

Annex Two
To the Yakima Health District
Public Health Emergency Response Plan
(PHERP)

Pandemic Influenza

I. References

- A. Control of Communicable Diseases Manual, Current Edition, APHA.
- B. Washington State Guidelines for Notifiable Condition Reporting and Surveillance, Washington Department of Health, Latest Edition
 - 1. *Influenza (the Flu) Questions and Answers*. National Center for Infectious Diseases (CDC) (October 2003).
<http://www.cdc.gov/ncidod/diseases/flu/facts.htm>
 - 2. *Pandemic Influenza: A Planning Guide for State and Local Officials* (Draft 2.1). CDC National Vaccine Program Office (January 2003).
<http://www.cdc.gov/od/nvpo/pubs/pandemicflu.htm>
 - 3. *Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP)*. *MMWR* April 12, 2002 / 51(RR03);1-31.
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5103a1.htm>
 - 4. Additional Influenza links
 - a. The National Immunization Program (NIP), CDC.
<http://www.cdc.gov/nip>
 - b. Influenza Branch, National Center for Infectious Diseases, CDC
<http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm>
<http://www.cdc.gov/ncidod/diseases/flu/weekly.htm>
 - c. Center for Biologics Evaluation and Research (CBER), FDA.
<http://www.fda.gov/cber/index.htm>
 - d. National Institutes of Health (NIH), National Institute of Allergy and Infectious Diseases (NIAID). (<http://www.niaid.nih.gov/>)
 - e. Animal and Plant Health Inspection Service, Veterinary Services, U.S. Department of Agriculture. (<http://www.aphis.usda.gov/>)
 - f. The USDA Agricultural Research Service (ARS).
<http://www.ars.usda.gov/>
 - g. The Department of Defense Global Emerging Infections Surveillance and Response System.
<http://www.geis.ha.osd.mil/main2.html>).
 - h. The World Health Organization. World Health Organization's Influenza Programme (<http://www.who.org>)
<http://who.int/emc/diseases/flu/>

II. Responsibilities

A. Administrator

1. Provides overall public health management of influenza-like illness in Yakima County.
2. Invokes the powers of isolation and quarantine to control the outbreak.
3. Communicates with healthcare providers on the recommendations for prophylaxis and therapy for influenza-like illnesses.
4. Provides recommendations to the public on how they can prevent exposure during the epidemic.
5. Provides recommendations to healthcare providers on personal protection needed to protect them during an outbreak.
6. Coordinates with DOH and other LHJs on outbreak mitigation and control activities.
7. Requests the Strategic National Stockpile-Vendor Managed Inventory as outlined in Annex One.

B. Environmental Health

1. Provides recommendation on protection of food, water, and other consumables to the general public.
2. Provides recommendations to the public on vector and pest control to minimize disease transmission.
3. Provides recommendations on environmental decontamination and other environmental health and safety actions needed to protect the general public.
4. Coordinates with other local and state agencies on impact of environmental contamination and decontamination efforts.
5. Coordinates with the Yakima County coroner on actions needed if there are excess deaths and inadequate facilities for storage of deceased prior to burial.

C. Community and Family Health

1. Manages the dispensing of pharmaceuticals or administration of vaccines.
2. Manages the quarantine of individuals potentially exposed to influenza.
3. Coordinates with hospitals on the isolation of patients ill with influenza-like illness.
4. Coordinates the submittal of laboratory samples to the state's public health laboratories by hospitals and/or healthcare providers.
5. Manages the tracking of adverse events following administration of vaccines or chemoprophylactic agents.

III. Background

- A. The worst natural disaster in modern times was the infamous "Spanish flu" of 1918-1919, which caused 20 million deaths worldwide and over 500,000 deaths in the U.S. Although the Asian influenza pandemic of 1957 and the Hong Kong influenza pandemic of 1968 were not as deadly as the Spanish influenza pandemic, both were associated with high rates of illness and social disruption.

- B. Influenza is a highly contagious viral disease. Pandemics occur because of the ability of the influenza virus to change into new types, or strains. People may be immune to some strains of the disease either because they have had that strain of influenza in the past or because they have recently received influenza vaccine. However, depending on how much the virus has changed, people may have little or no immunity to the new strain. Small changes can result in localized epidemics. But, if a novel and highly contagious strain of the influenza virus emerges, an influenza pandemic can occur and affect populations around the world.
- C. An influenza pandemic is unlike any other public health emergency or community disaster:
1. Many experts consider influenza pandemics to be inevitable, yet no one knows when the next one will occur.
 2. There may be very little warning. Most experts believe that we will have between one and six months between the time that a novel influenza strain is identified and the time that outbreaks begin to occur in the U.S.
 3. Outbreaks are expected to occur simultaneously throughout much of the U.S., preventing sharing of human and material resources that normally occur with other natural disasters.
 4. The effect of influenza on individual communities will be relatively prolonged -- weeks to months -- when compared to minutes-to-hours observed in most other natural disasters.
 5. Because of the substantial lead times required for vaccine production once a novel strain has been identified, it is likely that vaccine shortages will exist, especially during the early phases of the pandemic. Effective preventive and therapeutic measures -- including antiviral agents -- will likely be in short supply, as may some antibiotics to treat secondary infections.
 6. When vaccine becomes available, it is expected that individuals will need an initial priming dose followed by a second dose approximately 30 days later to achieve optimal antibody responses and clinical protection.
 7. Health-care workers and other first responders will likely be at even higher risk of exposure and illness than the general population, further impeding the care of victims.
 8. Widespread illness in the community will also increase the likelihood of sudden and potentially significant shortages of personnel in other sectors who provide critical community services: police, firefighters, utility workers, transportation workers, and health workers, just to name a few.

IV. Concept of Operations

- A. Phases of Alert.** For purposes of consistency, comparability, and coordination of the national, state, and local response, identification and declaration of the following “phases” will be done at the national level:

Pandemic Phases
<p>Interpandemic period Phase 1. No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.</p>
<p>Phase 2. No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.</p>
<p>Pandemic alert period. Phase 3. Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.</p>
<p>Phase 4. Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.</p>
<p>Phase 5. Larger cluster(s) but human-to-human spread is still localized, suggesting that the virus is becoming increasingly better adapted to human, but may not yet be fully transmissible (substantial pandemic risk).</p>
<p>Pandemic period Phase 6. Pandemic phase: increased and sustained transmission in general population.</p>
<p>Postpandemic period Return to interpandemic period.</p>

B. As the pandemic develops, the World Health Organization (WHO) will notify the Centers for Disease Control and Prevention (CDC) and other national health agencies of progress of the pandemic from one phase to the next. CDC will communicate with DOH and other state agencies about pandemic phases, vaccine availability, virus laboratory findings, and national response coordination. The State will communicate with local health agencies through the Health Alert Network (HAN) and eventually through WA-SECURES.

C. The Federal Role. The Federal government has assumed primary responsibility for a number of key elements of the national plan, including:

1. Surveillance in the U.S. and globally
2. Epidemiological investigation in the U.S. and globally
3. Development and use of diagnostic laboratory tests and reagents
4. Development of reference strains and reagents for vaccines
5. Vaccine evaluation and licensure
6. Determination of populations at highest risk and strategies for vaccination and antiviral use
7. Assessment of measures to decrease transmission (such as travel restrictions, isolation, and quarantine)
8. Deployment of federally purchased vaccine
9. Deployment of antiviral agents in the Strategic National Stockpile

10. Evaluation of the efficacy of response measures
11. Evaluation of vaccine safety
12. Deployment of the Commissioned Corps Readiness Force and Epidemic Intelligence Service officers
13. Medical and public health communications

D. The State Role

1. Identification of public and private sector partners needed for effective planning and response.
2. Development of key components of pandemic influenza preparedness plan: surveillance, distribution of vaccine and anti-viral medication, and communications.
3. Integration of pandemic influenza planning with other planning activities conducted under CDC and HRSA's bioterrorism preparedness cooperative agreements with states.
4. Coordination with local areas to ensure development of local plans as called for by the state plan and provide resources, such as templates to assist in planning process.
5. Development of data management systems needed to implement components of the plan.
6. Assistance to local areas in exercising plans.
7. Coordination with adjoining jurisdictions.

E. Yakima Health District Response

1. In the Interpandemic phase emphasis will be placed upon vaccination of personnel who are needed to maintain the human infrastructure of the community during an epidemic. The absence of services provided by these personnel would pose a serious threat to public safety or would significantly interfere with the ongoing response to the pandemic. These key personnel, who would also be the Health District's first priority for administration of influenza vaccine or anti-viral medication, may include, but are not limited to:
 - a. Public health staff
 - b. Hospital employees
 - c. Physicians, pharmacists, and other clinicians
 - d. Local government decision-makers
 - e. First responders: Public Safety, Fire, and EMS
 - f. Utility, food service, and transportation personnel
 - g. Family members of the key personnel listed

2. Novel Virus Alert. Novel virus detected in humans. Continue to monitor the situation and update infectious disease and infection control partners in hospitals.
3. Novel virus detected in two or more humans. There is little or no immunity in the general population; potential, but not inevitable, precursor to a pandemic.
 - a. Surveillance
 - (1) Monitor bulletins from CDC and DOH regarding virologic, epidemiologic, and clinical findings associated with new variants isolated within or outside the U.S.
 - (2) Meet with appropriate partners and stakeholders and review major elements of enhanced surveillance activities; modify and update plan as needed.
 - (3) Activate enhanced local surveillance to detect importation and local spread in coordination with the Public Health Laboratory.
 - (4) Obtain appropriate reagents from the PHL, if appropriate, to detect and identify the novel strain.
 - b. Vaccine and Pharmaceutical Delivery
 - (1) Meet with hospitals, health care providers, and other partners and stakeholders to review major elements of the vaccine distribution plan, including plans for storage, transport, and administration of vaccines and anti-viral medications.
 - (2) Modify plan as needed to account for updates, if any, on recommended target groups and projected vaccine supply.
 - c. Emergency Response and Communications
 - (1) Test local communication systems, including HAN WA-SECURES, to ensure that local and statewide communications are functional.
 - (2) Notify hospitals, health care providers, and other partners and stakeholders of the novel virus alert. Attachment 1 is an example of the Novel Virus Alert.
 - (3) Modify communications plan (and written materials) as needed (in collaboration with state officials) to account for updates, if any, on projected effects of the novel virus.
 - (4) Implement contingency plans, if any, for obtaining critical hardware, software, or personnel to expand communications systems if needed for a pandemic.
 - (5) Ensure ongoing coordination among surveillance, epidemiology, laboratory, EMS, Yakima Valley Office of Emergency Management, and other local response efforts.

-
- (6) Develop and/or update press release templates. Develop materials for responding to questions that may come from the media.
3. Pandemic Alert Period. Novel virus demonstrates sustained person-to-person transmission and causes multiple cases in the same geographic area. Novel virus alert activities will be continued at a more advanced level and other activities will be added.
 - a. Surveillance
 1. Fully activate enhanced surveillance activities. Assess functionality, timeliness, and completeness of data entry and dissemination, data links, and feedback mechanisms throughout the local the system.
 2. Monitor daily CDC and state reports.
 3. Meet with surveillance partners to increase the amount of patient demographic information collected, in order to identify groups with increased risk.
 4. Inform surveillance partners of the need to increase specimen collection for detection of novel virus and alert laboratories to prepare for increased numbers of specimens.
 5. If requested by PHL, distribute specimen collection kits to hospitals and clinicians and obtain cooperation to facilitate sending isolates to PHL.
 6. Recruit pharmacies to participate in reporting antiviral prescriptions filled.
 7. Assess inventory of laboratory equipment and supplies, noting what is needed.
 8. Assess inventory of medical equipment and supplies (including ventilators, ICU equipment, and oxygen saturation monitors), noting what is needed.
 9. Develop contingency plans for procurement of laboratory equipment and supplies, and also for possible redirection and hiring of additional laboratory employees, including clerical/data entry personnel.
 10. Explore re-certification of non-traditional labor pool and redirection of staff with appropriate skills to alleviate need for additional laboratory personnel.
 - b. Vaccine and Pharmaceutical Delivery. During the pandemic alert stage, vaccine would not yet be available, and may not be for several months.
 - (1) Monitor reports from the CDC, FDA, and DOH to obtain information on plans for vaccine manufacture.
 - (2) Prepare to implement plan for storing and delivering vaccine as it becomes available to YHD (vs. private distribution).

- (3) Review elements of plan for vaccine delivery with partners and stakeholders.
 - (4) Ensure that human resources, equipment, and plans for mass immunization clinics are in place (see Annex One).
 - (5) Obtain latest DOH recommendations for priority groups for vaccine allocation and modify as necessary based on current surveillance data.
 - (6) Meet with local pharmacists and medical association to discuss potential need to:
 - (a) increase antiviral and antimicrobial supplies.
 - (b) increase role of pharmacists in vaccine delivery.
 - (7) Coordinate with DOH to receive satellite broadcast training/refresher on vaccine administration techniques for persons who do not normally administer vaccines, but will be enlisted to do so in a pandemic;
 - (a) arrange for viewing by appropriate groups.
 - (b) provide video copies of the broadcast for local training.
- c. Emergency Response and Communications
- (1) Ensure communication among the epidemiology and laboratory surveillance programs and emergency management.
 - (2) Alert surveillance groups to increase surveillance activities.
 - (3) Identify contact person (and backup person) for communication with DOH.
 - (4) Identify spokesperson (and backup person) for communication with press, public, etc.
 - (5) Prepare fact sheets detailing responses to questions coming from the media and the public:
 - (a) include documents intended for electronic distribution on the YHD web site.
 - (b) include telecommuting advice to employers, labor organizations, and others.
 - (c) include travel alert information received from the State and/or CDC.
 - (6) Respond to media inquiries regarding outbreak.
 - (7) Notify hospitals, health care providers, emergency responders, coroners, and mortuary organizations via HAN, WA-SECURES, or other means as needed. Attachment 2 is an example of a Pandemic Eminent Alert.
 - (8) Increase laboratory surveillance and disease surveillance.
 - (9) Alert emergency responders to work with EMS to inventory critical supplies and solve problems arising from high response volumes.

-
- (10) Alert neighborhood-watch, and/or other community-based response organizations.
 - (11) Conduct inventory of critical equipment, supplies, and personnel, including availability of hospital beds, antiviral pharmaceuticals, refrigerated depots for vaccines, and transport for delivery of vaccines.
 - (12) Identify methods to address personnel and supply shortfalls.
 - (13) Plan for implementation of emergency medical treatment sites and temporary infirmary locations, in coordination with local mass-care organizations such as Red Cross and/or Salvation Army.
 - (14) Send bulletins to private providers via local medical association and/or lists acquired from state licensing boards.
 - (15) Issue guidelines on influenza precautions for workplaces, emergency departments, airlines, schools, jails and prisons, public safety agencies, and individuals.
4. Phase 1.
- a. Surveillance
 - (1) Outside of normal surveillance season, verify that hospital and health care surveillance has been activated and DOH is receiving ongoing reports of cases within the county.
 - (2) Report the data collected to all participating facilities as well as to DOH.
 - (3) Analyze the inpatient data to determine which population groups are at greatest risk and provide the information to DOH and to those determining priority groups for vaccine allocation when the supply is limited.
 - (4) Participate in special studies, as requested by DOH:
 - (a) to describe unusual clinical syndromes.
 - (b) to describe unusual pathologic features associated with fatal cases.
 - (c) to conduct efficacy studies of vaccination or chemoprophylaxis.
 - (d) to assess the effectiveness of control measures such as school and business closings.
 - (5) Maintain increased laboratory surveillance and other activities outlined previously in the pandemic alert section.
 - b. Vaccine and Pharmaceutical Delivery
 - (1) Continue activities as listed in Phase 0, Level 3, including meetings with the local pharmacist and medical associations.

-
- (2) Increase public information effort designed to keep ill persons at home, providing translations into Spanish and other languages commonly spoken in Yakima County.
 - (3) If vaccine delivery date is predicted by CDC, work with DOH to:
 - (a) establish local delivery date.
 - (b) review distribution plan and update when new information is available.
 - (c) obtain signed agreements with hospitals and private providers on priority order of groups to receive vaccine when supply is limited.
 - (d) alert to need for security at immunization sites.
 - (e) alert to need for reporting adverse events to VAERS system.
 - (4) If vaccine is available, fully activate the immunization program.
 - (5) Obtain data on antiviral and antimicrobial supplies.
 - (6) Prepare or update recommendations and plans for allocation of antiviral and antimicrobial supplies.
- c. Emergency Response and Communications
- (1) Notify hospitals, health care providers and first response agencies of pandemic imminent stage. Set up information flow to all partners and stakeholders, including posting information on YHD website, HAN, and WA-SECURES. Attachment 2 is an example of a Phase 1 Alert.
 - (2) Update documents and fact sheets based on current surveillance information.
 - (3) Provide translations of all public information messages into Spanish and the other major languages in Yakima County.
 - (4) Monitor the ability of hospitals and outpatient clinics to cope with increased patient loads.
 - (5) Implement health education campaign with emphasis on the following:
 - (a) hand washing.
 - (b) stay home rather than be exposed to/spread the influenza virus.
 - (c) check on family, friends living alone.
 - (d) vaccination clinic locations.
 - (e) signs, symptoms.
 - (f) vaccine safety and storage.
 - (6) Work with employers and labor organizations to implement a telecommuting system so more people can stay home.

-
- (7) Activate emergency response system, including Yakima County Operational Area Emergency Operations Center (OA EOC), as appropriate.
 - (8) Implement mutual aid or other procedures to address supply and personnel shortfalls.
 - (9) Conduct inventory of critical supplies/personnel and solve problems: shortage of supplies (gloves, safety needles, ventilators), personnel shortage (how to get nontraditional labor pool re-certified or alternative staff redirected).
 - (10) Develop plan for counseling/psychiatric services (Department of Health and Human Services, private mental health agencies).
 - (11) Develop plans for children orphaned by death of parents (Department of Health and Human Services, private welfare agencies).
5. Phase 2. Further spread of influenza disease with involvement of multiple continents.
- a. Surveillance
 - (1) Influenza morbidity and mortality surveillance systems will likely become overwhelmed.
 - (2) Continue to monitor selected vital statistics for mortality and morbidity data received from the inpatient diagnosis surveillance system to establish age- and geographic area-specific rates.
 - (3) Use above data to establish priority groups for immunization as vaccine availability changes, providing data to DOH, hospitals, and private providers.
 - (4) Continue to monitor reports from WHO, CDC, and DOH on national and worldwide morbidity and mortality data.
 - (5) Laboratory surveillance will focus on detection of antigenic drift variants and resultant viruses that could limit the efficacy of vaccines produced against the original pandemic strain.
 - b. Vaccine and Pharmaceutical Delivery
 - (1) Continue all Phase 1 activities. Presumably vaccine would be available for a sizable proportion of the population.
 - (2) Monitor VAERS data for evidence of adverse reactions to the influenza vaccine. Report findings routinely to DOH.
 - (3) Modify recommendations and agreements on priority groups for receiving the vaccine to reflect greater availability of vaccine.
 - (4) Review surveillance data for changes in risk factors that could require modification of recommendations for priority groups for receiving vaccine.

-
- (5) Monitor availability of anti-viral medication and, when appropriate, recommend changes in priority groups for receiving vaccine or anti-viral medication.
 - c. Emergency Response and Communications
 - (1) All of the activities of the pandemic imminent stage and the following:
 - (2) Notify hospitals, health care providers, and first responder agencies of Pandemic Stage. Attachment 3 is an example of a Pandemic Alert. Attachment 4 is an example of an information update during the Pandemic.
 - (3) Implement emergency medical treatment sites and temporary infirmary locations as needed in coordination with local mass-care organizations, such as Red Cross and Salvation Army, to respond to the overwhelming caseload.
 - (4) Increase public information effort designed to keep ill persons at home, providing translations into Spanish and other major languages in Yakima County.
 - (5) Request law enforcement mutual aid, if needed. If law enforcement mutual aid system is overwhelmed, the Governor may issue a waiver to allow National Guard and military to act as law enforcement.
 - (6) If the medical/health mutual aid system is overwhelmed, the State may request health care workers from other states and/or the federal government.
 6. Phase 3, End of first wave. Continue surveillance as above, monitor the availability of vaccine and anti-viral medication, update plans and prepare for second wave.
 7. Phase 4, Second Wave.
 - a. Typically in a pandemic, the number of new cases of influenza peaks and then declines, giving the impression that the pandemic is over. Then within a few months, influenza incidence once again increases. State and local officials and health care providers need to remain vigilant for a return of the epidemic activity. This is especially difficult given that all personnel and supplies involved in responding to the epidemic will be exhausted by efforts to respond to the pandemic. The perceived “end of the pandemic” may be viewed as an opportunity to relax and recover. However, all essential functions should be restored to return to pandemic imminent status.
 - b. Public health personnel who provide the data to DOH will probably still be backlogged with reports, but should be encouraged to maintain extra staffing levels.
 - c. All sources of surveillance data will need to be convinced that their contributions are still essential because of the likelihood of a

- second wave. If the decline in the number of cases occurs outside the normal influenza season, it will be necessary to explain the importance of maintaining vigilance because the second wave could occur at any time.
- d. Immunization efforts in lower risk groups should continue as vaccine becomes available to increase “herd immunity” in the population in the event of a second wave.
 - e. Laboratory surveillance should also return to pandemic imminent status while maintaining surveillance for possible antigenic drift.
 - f. Attachment 5 is an example of a Second Wave information release.
- F. Public Information and Risk Communication
- 1. Dissemination and sharing of timely and accurate information with the health care community, the media, and the general public will be one of the most important facets of the pandemic response. Instructing the public in actions they can take to minimize their risk of exposure or actions to take if they have been exposed will reduce the spread of the pandemic and may also serve to reduce panic and unnecessary demands on vital services.
 - 2. The Public Health PIO in consultation with the Health Officer and Communicable Disease staff will identify public health issues and concerns that will or may need to be addressed through public information messages regarding pandemic influenza and will identify affected target audiences for messages. Attachment 6 is a public information release to use upon declaration of a Public Health Emergency. Additionally, Attachment 7 is a media background paper on pandemic influenza.
 - 3. Messages will address, but not be limited to, vaccine supply, anti-viral medication use, low-tech prevention methods, and maintenance of essential services. They will also identify appropriate strategies for dissemination of messages including postings to the Public Health website.
 - 4. The following examples of statements to providers and to the media and public may be used as templates and revised as appropriate to the actual event.

Attachments:

- 1. Sample Provider Novel Virus Alert
- 2. Sample Provider Stage 1 Alert
- 3. Sample Provider Information Statement – Pandemic Alert Declaration
- 4. Sample Provider Information Statement – Pandemic Alert Case Information
- 5. Sample Provider Information Statement – Pandemic Second Wave
- 6. Influenza Alert for Public Release
- 7. Information for the Media
- 8. YHD Checklist

This page blank intentionally.

Attachment I
Sample Provider Information Statement – Novel Virus Alert

Novel Virus Alert

As you are aware, one or more human cases of a novel virus, for which there is no immunity in the general population, has been detected in _____. This could potentially, but not inevitably, be a precursor to a pandemic.

The Yakima Health District is working closely with the State to monitor reports of disease progression and surveillance to detect the arrival of disease caused by the novel virus in Washington. Currently there have been no reported cases in Yakima County.

The CDC has issued recommendations for enhanced influenza surveillance for state health departments. The purpose of these recommendations is to enhance the capacity to rapidly identify an importation of this virus. Current recommendations are at www.cdc.gov_____.

We will continue to provide you with updates on influenza activity and will distribute recommendations on any additional surveillance activities that may become necessary.

If you have any questions please call Yakima Health District Disease Control and Surveillance office at (509) xxx.xxxx.

This page blank intentionally.

Attachment 2 Sample Provider Information Statement – Phase 1

Pandemic Imminent

The _____ novel virus_____ is causing unusually high rates of morbidity and mortality in widespread geographic areas. Travel advisories remain in effect for the following areas:

If your patient is ill with influenza-like illness and has recently traveled to these areas, or is a close contact to someone who has traveled to these areas the following recommendations should be considered:

- 1) home isolation
- 2) antivirals for household contacts
- 3) self-monitoring of symptoms
- 4) report to Public Health (?)

Benton-Franklin Health District continues to work closely with the State and CDC regarding influenza vaccine. We do not have a manufacturer's release date at this time but continue to review plans for distribution.

Providers are encouraged to use antivirals for household contacts of confirmed or strongly suspected cases of influenza.

Enforcement of respiratory hygiene is essential. Continue to implement respiratory programs in your area of practice:

- At entry, triage, or registration, ask all patients with symptoms of respiratory illness to wear a surgical mask, and provide instructions on their proper use and disposal.
- Offer masks to all other persons who enter the emergency room to use voluntarily for their own protection.
- For patients who cannot wear a surgical mask, provide tissues to cover the nose and mouth when coughing or sneezing and a small bag for mask and tissue disposal.
- Encourage and provide access to hand washing or a waterless hand hygiene product and instruct patients to decontaminate their hands after handling respiratory secretions and before their contact with a healthcare worker.
- Separate patients with respiratory illness from other patients by either placing them into a cubicle, examination room, or some physical separation by at least 3 feet.

This page blank intentionally

Attachment 3

Sample Provider Information Statement – Pandemic Alert Declaration

Pandemic Alert Declaration

A formal declaration was made today by the CDC regarding the influenza pandemic. Further spread with involvement of multiple continents has been reported.

The United States reported _____ hospitalizations or deaths to the CDC with _____ being from Washington.

Yakima County has had _____ related to complications from influenza.

Manufacturers of flu vaccine report a release date of _____. Yakima County continue to make plans for mass vaccination/prophylaxis/ public education. Current supply of anti-virals remains low.

Up-to-date summaries of influenza activity are available at:

This page blank intentionally.

Attachment 4
Sample Provider Information Statement – Pandemic Alert Case Information

Pandemic Alert Case Information
The novel virus _____ has demonstrated sustained person-to-person transmission and multiple cases in the same geographic area.
Confirmed case definition:
Probable case definition:
Possible case definition:
The number of confirmed cases are _____. Number of deaths are _____.
The CDC and Washington Department of Health has released a travel advisory for _____.
Daily updates can be obtained at the state web site www.doh.----- , or www.cdc.gov.____ .
Yakima Health District has reported _____ number of confirmed/ probable case (s) of influenza A _____. No deaths have been reported.
Antivirals are recommended for household contacts of confirmed cases and strongly suspected cases of influenza. Recommendations for asymptomatic household contacts can be downloaded from the county website at www.bfhd.wa.gov----- .

This page blank intentionally.

Attachment 5
Sample Provider Information Statement – Pandemic Second Wave

Pandemic Second Wave

Typically in a pandemic, the number of new cases of influenza peaks and then declines, giving the impression that the pandemic is over. Health care providers need to remain vigilant for the return of the epidemic activity. Health care providers must make use of the interim period to prepare for a resurgence of disease.

Yakima Health District continues to urge providers to keep a respiratory hygiene program in place. Inventory and order supplies that may be necessary for disease resurgence. Continue to vaccinate (if applicable).

Log onto the Yakima Health District web site www.bfhd.wa.gov for current information about self protection.

Attachment 5
Sample Provider Information Statement – Pandemic Second Wave

Pandemic Second Wave

Typically in a pandemic, the number of new cases of influenza peaks and then declines, giving the impression that the pandemic is over. Health care providers need to remain vigilant for the return of the epidemic activity. Health care providers must make use of the interim period to prepare for a resurgence of disease.

Yakima Health District continues to urge providers to keep a respiratory hygiene program in place. Inventory and order supplies that may be necessary for disease resurgence. Continue to vaccinate (if applicable).

Log onto the Yakima Health District web site www.bfhd.wa.gov for current information about self protection.

Attachment 6 Influenza Alert for Public Release

FOR PUBLIC RELEASE	
Influenza Alert	
For Immediate Release	Contact: _____
Date: _____	Title: _____
<p>Yakima - ??? Health Officer, declared a public health emergency this morning/evening, alerting Yakima County residents to take precautions to minimize the spread of the influenza virus. There is new strain of influenza virus that is unusually virulent, which means that most people have little or no natural immunity to protect them from illness. This means that, not only have more people come down with the "flu," the illness likely to be more severe. <i>(Add data about current number of local hospitalizations, etc.)</i></p> <p>At this time, there is no vaccine available to prevent this new strain of the flu. Vaccine development may be delayed and vaccine may initially be in short supply. This makes prevention measures even more important.</p> <p>Symptoms of the flu include abrupt onset of chills and fever, muscle aches, sore throat, and cough. Those who develop flu symptoms should notify their health care provider. <i>(Consider if we want everyone to do this, or just recommend that the elderly and those with medical conditions that increase their risk contact their provider.)</i></p> <p><u><i>Influenza virus is contagious from person-to-person. Infection spreads when droplets from a cough or sneeze of an infected person reach the mucous membranes of another person's mouth, nose, or eyes, or if they touch a surface or object (such as a doorknob or stair railing contaminated with infectious droplets and then touch their own mouth, nose, or eyes.</i></u></p> <p><u><i>The risk of becoming ill can be reduced by frequent hand washing and keeping your hands away from your eyes, nose, and mouth. Also, try to avoid contact with people who have respiratory illnesses.</i></u></p> <p>Those who become ill should stay home. This is crucial to preventing the spread of this disease to others, including co-workers and other people who would be encountered in public places.</p> <p><u><i>If someone in the household has the flu, other family members can decrease their risk of becoming ill by wearing a mask over their nose and mouth whenever they come within three feet of the sick person. They should wear gloves whenever they come in contact with him or her or items they have handled and wash their hands after removing the gloves.</i></u></p> <p>For more information, visit the Yakima Health District website at: Http://www.bfhd.wa.gov</p> <p><i>(Consider more extreme measures, such as canceling public gatherings, encouraging telecommuting, etc.)</i></p>	

This page blank intentionally.

Attachment 7

Information for the Media

Overview of Influenza Pandemic

- Pandemics result from the emergence of Influenza A virus that is novel for the human population.
- The hallmark of pandemic influenza is excess mortality --- the number of deaths observed during an epidemic of influenza-like illness in excess of the number expected.
- During this century, pandemics occurred in 1918, 1957, and 1968.
- 1918-19 “Spanish flu” A caused the highest known influenza-related mortality: at least 500,000 deaths in the United States, and 20 million worldwide.
- 1957-58 “Asian flu” A: 70,000 deaths in the United States.
- 1968-69 “Hong Kong flu” A: 34,000 deaths in the United States.
- Although mortality rates associated with the pandemics of 1957 and 1968 were confined primarily to the elderly and chronically ill, both pandemics were associated with high rates of illness and social disruption, with combined economic losses of approximately \$32 billion (in 1995 dollars).
- The potential impact of an influenza virus in humans depends on its virulence (ability to cause severe illness or death) and on whether there is protective immunity in the population. Protective immunity will inhibit the virus’ ability to be passed from person-to-person and will decrease the severity of illness.
- Influenza viruses undergo two kinds of change. One is a series of mutations over time that causes a gradual evolution of the virus, known as antigenic drift. The other is an abrupt change in the surface antigen proteins, known as antigenic shift, thus suddenly creating a new subtype of the virus.
- When antigenic shift occurs, the population does not have antibody protection against the virus.
- Birds are the primary reservoir for influenza viruses. All 15 recognized influenza A subtypes have been found in birds.

In most years in the United States, influenza is responsible for 10,000-40,000 excess deaths, 50,000-300,000 hospitalizations, and approximately \$1-3 billion in direct costs for medical care.

Influenza: Background Information

The influenza (flu) epidemics that happen nearly every year are important events. Influenza is a respiratory illness that makes hundreds of thousands of people sick each year. The illness can cause severe health problems for the elderly and for younger people with diseases like diabetes, heart or lung disease, and illness that can weaken the immune system. Typical primary influenza illness lasts about a week and is characterized by abrupt onset of fever, muscle aches, sore throat, and nonproductive cough. In some persons, severe malaise and cough can persist for several days or weeks.

Influenza infection not only causes primary illness but also can lead to severe secondary medical complications, including influenza viral pneumonia; secondary bacterial pneumonia; worsening of underlying medical conditions, such as congestive heart failure, asthma, or diabetes; or other complications such as ear infections (i.e., otitis media) in children.

Elderly persons (i.e., those 65 years and over) and persons with certain underlying medical conditions, such as chronic heart or lung disease, are at increased risk for developing complications from influenza infection. These complications increase the risk for hospitalization or death.

One of the most important features about influenza viruses is that their structure changes slightly but frequently over time (a process known as “drift”), and that this process results in the appearance of different strains that circulate each year. The composition of the flu vaccine is changed each year to help protect people from the strains of influenza virus that are expected to be the most common ones circulating during the coming flu season.

The ability of the vaccine to protect against influenza during a particular season depends on several factors, but particularly 1) the match between influenza strains in the vaccine and strains circulating in the community, and 2) the ability of each person's immune system to mount a protective response as a result of the vaccination. Although the vaccine may not prevent everyone who takes it from getting sick, it does reduce the risk of severe illness, hospitalization, and death. That's why it is so important for anyone who wants to reduce his or her risk of getting severely ill from influenza to receive the vaccine each year.

In contrast to the more gradual process of drift, in some years the influenza virus changes dramatically and unexpectedly through a process known as “shift.” Shift results in the appearance of a new influenza virus to which few (if any) people are immune. If this new virus spreads easily from person-to-person, it could quickly travel around the world and cause increased levels of serious illness and death, affecting millions of people. **This is called an influenza pandemic.**

Fortunately, pandemics don't occur very often. There has not been an influenza pandemic since 1968. In 1997, however, a flu virus, that had previously infected only birds, caused an outbreak of illness in humans. This virus, known as the “avian flu,” resulted in 18 illnesses and six deaths in Hong Kong but did not easily spread from person-to-person. Still, it provided a frightening reminder that the next pandemic could occur at any time. Governments around the world took

notice. The U.S. government worked with state and local governments and private-sector partners to develop strategies and programs that would prepare our country for a pandemic.

How Does an Influenza Pandemic Start?

There are three main types of influenza viruses: A, B, and C. Influenza C causes only mild disease and has not been associated with widespread outbreaks. Influenza types A and B, however, cause epidemics nearly every year. Influenza A viruses are divided into subtypes, based on differences in two surface proteins: hemagglutinin (H) and neuraminidase (N). Influenza B viruses are not divided into subtypes. During an influenza flu season, usually one or more influenza A subtype and B viruses circulate at the same time.

A pandemic is possible when an influenza A virus makes a dramatic change (i.e., "shift") and acquires a new H or H+N. This shift results in a new or "novel" virus to which the general population has no immunity. The appearance of a novel virus is the first step toward a pandemic. However, the novel influenza A virus also must spread easily from person-to-person (and cause serious disease) for a pandemic to occur. Influenza B viruses do not undergo shift and do not cause influenza pandemics.

The reservoir for type A influenza viruses is wild birds, but influenza A viruses also infect animals such as pigs and horses, as well as people. The last two pandemic viruses were combinations of bird and human influenza viruses. Many people believe that these new viruses emerged when an intermediate host, such as a pig, was infected by both human and bird influenza A viruses at the same time, so that a new virus was created. Events in Hong Kong in 1997, however, showed that this is not the only way that humans can become infected with a novel virus. Sometimes, an avian influenza virus can "jump the species barrier" and move directly from chickens to humans and cause disease.

Since, by definition, a novel virus is a virus that has never previously infected humans, or hasn't infected humans for a long time, it's likely that almost no one will have immunity, or antibody to protect them against the novel virus. Therefore, anyone exposed to the virus--young or old, healthy or weak--could become infected and get sick. If the novel virus is related to a virus that circulated long ago, older people might have some level of immunity. It is possible that the novel virus may be especially dangerous to some age groups that are not usually at risk of severe illness or death from annual influenza (such as healthy young adults). Such widespread vulnerability makes a pandemic possible and allows it to have potentially devastating impact.

How Does a Pandemic Spread?

Although all pandemics begin with the appearance of a novel virus, most novel viruses do not spread and cause pandemics. It's more common for a novel virus to be detected and cause illness in a few people, but not go on to infect large numbers of people.

For a novel virus to cause a pandemic, a sequence of events must occur over time. A planning tool, developed by pandemic planners, of how those events might unfold can be found at the following web site: www.who.int/emc-documents/influenza/whocccsredec991c.html. However, the phases will not occur simultaneously around the world.

The Phases of a Pandemic

Pandemic Phases
<p>Interpandemic period Phase 1. No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.</p>
<p>Phase 2. No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.</p>
<p>Pandemic alert period. Phase 3. Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.</p>
<p>Phase 4. Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.</p>
<p>Phase 5. Larger cluster(s) but human-to-human spread is still localized, suggesting that the virus is becoming increasingly better adapted to human, but may not yet be fully transmissible (substantial pandemic risk).</p>
<p>Pandemic period Phase 6. Pandemic phase: increased and sustained transmission in general population.</p>
<p>Postpandemic period Return to interpandemic period.</p>

The Impact of a Pandemic: How Serious Might It Be?

There's no simple answer to the question of how serious a pandemic might be. It all depends on how virulent (severe) the virus is, how rapidly it can spread from population to population, and the effectiveness of pandemic prevention and response efforts. The 1918 Spanish flu is an example of a worst-case scenario because the strain was highly contagious and quite deadly. This pandemic killed more Americans than all the wars of the 20th century. Since our world today is vastly more populated, and people travel the globe with ease, the spread of a next pandemic could be more rapid than that of previous pandemics.

The impact of a pandemic isn't measured only by how many people will die. If millions of people get sick at the same time, major social consequences will occur. If many doctors and nurses become ill, it will be difficult to care for the sick. If the majority of a local police force is infected, the safety of the community might be at risk. If air traffic controllers are all sick at once, air travel could grind to a halt, interrupting not only business and personal travel, but also the transport of life-saving vaccines or antiviral drugs. Therefore, a vital part of pandemic planning is the development of strategies and tactics to address all these potential problems.

Historical Overview

History suggests that influenza pandemics have probably happened during at least the last four centuries. During the 20th century, three pandemics and several "pandemic scares" occurred. These are described in more detail below

1918: Spanish Flu

The Spanish influenza pandemic is the catastrophe against which all modern pandemics are measured. It is estimated that approximately 20 to 40 percent of the worldwide population became ill and that over 20 million people died. Between September 1918 and April 1919, approximately 500,000 deaths from the flu occurred in the U.S. alone. Many people died from this very quickly. Some people who felt well in the morning became sick by noon and were dead by nightfall. Those who did not succumb to the disease within the first few days often died of complications from the flu (such as pneumonia) caused by bacteria.

One of the most unusual aspects of the Spanish flu was its ability to kill young adults. The reasons for this remain uncertain. With the Spanish flu, mortality rates were high among healthy adults as well as the usual high-risk groups. The attack rate and mortality was highest among adults 20 to 50 years old. The severity of that virus has not been seen again.

1957: Asian Flu

In February 1957, the Asian influenza pandemic was first identified in the Far East. Immunity to this strain was rare in people less than 65 years of age, and a pandemic was predicted. In preparation, vaccine production began in late May 1957, and health officials increased surveillance for flu outbreaks.

Unlike the virus that caused the 1918 pandemic, the 1957 pandemic virus was quickly identified, due to advances in scientific technology. Vaccine was available in limited supply by August 1957. The virus came to the U.S. quietly, with a series of small outbreaks over the summer of 1957. When U.S. children went back to school in the fall, they spread the disease in classrooms and brought it home to their families. Infection rates were highest among school children, young adults, and pregnant women in October 1957. Most influenza- and pneumonia-related deaths occurred between September 1957 and March 1958. The elderly had the highest rates of death.

By December 1957, the worst seemed to be over. However, during January and February 1958, there was another wave of illness among the elderly. This is an example of the potential "second wave" of infections that can develop during a pandemic. The disease infects one group of people first, then infections appear to decrease, and thereafter infections increase in a different part of the population. Although the Asian flu pandemic was not as devastating as the Spanish flu, about 69,800 people in the U.S. died.

1968: Hong Kong Flu

In early 1968, the Hong Kong influenza pandemic was first detected in Hong Kong. The first cases in the U.S. were detected as early as September of that year, but illness did not become widespread in the U.S. until December. Deaths from this virus peaked in December 1968 and January 1969. Those over the age of 65 were most likely to die. The same virus returned in 1970 and 1972. The number of deaths between September 1968 and March 1969 for this pandemic was 33,800, making it the mildest pandemic in the 20th century. There could be several reasons why fewer people in the U.S. died due to this virus. First, the Hong Kong flu virus was similar in some ways to the Asian flu virus that circulated between 1957 and 1968. Earlier infections by the Asian flu virus might have provided some immunity against the Hong Kong flu virus that may have helped to reduce the severity of illness during the Hong Kong pandemic. Second, instead of peaking in September or October, like pandemic influenza had in the previous two pandemics, this pandemic did not gain momentum until near the school holidays in December. Since children were at home and did not infect one another at school, the rate of influenza illness among schoolchildren and their families declined. Third, improved medical care and antibiotics that are more effective for secondary bacterial infections were available for those who became ill.

1976: Swine Flu Scare

When a novel virus was first identified at Fort Dix, it was labeled the "killer flu." Experts were extremely concerned because the virus was thought to be related to the Spanish flu virus of 1918. The concern that a major pandemic could sweep across the world led to a mass vaccination campaign in the United States. In fact, the virus--later named "swine flu"--never moved outside the Fort Dix area. Research on the virus later showed that if it had spread, it would probably have been much less deadly than the Spanish flu.

1977: Russian Flu Scare

In May 1977, influenza A/H1N1 virus emerged in northern China, spread rapidly, and caused epidemic disease in children and young adults (< 23 years) worldwide. The 1977 virus was similar to other A/H1N1 viruses that had circulated prior to 1957. (In 1957, the A/H1N1 virus was replaced by the new A/H2N2 viruses). Because of the timing of the appearance of these viruses, persons born before 1957 were likely to have been exposed to A/H1N1 viruses and to have developed immunity against A/H1N1 viruses. Therefore, when the A/H1N1 reappeared in 1977, many people over the age of 23 had some protection against the virus, and it was primarily younger people who became ill from A/H1N1 infections. By January 1978, the virus had spread around the world, including the United States. Because illness occurred primarily in children, this event was not considered a true pandemic. Vaccine containing this virus was not produced in time for the 1977-78 season, but the virus was included in the 1978-79 vaccine.

1997: Avian Flu Scare

The most recent pandemic "scares" occurred in 1997 and 1999. In 1997, at least a few hundred people became infected with the avian A/H5N1 flu virus in Hong Kong and 18 people were hospitalized. Six of the hospitalized persons died. This virus was different because it moved directly from chickens to people, rather than having been altered by infecting pigs as an intermediate host. In addition, many of the most severe illnesses occurred in young adults similar to illnesses caused by the 1918 Spanish flu virus. To prevent the spread of this virus, all chickens in Hong Kong (approximately 1.5 million) were slaughtered. The avian flu did not easily spread from one person to another, and after the poultry slaughter, no new human infections were found.

In 1999, another novel avian flu virus – A/H9N2 – was found that caused illnesses in two children in Hong Kong. Although neither of these viruses have gone on to start pandemics, their continued presence in birds, their ability to infect humans, and the ability of influenza viruses to change and become more transmissible among people is an ongoing concern.

Ongoing Influenza Defense Tactics

Fighting the flu in the U.S. is a yearly battle that requires the combined resources of the Department of Health and Human Services, the World Health Organization (WHO), vaccine and drug companies, state and local health authorities, and the medical community. Early detection of changes in influenza viruses and rapid development of effective vaccines are the keys to defending against influenza each year and responding to the possibility of a pandemic. The cycle of surveillance and vaccine formulation is a never-ending process.

Ongoing Surveillance

The first line of defense against influenza is a worldwide surveillance system coordinated by WHO. This system makes it possible for changes in circulating influenza viruses and the emergence of novel influenza A viruses to be detected as soon as possible.

The task of identifying circulating strains of influenza--whether known or novel--is done by a worldwide network of 110 National Influenza Centers and many other WHO laboratories in 83 countries. WHO Collaborating Reference Centers for Influenza in London, Atlanta, Melbourne, and Tokyo coordinate the system and intensively analyze samples of virus isolated and collected by approximately 180 laboratories.

Each year, some influenza virus isolates from laboratories in the U.S. and overseas are sent to the Centers for Disease Control and Prevention (CDC) in Atlanta. Tests are done to determine the antigenic and molecular make-up of the viruses. CDC examines the viruses to determine which are the most important emerging influenza viruses and their ability to cause outbreaks, and then provides this information at yearly meetings held by the Food and Drug Administration (FDA) and by WHO so it can be used to formulate vaccine for the next influenza season.

During January through March, WHO, FDA, and CDC undertake the process of deciding which strains will be selected for vaccine production in the U.S.

In addition, the CDC actively monitors U.S. disease activity and deaths related to influenza between October and May of each year. This information is provided each week in influenza surveillance summaries.

Vaccine Development

The best method of preventing and reducing the severity of the flu is the timely development, distribution, and administration of influenza vaccine. The influenza vaccine used each year is an inactivated trivalent vaccine. This means that the flu vaccine contains three inactivated (or "killed") flu viruses that protect against three different strains of influenza virus (one influenza B and two influenza A strains). Because the current licensed vaccines are inactivated vaccines, flu vaccine cannot cause the flu – a common misconception. The effectiveness of the trivalent vaccine depends upon the "match" between strains of influenza that are circulating and the viruses in the vaccine. Although there is no guarantee that the strains picked for the vaccine will be the strains that go around during the following flu season, the match between vaccine strains and circulating strains is good about 90 percent of the time.

The vaccine strain selection process requires surveillance information collected year-round. In late January of each year, the FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) reviews worldwide surveillance data. The Committee usually makes an initial recommendation about at least one of the three strains to be included in the vaccine. By mid-February, the WHO completes its review and makes recommendations for the Northern Hemisphere vaccine. The WHO repeats this process in September for Southern Hemisphere vaccine recommendations. In March, VRBPAC meets to finalize the recommendations for the U.S. influenza vaccine.

While the vaccine strain selection process is going on, the four influenza vaccine manufacturers licensed in the U.S. begin preparations for vaccine production. Because flu vaccine viruses are grown inside eggs, manufacturers must buy enough eggs to manufacture 80 million or more doses of vaccine. The FDA prepares the specific viral material for the manufacturers to use, in order to begin vaccine production. During the manufacturing process, the live viral ingredient is killed so that the vaccine will not cause people to become sick with the flu. As the manufacturers produce vaccine, FDA reviews safety data. The last steps of vaccine preparation include production and bottling of vaccine, distribution to vaccine providers, and administration to patients. All this must be done in time for vaccination campaigns to begin by late September.

Working closely with State and local health authorities, partners in the private sector, CDC, FDA, and vaccine manufacturers have built a successful program for vaccine delivery each year. CDC and its Advisory Committee on Immunization Practices (ACIP) issue recommendations each year for the prevention and control of influenza. ACIP strongly

recommends influenza vaccine for any person, 6 months of age or older, who is at increased risk for complications of influenza. Groups at increased risk include persons 65 years of age and older; residents of nursing homes and other chronic-care facilities; adults and children with chronic lung, heart, metabolic, kidney, or immune system disorders; and women who will be in the 2nd or 3rd trimester of pregnancy during the influenza season. Influenza vaccine also should be given to people who have close contact with high-risk persons, such as health care providers, family members of such persons, and others such as medical volunteers. The reason for vaccinating the close contacts is to prevent transmission of flu viruses to people who are at high risk for developing serious complications from flu. Influenza vaccine should also be administered to any person who wishes to reduce the likelihood of becoming ill with influenza.

Anti-viral Drugs

In addition to vaccines, antiviral drugs are available for both the prevention and treatment of influenza. Currently, there are two classes of drugs--amantadines and neuraminidase inhibitors. The amantadines (amantadine and rimantadine) are approved for the treatment and prophylaxis of influenza A only. The neuraminidase inhibitors (zanamivir and oseltamivir) have activity against both influenza A and B, but are currently approved by FDA only for treatment.

To prevent the flu, antiviral drugs must be taken consistently before infection occurs. When used to reduce the impact of the flu for someone who is already infected, antiviral drugs must be taken within two days after flu symptoms start. It is important to know that antiviral drugs can have some potentially serious side effects.

In non-pandemic situations, antiviral drugs have been useful in helping to control outbreaks in settings such as nursing homes, where many people could become sick with flu and develop serious complications. In addition, antivirals can be useful in preventing influenza in certain individuals who have a weakened immune systems and, therefore, would not respond to the vaccine, or in those who have a known allergic reaction to the vaccine. There are important differences among the influenza antiviral drugs, including age-approved indications, side effects, and costs. A knowledgeable health care professional should be consulted when they are used.

During a pandemic, antiviral drugs are likely to play an important, but limited role. Guidelines are being developed to address how antiviral drugs should be used during a pandemic.

[Preparing for the Next Pandemic](#)

In the event of a pandemic, good surveillance, timely vaccine development and production, and the ability to administer vaccine to large numbers of people in a short amount of time will be very important.

The vaccination program during a pandemic will probably be different from current annual flu shot programs in several respects:

- More people will want and need to be vaccinated, so we will need a larger supply of vaccine.
- The warning period before a pandemic is likely to be short. Because the current vaccine manufacturing process takes a minimum of 6 months, it is likely that there will not be enough vaccine at the beginning of a pandemic to vaccinate everyone who wants it.
- It may be necessary for an individual to receive two doses of vaccine to be fully protected against the virus.

In addition, communication and emergency response systems are in place to assist in managing a pandemic. Since 1993, federal, state and local health officials have been working on several different preparedness efforts to reduce pandemic influenza-related deaths, sickness, and social disruption including enhancing surveillance and early detection of a novel virus, and improving the public health infrastructure so that pandemic-related programs can be effectively administered.

Source of "Information for the Media": <http://www.cdc.gov/od/nvpo/pandemics/>

Attachment 8

Pandemic Influenza Checklist

Interpandemic Period

Phases 1 and 2--Monitoring

- Notify YHD staff
- Meet with Infection Control Memorial and Regional Infectious Disease Physicians to discuss plans and treatment guidelines
- Meet with xxx Laboratory to discuss increased influenza testing
- Contact pharmacies for anti-viral surveillance
- Contact hospitals for current status on isolation, respirators, and PPE for staff
- Inform DOH of vaccine requirements
- Establish vaccination priority matrix
- Develop and distribute home and workplace information on respiratory hygiene
- Inform public and media of plans
- Continue staff and volunteer training
- Continue to plan with YV OEM on vaccination and treatment locations
- Continue active hospital influenza surveillance
- Develop plan for psychological impact mitigation of pandemic
- Continue monitoring hospital capability status
- Coordinate with Yakima County Coroner

Pandemic Alert Period

Phases 3, 4 and 5--Prevention and Containment

- Meet with Infection Control Memorial and Regional Infectious Disease Physicians to discuss plans and treatment guidelines
- Meet with xxx Laboratory to discuss increased influenza testing
- Contact pharmacies for anti-viral surveillance
- Contact hospitals for current status on isolation, respirators, and PPE for staff
- Continue active surveillance at hospitals
- Inform public and workplaces on actions they need to take
- Monitor activities at community treatment centers
- Provide testing and treatment guidelines to healthcare providers
- When vaccine is available, implement mass vaccination
- Continue Coroner Coordination

Pandemic Period

Phase 6--Response

- Meet with Infection Control Memorial and Regional and Infectious Disease Physicians to discuss plans and treatment guidelines
- Meet with xxx Laboratory to discuss increased influenza testing
- Contact pharmacies for anti-viral surveillance
- Contact hospitals for current status on isolation, respirators, and PPE for staff
- Continue active surveillance at hospitals
- Inform public and workplaces on actions they need to take
- Monitor activities at community treatment centers
- Provide testing and treatment guidelines to healthcare providers
- Implement mass vaccination

Postpandemic period

- Return to interpandemic period.

This page blank intentionally.