector but maybe that's just my own personal preference since I'm in public health.
- Give all attendees at least all panel members a copy of the current Pandemic Influenza Plan.
- Have note pages at start.

➢ ***Other Comments***

- Representation of Governor's office to fully explain the "police power" (i.e. quarantine) of the State Government.
- Increase elected officials in decision-making process.
- Ongoing facilitated dialogue at local regional levels.
- Great meeting, but discussion seemed to fizzle by end of Scenario 6.
- Kind of boring as an observer.
- I didn't think the ethicist types really seemed engaged.
- Form partnerships with the key stakeholders to make decisions.

➢ ***No Changes***

- Excellent workshop.
- Thanks for lunch and snacks.
- Excellent overall! Great job.
- Very good forum.
- Excellent discussion.
- Excellent program.
- Thanks for starting the needed discussion.
- Thanks for the opportunity.
- The facilitator did a great job keeping us on task!! Excellent!
- The facilitator did an excellent job in his role. Excellent forum to explain and discuss pandemic planning. Greatly appreciated the opportunity to participate and become more familiar with the many facets of a pandemic.
- Well organized, kept the pace very well and yet still covered all the questions/goals. Excellent job by facilitator.
- Thank you! Informative. Alarming. Much to consider. Much to do!
- It was useful. Glad for the opportunity. Infectious diseases, especially influenza really would pose severe hardships on all of society.
- Generally well done. Put together a team to take this show on the road to communities across Virginia.
- Excellent use of communication partners at table.
- Good discussion, I hope it leads to answers.
- Very good to have dialog with variety of stakeholders, good ideas came up.
- I was delighted to see private industry at the table! As well as ethics!
- Well done.
- The room layout was nice. It was helpful to be able to see who was talking. It would be nice if everyone was encouraged more to say what organization they were representing before they spoke.
- Nice facility. Good meeting.

Appendix A: List of Acronyms

ACF:	Administration for Children and Families
AED:	Academy for Educational Development
ARDS:	Acute Respiratory Distress Syndrome
AVs:	Antivirals
BT:	Bio-terrorism
CDC:	Centers for Disease Control and Prevention
CT:	Chemical Terrorism
DMORT:	Disaster Mortuary Operational Response Team
ED:	Emergency Department
EMS:	Emergency Medical Services
EMTALA:	Emergency Medical Treatment and Labor Act
FTE:	Full Time Equivalent
GIS:	Geographic Information System
HHS:	U.S. Department of Health and Human Services
HRSA:	Health Resources and Services Administration
ICS:	Incident Command System
I-Q:	Isolation and Quarantine
ME:	Medical Examiner
MMRS:	Metropolitan Medical Response System
MOU:	Memorandum/Memoranda of Understanding
MRC:	Medical Reserve Corps
OCME:	Office of the Chief Medical Examiner
OTC:	Over the Counter
PIO:	Public Information Officer
PODs:	Points of Distribution
QIO:	Quality Improvement Organization
SARS:	Severe Acute Respiratory Syndrome
SNS:	Strategic National Stockpile
SOPs:	Standard Operating Procedures
VA NG:	Virginia National Guard
VDH EPR:	Virginia Department of Health Emergency Preparedness and Response
WHO:	World Health Organization

Appendix B: Meeting Evaluation Form

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
www.vdh.virginia.gov

Pandemic Influenza Workshop; June 23, 2005

WORKSHOP EVALUATION FORM

Your feedback is important to the Virginia Department of Health. We would appreciate it if you could please take a moment to fill out the following evaluation form for today's meeting.

Please indicate whether you were a:

☐ Participant ☐ Observer ☐

Other:_____

SECTION ONE

We ask that after each scenario discussion you take a few moments to answer the three questions related to that scenario. After each statement, please indicate if you strongly agree, agree, disagree, or strongly disagree with the statement.

SCENARIO 1 – EMERGENCE OF A NOVEL INFLUENZA STRAIN

To what extent do you agree that…	Strongly Agree	Agree	Disagree	Strongly Disagree
A. this scenario was realistic?	1	2	3	4
B. the discussion of this scenario was productive?	1	2	3	4
C. the discussion of this scenario identified key issues for pandemic planning?	1	2	3	4

Comments:

SCENARIO 2 – WHO DECLARES ONSET OF INFLUENZA PANDEMIC

To what extent do you agree that…	Strongly Agree	Agree	Disagree	Strongly Disagree
A. this scenario was realistic?	1	2	3	4
B. the discussion of this scenario was productive?	1	2	3	4
C. the discussion of this scenario identified key issues for pandemic planning?	1	2	3	4

Comments:

SCENARIO 3 – THE PANDEMIC ARRIVES IN VIRGINIA

To what extent do you agree that…	Strongly Agree	Agree	Disagree	Strongly Disagree
A. this scenario was realistic?	1	2	3	4
B. the discussion of this scenario was productive?	1	2	3	4
C. the discussion of this scenario identified key issues for pandemic planning?	1	2	3	4

Comments:

SCENARIO 4 – WIDESPREAD OUTBREAKS AND CRITICAL SHORTAGES OCCUR ACROSS THE US

To what extent do you agree that…	Strongly Agree	Agree	Disagree	Strongly Disagree
A. this scenario was realistic?	1	2	3	4
B. the discussion of this scenario was productive?	1	2	3	4
C. the discussion of this scenario identified key issues for pandemic planning?	1	2	3	4

Comments:

SCENARIO 5 – THE FIRST BATCH OF VACCINE BECOMES AVAILABLE

To what extent do you agree that…	Strongly Agree	Agree	Disagree	Strongly Disagree
A. this scenario was realistic?	1	2	3	4
B. the discussion of this scenario was productive?	1	2	3	4
C. the discussion of this scenario identified key issues for pandemic planning?	1	2	3	4

Comments:

SCENARIO 6 – ADDITIONAL VACCINE ARRIVES IN VIRGINIA: PREPARATION FOR SECOND WAVE

To what extent do you agree that…	Strongly Agree	Agree	Disagree	Strongly Disagree
A. this scenario was realistic?	1	2	3	4
B. the discussion of this scenario was productive?	1	2	3	4
C. the discussion for this scenario identified key issues for pandemic planning?	1	2	3	4

Comments:

AT THE END OF THE MEETING PLEASE CONTINUE TO THE NEXT PAGE AND ANSWER THE QUESTIONS IN SECTION TWO.

SECTION TWO

1. Please answer the following statements about the meeting. After each statement, please indicate if you strongly agree, agree, disagree, or strongly disagree with the statement. If the statement is not applicable, please choose N/A.

Statements About the Meeting	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
A. The purpose of the meeting was clear.	1	2	3	4	8
B. The meeting met my expectations.	1	2	3	4	8
C. The framework for participant discussion in the meeting was clearly explained	1	2	3	4	8
D. The role of observer was clearly explained.	1	2	3	4	8
E. The Facilitator was effective at engaging participants in discussions around the six scenarios.	1	2	3	4	8
F. The Facilitator was attentive to participant concerns and needs.	1	2	3	4	8
G. The meeting facilities were satisfactory.	1	2	3	4	8
H. The location of the meeting was convenient.	1	2	3	4	8

2. Please indicate whether you strongly agree, agree, disagree or strongly disagree that the following meeting objectives were achieved.

Objective	Strongly Agree	Agree	Disagree	Strongly Disagree
A. The essential factors of a pandemic response were identified.	1	2	3	4
B. Key policy decisions that are needed for an effective response were identified.	1	2	3	4
C. The prospective role of each organization in the response to a pandemic was identified.	1	2	3	4

(Continued on next page)

3. What resources would be useful to your agency or organization to assist with planning for pandemic influenza?

4. How will you apply the information gained from the meeting to your current and future work?

5. How could the meeting be improved?

6. What would you like done at future meetings or workshops addressing Pandemic Influenza?

7. What other comments or suggestions do you have about the meeting?

THANK YOU FOR YOUR FEEDBACK.
YOUR COMMENTS ARE IMPORTANT TO US.