



Pandemic Flu Response Plan

PURPOSE

The purpose of this plan is to outline the City of Sumner's response to a potential pandemic flu threat. It is intended to supplement the extensive work that is being done at the federal, state and county level in this field. This response plan also supplements the City's Emergency Management Plan. Rather than including them directly, numerous references, usually available on the internet, are cited at the end of the plan. The response is built on the significant role that the public health and health care delivery systems have in addressing this threat. Although many other and larger entities would be involved in a response to a flu pandemic, recent national disasters have demonstrated that people will and must rely on local responders first and in our case, the City of Sumner.

While there is low likelihood of pandemic flu, the severity risk associated with pandemic flu warrants the City's investment in preparation. Further, planning for pandemic flu has valuable parallels and applications to the preparation for other emergencies.

THREAT

A worldwide outbreak of influenza—or a pandemic—would occur when a new influenza virus appears for which humans have no immunity. The virus would be easily spread from person to person and would circle the globe in waves over extended periods of time. Because it may likely strike in many areas of the state—and the country—at the same time, emergency response resources would be severely limited.

History has demonstrated that pandemics happen. The 1918 flu had extensive consequences, with two more less severe pandemics in 1957 and 1968. The avian flu has received so much attention because the virus looks similar to the make-up of the flu in 1918. Thus, the important note is to be prepared for a pandemic flu, whether that turns out to be the avian flu or a different virus.

Because of international travel through the Puget Sound, this area could anticipate being one of the first to experience pandemic. One possible virus that could cause a pandemic

is the avian flu. Labeled H5N1, this virus originated in the wild bird population and spread to domestic birds and eventually to humans. It has been found on the non-American continents in birds and humans, although there is no record of the virus transmitting from human to human. So far, all human cases were contracted from prolonged, close contact with live, sick birds.

Locally, the challenges of any pandemic could include rapid spread, insufficient medical supplies and equipment/facilities, overloading of staff, social disruption from closures and social distancing, sustainability of public services, overloading of medical services, and financial and economic impacts from the closure of businesses and financial institutions.

Estimates are that a pandemic influenza would cause over 200,000 deaths in our country, with as many as 5,000 fatalities in Washington. Our state could also expect 10,000-24,000 people needing hospital stays and 480,000-1,119,000 people requiring outpatient visits. During a severe pandemic, these numbers could be much higher.

ASSUMPTIONS

The planning assumptions for the City of Sumner are the Planning Assumptions provided by the US Department of Health and Human Services, Attachment 1.

RESPONSE POLICY

The City's response to a pandemic incident will be guided by its Emergency Management Plan in partnership with other agencies with jurisdiction and expertise. The City will focus resources on the provision of essential services and use additional resources to support essential service provision and maintain the continuity of government for the duration of an event.

CITY FUNCTION HIERARCHY

In order to prioritize City services and functions, City functions have divided into three categories as described below:

Level I – Essential to preservation of life and property and generally subject to a high degree of exposure to risk

- Police 1st response
- 911 Communications
- Fire 1st response
- Utilities/Streets – water supply, traffic signals, etc.
- Wastewater Treatment – general operation
- Cemetery – emergency burials

Level II – While generally not providing direct service to customers, they are necessary in order to support Level I functions and typically can be done from remote locations.

- Information Technology

- Communications – public and employee
- Dangerous animals
- Payroll
- Court
- Financial transactions
- City Council

Level III – Those functions which do not meet the standards for Level I or II and for whom the primary response will be suspension of the activities.

- Animal Control
- Recreation
- Permitting
- Comprehensive Planning
- Hearing Examiner

RESPONSE PLAN

The City's planning and preparation for a pandemic flu event is organized into five categories as sorted and defined below. For most items, the lead department or division is included along with a deadline for completion. The Mind Map version of the Response Plan follows.

1. Employee Preparation

- a. Essential Function Recognition/Communication – Define for all employees their status in essential function response or support. (All Department Directors: Training complete by 12/06)
- b. 7-day Preparation Campaign – Market 7-day preparation campaign to all staff. (Communications: Campaign 7/06-9/06)
- c. Education and Training – Provide all employees with information on alternative communications options (IT & HR: complete by 8/06; Training on new policies)
- d. Policy Development – Draft policies to address emergency response, mandatory sick leave, payroll, alternative working conditions, identification, etc. (Administrative Services by 10/06)

2. Community Preparation/Education

- a. Theme: Preparing for pandemic flu helps us prepare for almost any emergency
- b. Build on County and State products to educate the public on 7-day preparation (Fire and Communications: Initiate by 7/06 and on-going)
 - i. Newsletter
 - ii. Website
 - iii. Speakers
 - iv. Brochure (from others)
 - v. RCC broadcast

- c. Good hygiene education – cough and hand washing (Communications in partnership with Health Dept.: On-going and August Newsletter)
- d. Promote County **PC-Net** Program (Communications: 8/06 Newsletter and on-going)

3. City Active Response

- a. Authority and Proclamations (Legal: Review existing models for applicability and access 8/06)
- b. Essential Function Support (Executive: Convene further discussions on how to achieve this goal and what it would look like 9/06)
- c. Essential Functions (See above)
- d. Non-Essential Functions (See above)
 - i. Court Functions (Court: Study what others are doing 9/06)
- e. Continuity of Government
 - i. Council Meetings and Authority (Legal: Research and develop model ordinances for adoption 9/06)

4. Public Communication During Event

- a. RCC (Communications: Research mechanisms 7/06)
- b. Website (Communications: Ensure access and technology for off-site access 7/06)
- c. Media (Communications: Ensure contact ready to go for off-site access—both local and through Joint Information System 7/06)
- d. Phone Message System
- e. Reverse 911 System (County System)
- f. 911 (Need to build capacity in the Business Line – see below)
- g. Police Business Line (IT: Research and develop ability route calls 9/06)

5. Community Response

- a. Secondary Impact Response
 - i. Food supplies
 - ii. Integrity of utilities
 - iii. Schools
- b. Curfew (Legal: draft model 7/06)
- c. Social distancing/gatherings (Will take the lead from other jurisdictions)
- d. Neighborhood Response (Beyond PC-Net, can only encourage through regular community building)
- e. People going to “closed buildings” such as the Senior Center, Fire Station and City Hall (Communications: Develop signage to direct people 9/06)
- f. Volunteers (Human Resources/Senior Services: Develop Draft Policy for use of volunteers in this type of emergency 12/06)

REVIEW AND STATUS

The City will reconvene the involved departments as the need arises or by September 15, 2006, to review the progress of this plan’s implementation and new information. This

plan will be distributed to the City Council and our partners in the response (EPFR, Health Department, State of Washington, etc.)

REFERENCES:

“State and Local Pandemic Influenza Planning Checklist” Centers for Disease Control, Version 4.4, December 2, 2005

www.pandemicflu.gov

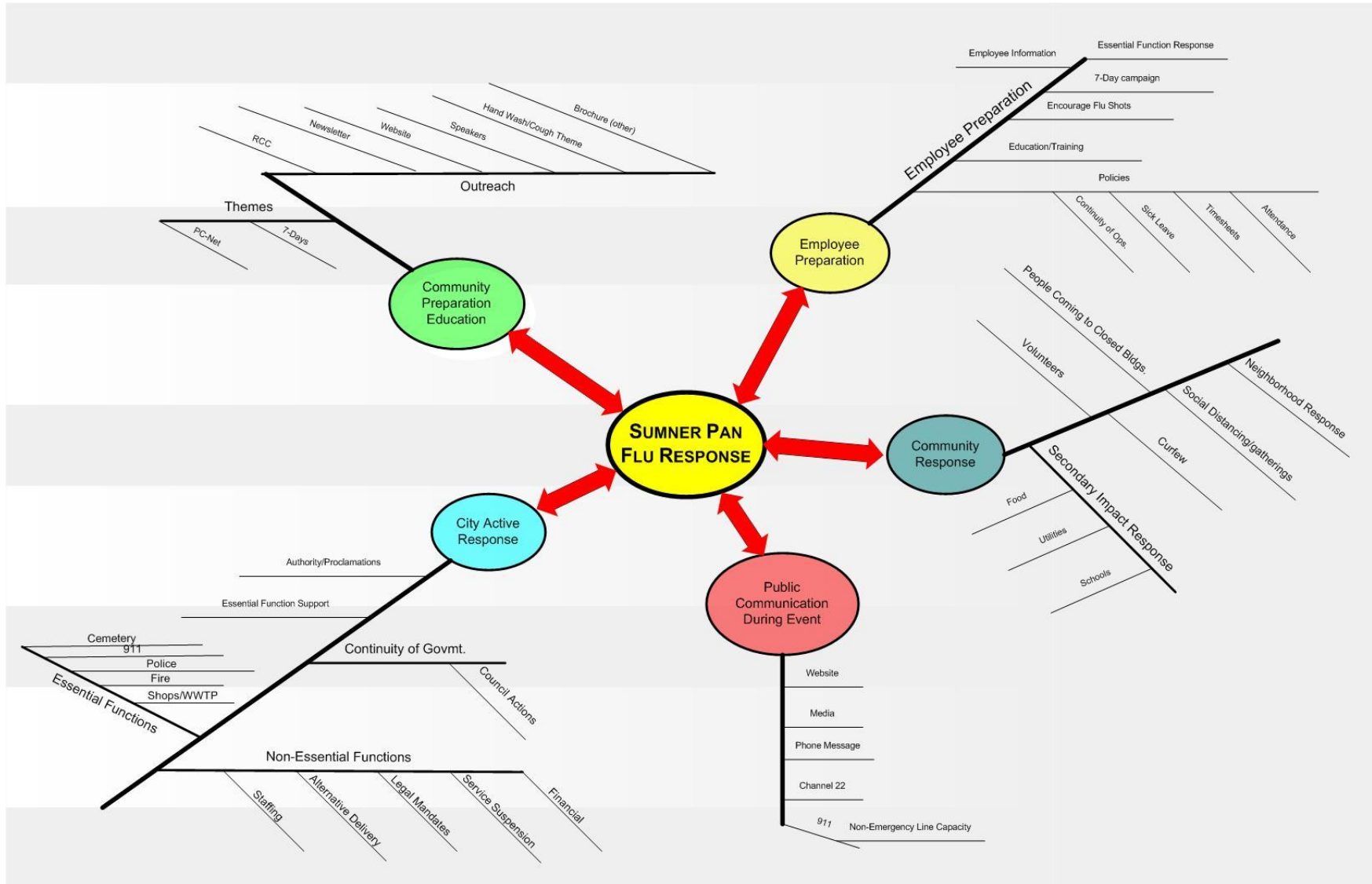
www.doh.wa.gov/panflu

www.npr.org/templates/story/story.php?storyId=4949542&sourceCode=gaw

<http://www.whitehouse.gov/homeland/pandemic-influenza.html>

<http://virus.stanford.edu/uda/>

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



1.1. Planning Assumptions

1.1.1. Susceptibility to the pandemic influenza virus will be universal.

1.1.2. Efficient and sustained person-to-person transmission signals an imminent pandemic.

1.1.3. The clinical disease attack rate will likely be 30% or higher in the overall population during the pandemic. Illness rates will be highest among school-aged children (about 40%) and decline with age. Among working adults, an average of 20% will become ill during a community outbreak.

1.1.3.1. Some persons will become infected but not develop clinically significant symptoms. Asymptomatic or minimally symptomatic individuals can transmit infection and develop immunity to subsequent infection.

1.1.4. Of those who become ill with influenza, 50% will seek outpatient medical care.

1.1.4.1. With the availability of effective antiviral drugs for treatment, this proportion may be higher in the next pandemic.

1.1.5. The number of hospitalizations and deaths will depend on the virulence of the pandemic virus. Estimates differ about 10-fold between more and less severe scenarios. Two scenarios are presented based on extrapolation of past pandemic experience (Table 1). Planning should include the more severe scenario.

1.1.5.1. Risk groups for severe and fatal infection cannot be predicted with certainty but are likely to include infants, the elderly, pregnant women, and persons with chronic medical conditions.

1.1.6. Rates of absenteeism will depend on the severity of the pandemic.

1.1.6.1. In a severe pandemic, absenteeism attributable to illness, the need to care for ill family members, and fear of infection may reach 40% during the peak weeks of a community outbreak, with lower rates of absenteeism during the weeks before and after the peak.

1.1.6.2. Certain public health measures (closing schools, quarantining household contacts of infected individuals, “snow days”) are likely to increase rates of absenteeism.

1.1.7. The typical incubation period (interval between infection and onset of symptoms) for influenza is approximately 2 days.

1.1.8. Persons who become ill may shed virus and can transmit infection for up to one day before the onset of illness. Viral shedding and the risk of transmission will be greatest during the first 2 days of illness. Children usually shed the greatest amount of virus and therefore are likely to post the greatest risk for transmission.

1.1.9. On average, infected persons will transmit infection to approximately two other people.

1.1.10. In an affected community, a pandemic outbreak will last about 6 to 8 weeks.

1.1.11. Multiple waves (periods during which community outbreaks occur across the country) of illness could occur with each wave lasting 2-3 months. Historically, the largest waves have occurred in the fall and winter, but the seasonality of a pandemic cannot be predicted with certainty.

Table 1. Number of Episodes of Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic Influenza Scenarios*

Characteristic	Moderate (1958/68-like)	Severe (1918-like)
Illness	90 million (30%)	90 million (30%)
Outpatient medical care	45 million (50%)	45 million (50%)
Hospitalization	865,000	9,900,000
ICU care	128,750	1,485,000
Mechanical ventilation	64,875	745,500
Deaths	209,000	1,903,000

*Estimates based on extrapolation from past pandemics in the United States. Note that these estimates do not include the potential impact of interventions not available during the 20th century pandemics.