Pandemic Influenza Plan

March 30, 2006

State of Oregon
Emergency Management Plan
Annex F Public Health and Medical Services
Hazard Appendix 4.1
This appendix is part of Annex F of the State of Oregon Emergency Management Plan and should be used in conjunction with the other appendices. It is not a stand-alone plan.
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Executive Summary

Influenza virus typically causes annual winter outbreaks of respiratory illness characterized by fever, cough, muscle aches, and malaise; complications such as lung infection (pneumonia) occur mostly in the elderly. An influenza pandemic begins when a new strain of influenza virus, to which humans have no immunity, emerges and causes disease that is more widespread and more severe than usual. Pandemics are characterized by higher-than-usual numbers of illness and an increase in the death rate. A severe human influenza pandemic is a global health emergency and has not been encountered for nearly 90 years. We cannot predict when a pandemic will occur and whether it will be a “worst-case scenario” (such as the oft-noted 1918 experience in which an estimated 500,000 people died in the United States) or a much milder scenario (such as the pandemics that occurred in 1957 and 1968).

The 2006 Oregon Pandemic Influenza Plan builds on a planning effort that began in 2001. The detailed federal Health and Human Services plan released in November 2005 and the steady spread of a new type of severe influenza in birds (H5N1) prompted the expansion and revision of the Oregon plan. The Oregon Pandemic Influenza Plan is a “Hazard-Specific Appendix” of the Health and Medical (ESF 8) Annex of the State of Oregon Emergency Plan; it contains information and concepts that are specific for pandemic influenza and is not intended as a stand-alone plan.

The Oregon Pandemic Influenza Plan assumes a “moderate” scenario and makes the following important assumptions about the pandemic threat:

- Approximately 35% of the population will become ill.
- Outbreaks will occur in one or more waves, each lasting six or more weeks in a given community.
- Concurrent outbreaks will limit mutual aid between communities, states or countries.
- Of 3.6 million Oregonians, approximately 12,000 will require hospitalization and nearly 3,000 will die.
- An effective vaccine will not be available at the onset of a pandemic.
- The value of nonmedical measures (e.g., quarantine) to control a pandemic is unknown.
- The capacity of the health care system will be degraded by illness among health care workers and shortages of essential supplies.

The World Health Organization (WHO) developed a planning framework that describes 3 periods of pandemic threat: Interpandemic (no threat), Pandemic Alert (possible threat), and Pandemic (outbreak started). This plan follows the WHO scheme with the understanding that actual events may not be so easily characterized. The public health response will intensify as a pandemic appears more likely and with the proximity of a new strain of influenza to North America or the Northwest.

If a pandemic occurs, Oregon State Public Health (OSPH) will be the lead state agency in Oregon and will operate under a National Incident Management System-compliant Incident Command System, in collaboration with Oregon’s 34 local health departments.
as well as American Indian tribal jurisdictions. Timely and consistent information for the public, hospitals, health care providers and other partners will be coordinated through a Joint Information Center (JIC). OSPH and local health departments will support hospitals and health care providers in their efforts to provide essential routine care as well as the additional emergency care needed during a pandemic.

During the Pandemic Alert period surveillance will focus on laboratory detection of cases and intensive follow-up of exposed contacts; during the pandemic period efforts will emphasize tracking deaths and hospitalizations to determine those groups of people at greatest risk for severe outcome.

OSPH and local health departments will support hospitals and health care systems in their efforts to provide essential routine care as well as the additional emergency care needed in a pandemic. Early in a pandemic OSPH will take the lead in receiving, storing and staging antiviral drugs and other medical supplies from the federal Strategic National Stockpile to be distributed to hospitals, clinics and local health departments. The same mechanisms will be used to distribute vaccine when it becomes available. Meanwhile OSPH will endeavor to coordinate the consistent and rational use of community control measures, such as school closures, across local, state, tribal and federal jurisdictions. These efforts will emphasize the use of well-reasoned voluntary measures by enlisting the cooperation of the public.

Finally, the importance of maintaining a functioning community cannot be overemphasized, and this plan begins to address the emotional needs of those responding to and affected by the pandemic. The ongoing provision of essential services across the state will help to minimize the impact of a pandemic.

In writing this plan, the following key areas for further effort were identified:

- Coordination of the many Incident Command Systems that will be operating at the state and local levels during a pandemic.
- Integration of communication response among public health agencies across the state and between public health, hospitals, health care systems and other emergency-response organizations for a prolonged period.
- The development of systems to provide basic medical care for a sudden increase in patient volume in a widespread health emergency.
- The development of a process to make, communicate and implement “community containment” measures, such as school closures and quarantine (voluntary or mandatory).

The Pandemic Influenza Plan can be used by the many public and private partners of OSPH to understand how the public health system will respond to an influenza pandemic. We expect that this will prompt further definition and refinement of the roles and responsibilities of all involved. In addition, the plan will be used within OSPH to identify gaps in planning and to help develop the exercises needed to test whether the plan is workable and effective.
1.0 Introduction

A global outbreak of a new strain of human influenza is an influenza pandemic; such an event is inevitable, but the timing and the severity of the pandemic cannot be predicted. The Oregon Pandemic Influenza Plan describes how Oregon State Public Health (OSPH) will prepare for and respond to an influenza pandemic.

This plan is an appendix to the Oregon State Emergency Management Plan. It is organized into the following parts:

- The appendix explains the roles and strategies of OSPH in coordinating the public health response to a pandemic with the federal government, local health departments, the health care community, and other key partners.
- Attachments to this appendix describe specific OSPH activities, such as communication, surveillance, and distribution of vaccine and antiviral drugs before, during and after a pandemic.
- Tabs in each attachment provide more detailed descriptions of these activities.

1.1 Pandemic Influenza Background

Influenza A, a contagious viral respiratory disease, causes widespread infection in all age groups every year. Influenza pandemics occur intermittently because influenza A can change into new subtypes of the virus to which humans have no immunity. Influenza pandemics occurred three times in the 20th century (1918, 1957, and 1968). Over 20 million deaths occurred worldwide in the 1918 pandemic, while in 1957 and 1968 mortality was much, much less. When the next pandemic occurs, people across the globe will be affected within a few months, which will severely limit options to provide mutual aid across jurisdictions. For more detailed information about past pandemics, visit the U.S. Department of Health and Human Services (HHS) pandemic flu Web site (http://www.pandemicflu.gov).

In 2003 an outbreak of a particular influenza A subtype, called H5N1, was detected in wild and domestic birds in Asia and is likely to spread to all continents. Although this is not an inevitable precursor to a human pandemic, widespread disease in birds may increase the chance that a new strain will emerge in humans. Therefore, this plan also addresses detection and response activity around humans exposed to birds infected by H5N1. The biology and transmission of human and non-human influenza viruses are the basis for the World Health Organization (WHO) “Pandemic Phases.”

1.2 World Health Organization Pandemic Phases

This plan follows the framework used by the WHO to describe the phases of pandemic influenza (see Table 1). Each phase is defined by the frequency and communicability of a new influenza virus in humans. From early in 2004 to March 2006, the global status has been Phase 3. The Oregon response follows the progression suggested by the WHO phases, modified for disease activity in the United States and Oregon.
### Table 1: WHO Pandemic Phases

<table>
<thead>
<tr>
<th>Period</th>
<th>Phase</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-pandemic</td>
<td>1</td>
<td>No new influenza subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If persistent in animals, the risk of human infection or disease is considered to be low.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>No new influenza subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.</td>
</tr>
<tr>
<td>Pandemic Alert</td>
<td>3</td>
<td>Human infection with a new subtype has been detected, with no human-to-human transmission or at most rare instances of spread to a close contact.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Small cluster(s) of human infection with limited human-to-human transmission have been detected, but spread is highly localized, suggesting that the virus is not well adapted to humans.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Larger cluster(s) of human infection have been detected, but human-to-human transmission is still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk).</td>
</tr>
<tr>
<td>Pandemic</td>
<td>6</td>
<td>Increased and sustained transmission is occurring in the general population.</td>
</tr>
<tr>
<td>Post-pandemic</td>
<td></td>
<td>Recovery, return to the interpandemic period (Phase 1).</td>
</tr>
</tbody>
</table>

### 2.0 Purpose and Authorities

The purpose of the Oregon Pandemic Influenza Plan is to lessen the impact of an influenza pandemic on the residents of Oregon. This plan focuses on elements unique to an influenza pandemic. Wherever response is typical of response to any communicable disease or other public health emergency, this plan refers to the appropriate section of Annex F, ESF-8 Health and Medical Services in the Oregon State Emergency Management Plan. Annex F can be found on the Health Alert Network (HAN) Web site ([www.oregonhan.org](http://www.oregonhan.org)) or can be requested by contacting the OSPH Public Health Preparedness Program (971-673-1308).

Table 2 lists the most relevant Oregon Revised Statues for pandemic influenza planning and response. In addition, specific authorities are stated where pertinent in each attachment.
Table 2: Selected Legal Authorities

<table>
<thead>
<tr>
<th>Oregon Revised Statute</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>401.015</td>
<td>Statement of policy and purpose (emergencies).</td>
</tr>
<tr>
<td>401.035</td>
<td>Responsibility for emergency services systems.</td>
</tr>
<tr>
<td>401.043</td>
<td>Emergency Management Assistance Compact.</td>
</tr>
<tr>
<td>401.055</td>
<td>Declaration of state of emergency; procedures.</td>
</tr>
<tr>
<td>401.065</td>
<td>Police powers during state of emergency; suspension of agency rules.</td>
</tr>
<tr>
<td>401.115</td>
<td>Additional powers during emergency.</td>
</tr>
<tr>
<td>401.515</td>
<td>Nonliability for emergency services; exception; emergency service workers as agents of state or local governments.</td>
</tr>
<tr>
<td>401.654</td>
<td>Registry of emergency health care providers.</td>
</tr>
<tr>
<td>431.110</td>
<td>General powers of Department of Human Services.</td>
</tr>
<tr>
<td>431.120</td>
<td>Duties of Department of Human Services; rules.</td>
</tr>
<tr>
<td>431.150</td>
<td>Enforcement of health laws generally.</td>
</tr>
<tr>
<td>431.170</td>
<td>Enforcing health laws and rules when local officers are delinquent.</td>
</tr>
<tr>
<td>431.530</td>
<td>Authority of local health administrator in emergency.</td>
</tr>
<tr>
<td>431.550</td>
<td>Authority of Department of Human Services to collect information from local public health administrators.</td>
</tr>
<tr>
<td>433.004</td>
<td>Reportable diseases; duty to report; effect of failure to report; rules.</td>
</tr>
<tr>
<td>433.006</td>
<td>Investigation and control measures.</td>
</tr>
<tr>
<td>433.019</td>
<td>Procedure to impose public health measure; enforcement.</td>
</tr>
<tr>
<td>433.022</td>
<td>Taking subject into custody; information to subject; notice to court; court order; duration of custody.</td>
</tr>
<tr>
<td>433.035</td>
<td>Examination of certain persons prior to imposition of public health measure.</td>
</tr>
<tr>
<td>433.040</td>
<td>Vaccine Education and Prioritization Plan; implementation of plan during vaccine shortage; rules; penalties.</td>
</tr>
<tr>
<td>433.106</td>
<td>Power to impose public health measures.</td>
</tr>
<tr>
<td>433.441</td>
<td>Proclamation of state of impending public health crisis.</td>
</tr>
<tr>
<td>448.160</td>
<td>Emergency plans.</td>
</tr>
</tbody>
</table>

3.0 Situation and Assumptions

The estimated health impact of the next influenza pandemic on Oregon’s 3.4 million population (based on 2000 census data) depends on the assumptions used. The HHS pandemic influenza plan makes estimates for the entire United States using two sets of assumptions: one moderate and one severe (see the 2005 HHS Pandemic Influenza Plan). In this plan, the estimates have been modified to be Oregon specific by assuming that 1.3% of the U.S. population resides in Oregon. The scenarios differ in the severity of illness (e.g., hospitalizations and deaths) but not in the number of illnesses or number of people seeking medical care (Table 3).
Note: This plan is based on the moderate scenario with the intention that responses will be scaled upward if the impact is more severe.

Table 3: Health Impacts of Moderate and Severe Influenza Pandemics on Oregon

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Moderate Pandemic</th>
<th>Severe Pandemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness</td>
<td>1.17 million</td>
<td>1.17 million</td>
</tr>
<tr>
<td>Outpatient</td>
<td>585,000</td>
<td>585,000</td>
</tr>
<tr>
<td>Hospitalized</td>
<td>11,245</td>
<td>128,700</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>1677</td>
<td>19,305</td>
</tr>
<tr>
<td>Ventilator Use</td>
<td>845</td>
<td>9646</td>
</tr>
<tr>
<td>Death</td>
<td>2717</td>
<td>24,700</td>
</tr>
</tbody>
</table>

Assumptions. This plan makes the following assumptions about pandemic influenza:

- Oregon State Public Health is the lead state agency for responding to pandemic influenza.
- A pandemic is a public health emergency with political, social and economic dimensions; it is likely to affect everyone in Oregon.
- The entire population will be at risk of illness from a new subtype of influenza.
- The overall estimated clinical attack rate will be 35%, ranging from 20% among working adults to 40% among school-aged children.
- Of those who become ill, 50% will seek medical care.
- Risk groups for severe infections cannot be completely predicted ahead of time; the elderly, the very young, and those with compromised immune systems are likely to be at high risk.
- For seasonal influenza, the typical incubation period (the time between acquiring the infection until becoming ill) is two days. This plan assumes the same incubation period for a new strain of influenza.
- People who become ill may transmit the virus for up to one day before the onset of symptoms.
- In an affected community, a pandemic outbreak will last six to eight weeks. Illness is expected to occur in distinct outbreaks or “waves” separated by weeks to months, lasting up to 18 months.
- Outbreaks are expected to occur simultaneously throughout much of the United States, limiting mutual aid of human and material resources that normally occurs with other natural disasters.
- The number of hospitalizations and deaths will depend on the virulence of the pandemic virus. Estimates differ about 10-fold between the moderate and severe scenarios.
- Vaccine is not expected to be available in large quantities at the onset of a pandemic.
- Certain pharmaceuticals, especially influenza antiviral drugs and antibiotics to treat secondary infections, will likely be in short supply.
- Community containment will be the only means of disease control until a vaccine is available, but these measures are of unproven benefit in a pandemic.
Planning for the continuity of state and local government and private business operations is an essential component of preparedness. This plan assumes that continuity planning will occur in both the public and private sectors.

Challenges. The next influenza pandemic will create challenges for public health including the following:

- The timing and severity of the next influenza pandemic is unpredictable.
- Very little time may elapse between the identification of a novel influenza strain and the onset of outbreaks in the United States.
- The public health response to influenza will be prolonged, possibly lasting more than a year.
- Highly visible decisions will be needed concerning community containment in a setting of considerable scientific uncertainty about their effectiveness.
- The likely vaccine shortage will leave public health responders with no proven interventions to limit spread.
- Health care workers and other first responders will be at risk of illness, which may further degrade the capacity to care for victims.
- The surge in demand for health care during a pandemic could overwhelm the existing capacity of hospitals and clinics.

4.0 Concept of Operations

This section describes the emergency management structure that OSPH will use during an influenza pandemic to manage resources under state control. As the state agency primarily responsible for public health and medical services (Emergency Support Function 8), OSPH will lead the preparedness, response, and recovery activities for pandemic influenza. The OSPH response to a pandemic will comply with the National Incident Management System (NIMS) provisions, including the use of an Incident Command System (ICS). OSPH has primary responsibility for activating the pandemic influenza response at the level appropriate to the specific phase of a pandemic.

Within OSPH, the ICS will include the Public Health Director, the Agency Operations Center (AOC), and various state public health program staff, as needed. The OSPH ICS will coordinate with other state and local incident management systems as discussed in section 4.1.
Figure 1: Proposed Incident Command Organization Chart for Oregon State Public Health
4.1 Coordination with State and Local Incident Management Systems

During a widespread health emergency such as an influenza pandemic, all local health departments, and their respective county Emergency Operation Centers (EOCs), will adopt an incident management structure. These systems will need to interact effectively with each other, with the Oregon Emergency Coordination Center (ECC), and with the OSPH Agency Operations Center, as well as with other city and county response organizations.

At least two types of coordination will be needed between local health departments and the state of Oregon. First, requests for resources (material or personnel) will flow from county EOCs to the state ECC as described in the Oregon Emergency Management Plan.

Second, there will be an on-going need for high-level coordination of communication, exchange of information, and public health decision making between OSPH and the local health departments. This aspect of coordination is under active discussion; development of NIMS-compliant structures for a prolonged, statewide health emergency is a high priority for 2006. This plan will be updated when this topic has been clarified.

4.2 Operational Priorities

To minimize the health and societal effects of a pandemic, the operational priorities for OSPH are to:

- Coordinate state and federal activities with local public health partners.
- Support preparedness and response actions of health care organizations.
- Support other agencies as they deliver services essential to society.
- Identify the arrival in Oregon of a novel influenza virus by laboratory testing.
- Track influenza deaths and hospitalizations to identify high-risk groups.
- If disease is limited, identify the exposure source, protect the population at risk, and control further spread.
- Slow the spread of influenza through broad medical and community containment strategies.
- Disseminate accurate information for resource and policy decisions in public health and health care delivery settings.
- Publicize up-to-date information to encourage community support of public health policies and recommendations.
- Ensure equitable and scientifically-based distribution of scarce health care resources (such as vaccine and antiviral drugs) under state control to prevent severe illness or death and to limit further spread of disease.

WHO will designate the global pandemic phase as outlined in section 1.2 on page 6. The Centers for Disease Control and Prevention (CDC), in coordination with the WHO, will designate the U.S. pandemic phase, which will be the basis for OSPH activities. Operational priorities will change with the different pandemic phases and as new information becomes available. A pandemic may not follow the specific time course of
events suggested by the WHO phases, and the activities and priorities of OSPH will be modified based on the threat to Oregon and the United States. Examples of priorities by pandemic period are summarized in Table 4.

Table 4: OSPH Priorities by Pandemic Period

<table>
<thead>
<tr>
<th>Period</th>
<th>Operational Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-pandemic</td>
<td>• Strengthen pandemic influenza preparedness at the state and local levels.</td>
</tr>
<tr>
<td>(Phases 1 and 2)</td>
<td>• Collaborate with agricultural and wildlife officials to monitor any humans who contact animals potentially infected with a new influenza virus subtype that could be transmitted to humans.</td>
</tr>
<tr>
<td>Pandemic Alert</td>
<td>• Ensure rapid early detection, notification and response to any cases of novel influenza in Oregon. Identify key areas of need and barriers to response. Complete initial state, local, hospital, and business pandemic planning. Exercise plans to test coordination.</td>
</tr>
<tr>
<td>(Phases 3, 4, &amp; 5)</td>
<td>• If cases are present in Oregon, contain the new virus within limited clusters to delay or stop spread. Activate AOC and pandemic influenza response plan; assess gaps. Finalize disease reporting, communication, vaccination, and antiviral drug plans and policies.</td>
</tr>
<tr>
<td>Pandemic</td>
<td>Minimize the impact of the pandemic, while striving to maintain provision of essential services.</td>
</tr>
<tr>
<td>(Phase 6)</td>
<td></td>
</tr>
<tr>
<td>Post-pandemic</td>
<td>Continue public health actions, evaluations and preparations for additional outbreaks or waves of disease.</td>
</tr>
</tbody>
</table>

4.3 Activation of the Emergency Management Organization

The OSPH emergency management organization will be activated either by the first detection of laboratory-confirmed novel influenza virus in a human anywhere in the United States or by evidence of sustained human-to-human transmission of the virus anywhere in the world (WHO Pandemic Phase 5). The OSPH Director may then request that the Governor declare an impending public health crisis or proclaim a State of Emergency. Staff in all OSPH programs may be mobilized during an emergency to fill incident management positions and perform duties outside their normal roles.

The first human case of influenza caused by a novel influenza virus in Oregon will likely be detected by clinical evaluation and laboratory testing of a patient with a respiratory illness. Up-to-date case definitions and criteria for testing will be distributed to clinicians and health care facilities through established channels (CD Summary, the Health Alert Network, fax alert system) as the global situation evolves. At the time of the publication of this plan in March 2006, the case definitions used in the 27 December 2005 CD Summary are current (oregon.gov/DHS/ph/cdsummary/2005/ohd5426.pdf).
4.4 Agency Operations Center (AOC)

The OSPH AOC is the physical location for OSPH staff to coordinate activities. The AOC will:

- Serve as the site of the ICS for OSPH
- Coordinate the OSPH response including surveillance, laboratory testing, public health policy, and communication.
- Coordinate information flow to and from:
  - Federal agencies
  - OSPH programs and other state agencies
  - Local health departments
  - Tribal governments
  - Health care organizations
  - Health care providers and medical suppliers
- Assist the state ECC in fulfillment of local and state medical and health resource requests by acquiring public health and medical personnel, medical supplies, pharmaceuticals and equipment through appropriate channels.
- Provide a coordination center for technical questions and medical issues for the Oregon local health departments.
- Provide medical and public health input to policy makers.

The Oregon Emergency Response System (OERS), will be notified when the AOC is activated. During initial activation of the AOC, the Incident Commander will coordinate with both key OSPH staff and with local health departments, key state agencies, and other local contacts to determine the appropriate public health actions and priorities.

5.0 Roles and Responsibilities

This section outlines the roles and responsibilities of the federal, state, and local agencies involved in the pandemic flu preparedness and response.

5.1 Federal

Agencies of the HHS have assumed primary responsibility for a number of key elements of the national pandemic influenza plan, including:

- Coordinating national and international virus surveillance, monitoring health impacts, and providing laboratory support.
- Directing and funding research on influenza virus, vaccine and antiviral drugs.
- Evaluating, licensing and providing liability programs for vaccine.
- Developing a national clearinghouse for vaccine availability, distribution and redistribution.
- Leading communication with states and other public health agencies.
- Providing policy guidance on pandemic response activities.
- Managing the Strategic National Stockpile (SNS), which caches influenza antiviral drugs.
The many other federal roles in pandemic response are outlined in the *HHS Pandemic Influenza Plan*, page 26 ([www.hhs.gov/pandemicflu/plan](http://www.hhs.gov/pandemicflu/plan)).

### 5.2 Oregon State Public Health (OSPH)

The section outlines the roles and responsibilities of the people and programs within OSPH who are involved in a pandemic influenza response.

#### 5.2.1 OSPH Director

The OSPH Director is responsible for the following:

- Serve as Senior Policy Advisor.
- Activate the OSPH emergency management organization as necessary in coordination with the Public Health Preparedness program.
- Convene the Oregon Pandemic Influenza Coordinating Committee for making recommendations to the Governor’s Office and to state and local agencies that respond to pandemic flu.
- Direct all necessary OSPH resources to respond to the emergency.
- Maintain continuity of OSPH management and operations.
- Ensure continuation of critical public health functions that are not related to pandemic flu.

#### 5.2.2 Pandemic Influenza Coordinating Committee (PICC)

During a pandemic, a spectrum of prompt, well-coordinated health decisions will be needed. At one extreme, minor decisions, such as individual patient isolation, will be made by local health departments or health care facilities; at the other extreme, major decisions affecting large segments of the population or the economy will be made and enforced by state or federal elected officials. Recommendations to elected officials for such major decisions will come from the OSPH Director in conjunction with the Pandemic Influenza Coordinating Committee (PICC).

Instead of forming a new committee specifically for pandemic influenza, OSPH will solicit advice from two standing committees, the Public Health Preparedness Leadership Team (PHPLT) and the Council of Local Health Officers (CLHO), and from other experts as needed.

The PHPLT advises on public health emergency preparedness issues to ensure integration between the local and state levels. It includes senior OSPH managers and CLHO representatives from across Oregon and is co-chaired by local and state representatives.

The Integrated HRSA Oversight Committee (IHOC) advises on policies, coordinating mechanisms and a planning framework to define and strengthen health care system preparedness in response to any emergency that creates a surge capacity event requiring a significant health care response. Its membership includes:

- Senior OSPH managers
- Primary care, critical care, and trauma physicians
• Emergency medical services
• Mental health representatives
• Representatives from clinics and hospitals

The IHOC is co-chaired by OSPH and the Oregon Association of Hospitals and Health Systems.

5.2.3 Risk Communication Team

The Risk Communication Team consists of the OSPH Communication Officer, the Public Health Preparedness Risk Communication Section, and a content expert from Acute and Communicable Disease Prevention (ACDP). This team has the following responsibilities:

• Organize an overall public information campaign.
• Create and maintain messages and information for the news media, the public, health care workers and other partners.
  o Provide public information support for local health departments.
  o Provide content for the OSPH Web site.
• Develop fact sheets for health care workers, local health departments, and the public.
• Arrange for translation of informational materials.
• Establish a telephone hotline.
• Manage the ICS Joint Information System.

5.2.4 Oregon State Epidemiologist

The State Epidemiologist will:

• Provide scientific support to the OSPH Director, communications staff, and policymakers.
• Determine surveillance objectives as the pandemic evolves.
• Facilitate and oversee communications with CDC scientific staff.

5.2.5 Acute and Communicable Disease Prevention (ACDP)

ACDP will:

• Provide staff to serve in the OSPH AOC as operation branch leaders and as technical content consultants to the Risk Communication Team.
• Distribute information from the WHO and the CDC.
• Ensure activation and coordination of the following activities:
  o Influenza surveillance in cooperation with local health departments, hospitals and health care systems.
  o Development and dissemination of disease reporting requirements, including influenza death and hospitalization.
  o Investigation of novel influenza outbreaks during Phases 4 and 5 when disease is widespread. During Phase 6 investigations will be limited to special circumstances.
  o Provision of technical advice for the ICS Joint Information Center, local health departments, and health care providers.
o Development of policy recommendations regarding antiviral drugs, vaccine, and community containment measures in collaboration with local health departments, the CDC, and other partners (see Attachments E, F, and G).

5.2.6 Public Health Preparedness (PHP) Program

PHP will support the operation of the OSPH AOC during a pandemic and will perform the following functions:
- Provide personnel to serve as ICS General Staff.
- Provide guidance to Oregon DHS on the ICS organization and function.
- Provide liaisons to the Oregon ECC and to hospitals and health care systems.
- Issue alerts through the Oregon Health Alert Network.
- Support local health department activities.
- Support management and distribution of vaccines and pharmaceuticals to local health departments as necessary through the Strategic National Stockpile Plan.

5.2.7 Immunization Program

The Immunization Program will perform the following tasks:
- Prepare and deliver educational materials for vaccine providers.
- Prepare to receive and distribute assets from the SNS, vendor-managed inventory, or normal channels.
- Track the delivery of vaccine.
- Monitor vaccine adverse events.
- Provide staff to the AOC Planning and Operations sections.
- Develop and publicize vaccine use guidelines.

5.2.8 Oregon State Public Health Laboratory (OSPHL)

OSPHL provides laboratory testing to support OSPH and local health departments. During a pandemic, the lab will perform the following tasks:
- Provide influenza laboratory testing.
- Provide printed and Web-based instructions on specimen collection for health care providers.
- Provide specimen collection material on request.
- Communicate testing results to clinicians and to local, state, and federal health officials.
- Collaborate with the WHO and CDC laboratory network.
- Develop and distribute novel influenza testing criteria and communication plans in collaboration with the ACDP.
5.3 Local Health Departments

Oregon’s public health system relies on the authority and responsibility of local health departments for public health preparedness and response. OSPH will lead and coordinate the pandemic response in collaboration with local health departments. The local health departments are responsible for the following tasks:

- Lead local preparedness activities
- Collaborate with the Joint Information Center to ensure consistent communication with the public and healthcare providers.
- Provide disease surveillance and community education in collaboration with OSPH.
- Coordinate the dispensing of pharmaceuticals and vaccines to the public.
- Facilitate cooperation among all local involved parties (e.g., government officials, emergency responders, health experts, businesses and the public).
- Work with other governmental agencies to implement community control measures.
- Coordinate medical volunteers
- Collaborate with health care providers to provide information about access to health care.

When local health departments need additional resources, they will contact the state ECC through their county EOC.

5.4 Hospitals and Health Care Systems

Hospitals and health care systems are expected to develop plans for pandemic influenza that describe how the organization will perform the following tasks:

- Implement decision-making structures.
- Handle surge capacity and business continuity.
- Fulfill proposed disease reporting requirements, using automated methods whenever possible.
- Request assistance from government agencies when needed.
- Deliver state-controlled antiviral drugs to hospitalized influenza patients.
- Ensure antiviral treatment of ill health care workers who have direct patient care responsibility.
- Ensure that employees in high priority groups receive vaccine or antiviral drugs as available.
6.0 Overview of Attachments

State activities to prepare for, respond to, and recover from an influenza pandemic are summarized in the attachments to this plan and are further detailed in the tabs to each attachment. This section gives a brief overview of each attachment.

Attachment A: Public Health Communications
Timely, accurate, consistent and seamless communication with the public and among the various partners who will play a role in responding to a pandemic influenza outbreak is essential to protecting the lives of Oregon’s citizens. This attachment describes OSPH plans to establish communication with local health departments, health care providers, and other partners through the Joint Information System. Because public trust is essential to containing the spread of a pandemic, tabs to this attachment provide key messages, FAQs, fact sheets, and other information for distribution to the public.

Attachment B: Surveillance
Surveillance for new subtypes of influenza will determine the start and end of an influenza pandemic in Oregon and will help define groups at high risk for complications. Prompt detection of the first cases of a new influenza subtype may provide opportunities to slow the spread even if the pandemic cannot be prevented.

This attachment describes OSPH plans to detect the arrival of a pandemic influenza subtype in Oregon and to monitor the spread of the pandemic. These plans will require hospitals to implement new reporting requirements. OSPH will provide technical assistance as described in this attachment.

Attachment C: Laboratory Diagnostics
Laboratory testing will identify the arrival of a novel strain of influenza in Oregon. This attachment describes OSPH plans for creating and distributing clinical testing criteria and guidelines, detecting new strains of influenza, and communicating results to clinicians and local, state, and federal health officials. It also explains how the OSPHL will coordinate with the WHO and CDC Laboratory Response Network (LRN).

Attachment D: Health Care Planning
Hospitals and health care systems will provide a key role in detecting and treating pandemic influenza. This attachment focuses on those areas in which the state will have a direct role interacting with hospitals before and during a pandemic. It describes OSPH plans for emergency management and communication and emphasizes the key role of hospitals in disease surveillance and distribution of vaccine and antiviral drugs. It also describes the distribution of training materials about pandemic influenza to hospital employees.
Attachment E: Vaccine Distribution and Use
Vaccination is the basis of influenza prevention during routine seasons. During a pandemic, vaccine for a novel virus is unlikely to be available for 3-6 months after the virus strain is identified, and once a vaccine is in production, the early supply will not be adequate. This attachment outlines state activities for vaccine distribution and prioritization.

Attachment F: Antiviral Drug Distribution and Use
Because an effective vaccine is not expected to be available at the onset of an influenza pandemic, treatment with antiviral agents will be one of the few interventions available to decrease complications of influenza. Only one agent, oseltamivir (Tamiflu®) is currently available in the Strategic National Stockpile. The HHS Pandemic Influenza Plan recommends 11 different priority groups for antiviral use and provides guidance on the current and anticipated future amounts of oseltamivir in the SNS. This attachment describes how the projected amount of oseltamivir available to Oregon would be used during a pandemic.

Attachment G: Community Disease Control and Prevention
During the early stages of an influenza pandemic, community containment measures, such as isolation, quarantine, or closing of public places, may be the only means available to slow the spread of disease and to allow additional time for the development of vaccines and the distribution and administration of antiviral drugs. This attachment describes OSPH plans for creating and disseminating public health measures to control the spread of the pandemic.

Attachment H: Managing Travel-Related Risk of Disease Transmission
Screening international and domestic travelers may slow the spread of influenza. This attachment describes how OSPH will coordinate with the appropriate federal agencies and local partners to develop and implement travel-related strategies to limit the spread of pandemic influenza into or out of Oregon. OSPH will coordinate with state and local partners to develop and implement strategies to limit spread within Oregon.

Attachment I: Behavioral Health Support
During times of high stress, such as during an influenza pandemic, it is important to provide behavioral health support services to both the work force responding to the pandemic and to the general public, including people in isolation and quarantine. This attachment describes behavioral health support services to help health care workers, first responders, and essential service workers manage emotional stress during an influenza pandemic. It also describes the plans to develop programs to assist the families of deployed workers. Finally, this attachment discusses plans to prepare and distribute informational materials for all Oregon citizens to help with personal, professional, and family issues.

Attachment J: Local Health Department Activities
This attachment outlines the responsibilities of local health departments. Each local health department will develop its own plans for public health emergencies.
**Attachment K: Infection Control**
This attachment, which is available as a link on our Web site, is the federal HSS *Pandemic Influenza Plan, Supplement 4, Infection Control*, which Oregon is adopting in full to promote national consistency on this topic. See [oregon.gov/DHS/ph/acd/flu/panflu.shtml](http://oregon.gov/DHS/ph/acd/flu/panflu.shtml).

**Attachment L: Clinical Guidelines**
This attachment, which is available as a link on our Web site, is the federal HSS *Pandemic Influenza Plan, Supplement 5, Clinical Guidelines*, which Oregon is adopting in full to promote national consistency on this topic. See [oregon.gov/DHS/ph/acd/flu/panflu.shtml](http://oregon.gov/DHS/ph/acd/flu/panflu.shtml).

### 7.0 Training and Exercises

The state strategic training plan identifies topics that will be important to pandemic influenza response including epidemiologic surge capacity, crisis and emergency risk communications, Laboratory Response Network, public health law, and so on. The complex nature of pandemic planning will require a series of on-going exercises to maintain proper readiness. Pandemic influenza response exercises have been incorporated into the public health emergency exercise program.

The training schedule and materials are available on the Oregon HAN Web site ([www.oregonhan.org](http://www.oregonhan.org)) in Toolbox > Document Library > Training and Presentations. Training materials can also be requested by contacting the Public Health Preparedness program.

### 8.0 Special Populations

Pandemic influenza may adversely impact persons who have special needs or live in institutions such as, assisted-living facilities, group homes, and jails. Additional planning efforts by these institutions will be necessary. The characteristics of the influenza outbreak may also require additional preparedness and response actions for certain segments of the population. These issues will be considered as the epidemiology of the pandemic is clarified.

*Detailed information on special population planning under development.*

### 9.0 Plan Maintenance

This plan will be reviewed annually in October, prior to the start of the influenza season. It will also be reviewed and revised as needed after emergency exercises, organizational change, or revisions in federal guidance.
10.0 Links to Web Sites

The links in this section were correct as of March 2006.

World Health Organization
   Pandemic alert and response Web site: www.who.int/csr/

Centers for Disease Control and Prevention
   Influenza Web site: www.cdc.gov/flu/
   Strategic National Stockpile: www.bt.cdc.gov/stockpile

U.S. Department of Homeland Security
   National Incident Management System: www.fema.gov/nims/

U.S. Department of Health and Human Services
   Pandemic and avian flu Web site: www.pandemicflu.gov/
   Pandemic Influenza Plan (2005): www.hhs.gov/pandemicflu/plan/

Oregon Department of Human Services
   Oregon Pandemic Influenza Plan:
   Oregon Health Alert Network: www.oregonhan.org
      (Note that the HAN Web site requires a user account and password.)

State of Oregon
   Oregon Emergency Management Plan:
      www.oregon.gov/OOHS/OEM/docs/library/or_emp_volum_2_emerg_oper.pdf
   Oregon Revised Statutes: www.leg.state.or.us/ors/
   Oregon Administrative Rules: arcweb.sos.state.or.us/banners/rules.htm
11.0 Acronyms and Glossary

List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACDP</td>
<td>Acute and Communicable Disease Prevention</td>
</tr>
<tr>
<td>AOC</td>
<td>Agency Operations Center</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CLHO</td>
<td>Council of Local Health Officials</td>
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<tr>
<td>DHS</td>
<td>Department of Human Services</td>
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<td>ECC</td>
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<td>EOC</td>
<td>Emergency Operations Center</td>
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<td>ESF</td>
<td>Emergency Support Services</td>
</tr>
<tr>
<td>HAN</td>
<td>Health Alert Network</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HRSA</td>
<td>Health Resources and Services Administration</td>
</tr>
<tr>
<td>ICS</td>
<td>Incident Command System</td>
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<tr>
<td>IHOC</td>
<td>Integrated HRSA Oversight Committee</td>
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<td>LHD</td>
<td>Local Health Department</td>
</tr>
<tr>
<td>NIMS</td>
<td>National Incident Management System</td>
</tr>
<tr>
<td>NRP</td>
<td>National Response Plan</td>
</tr>
<tr>
<td>OEM</td>
<td>Office of Emergency Management</td>
</tr>
<tr>
<td>OERS</td>
<td>Oregon Emergency Response System</td>
</tr>
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<td>OSPH</td>
<td>Oregon State Public Health</td>
</tr>
<tr>
<td>OSPHL</td>
<td>Oregon State Public Health Laboratory</td>
</tr>
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<td>Public Health Preparedness Leadership Team</td>
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<td>Public Health Preparedness Program</td>
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<td>PICC</td>
<td>Pandemic Influenza Planning Committee</td>
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<td>SNS</td>
<td>Strategic National Stockpile</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Glossary

**Antiviral drug.** A medication that destroys or inhibits the growth and reproduction of viruses.

**Community containment.** The use of measures to limit the spread of contagious diseases by limiting contact between people who could be contagious to others. Closing schools is one example.

**Emergency Support Function.** A functional area of response activity established to facilitate the delivery of Federal assistance required during the immediate response phase of a disaster to save lives, protect property and public health, and to maintain public safety.

**Epidemiology.** The study of the distribution and determinants of disease in populations, and the application of this to the control of health problems.

**General Staff.** A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief.

**H5N1 virus.** An influenza A virus subtype that occurs mainly in birds.

**Health Alert Network (HAN).** An Internet program used to communicate health and emergency messages.

**Incident Command System (ICS).** A standardized on-scene emergency management system that enables multiple agencies and jurisdictions to respond to single or multiple incidents using an integrated organizational structure.

**Incident Commander.** The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and release of resources. The Incident Commander has overall authority and responsibility for conducting incident operations and is responsible for managing all incident operations at the incident site.

**Influenza A.** A virus causing annual outbreaks of respiratory illness. Human influenza is classified as type “A” or type “B.” Type A is also found in other animals.

**Influenza-like illness (ILI).** The presence of fever equal to or greater than 100.0° F, with a cough or sore throat.

**Isolation.** The restriction of movement of people having or suspected of having a communicable disease.
Joint Information Center (JIC). A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media.

Joint Information System (JIS). Integrates incident information and public affairs into a cohesive structure to provide consistent, coordinated, timely information during an incident.

Laboratory Response Network. An integrated network of local, state, federal, military and international laboratories organized by the CDC.

National Incident Management System (NIMS). A system that provides a consistent nationwide approach for governments (federal, state, local, and tribal), private-sector businesses, and nongovernmental organizations to work effectively and efficiently together to prepare for and respond to incidents.

Novel influenza virus. An influenza virus subtype not previously or typically found in humans.

Operation Section. Under ICS, the section responsible for all tactical operations.


Planning Section. In an Incident Command, the section responsible for collecting, evaluation, and disseminating operational information related to the incident.

Quarantine. The restriction of movement of people who have been in contact with someone contagious.

Strategic National Stockpile (SNS). A federal cache of medical supplies and equipment used during emergencies and disasters.

Subtype. Identification of influenza A viruses according to the hemagglutinin (H) and neuraminidase (N) components of the virus, such as H3N2 or H5N1.

Surveillance. The collection, analysis and dissemination of data about a disease.

Vaccine. A preparation that is administered to produce or artificially trigger immunity to a particular disease.

Vaccine adverse event. Possible side effects that occur after a person has received a vaccine.
Attachment A: Public Health Communications

Timely, accurate, consistent and seamless communication with the public and among the various partners who will play a role in responding to a pandemic influenza outbreak is essential to protecting the lives of Oregon’s citizens by ensuring that they have the information they need to protect themselves and their families. The public information response to a health emergency or disease outbreak is described in more detail in the Health and Medical annex of the Oregon Emergency Management Plan (See Annex F, Functional Appendix 1, Public Health Communications and Appendix 10.6, Communication Around Outbreaks); activities may be accelerated depending on the features of the outbreak and the level of public anxiety.

An evolving communicable disease outbreak, such as pandemic influenza, may require a variety of measures in an attempt to contain the spread of the disease. Public trust is essential to containing the spread of disease and requires clear communication that addresses people’s fears and concerns, answers their questions, and provides guidance on protective actions they can take.

Understanding public perception and providing the right information at the right time can have a significant impact on maximizing public cooperation with response and recovery activities, avoiding misallocation or wasting of limited resources, and restoring normalcy.

Assumptions

- The Centers for Disease Prevention and Control (CDC) will maintain a national central information clearinghouse accessible on the Internet and will develop generic guidelines and information templates that can be modified and adapted as needed at the state and local levels, including fact sheets and questions and answers on influenza, influenza vaccine and antiviral agents.
- The CDC and Oregon State Public Health (OSPH) will assist in providing strategies and guidelines for interacting with the media and communicating effectively with the public health and medical communities and the general public.
- OSPH will maintain a central information clearinghouse accessible on the Health Alert Network Web site and will develop Oregon-specific informational materials that can be modified and adapted as needed at the local level.
- Local Health Departments (LHDs) will provide localized communications resources during all phases of a pandemic disease outbreak. These resources are outlined in the all-hazards standard operating procedures for before, during and following a public health emergency (Functional SOPs 1.1.1, 1.1.2 and 1.1.3).
- The Oregon DHS offices that will be responsible for public health communications include the Public Information Coordination section of the DHS Public Health Preparedness program, DHS Office of Public Affairs, and the Office of Disease Prevention and Epidemiology.
While much of the response to pandemic flu would be similar to other communicable respiratory diseases, some characteristics will create unique challenges for providing public information, including:

- Because the public health response to influenza will be prolonged, it will be necessary to explore creative solutions for keeping people informed and engaged throughout the pandemic.
- Because vaccine is unlikely to be available early in the pandemic, public health messages will need to focus on more traditional protection strategies and measures.

**Objectives**

- Encourage and maintain coordination of information and consistent public messaging with key partners and stakeholders.
- Provide public health and health care partners with information they can share with their clients and patients.
- Keep key decision makers and partners informed regarding the status and progression of the disease, public health response activities, and any changes in issues.
- Target specific internal and external audiences, including those with special information needs.
- Advise the public and news media on the imposition of public health measures to control the spread of disease.
- Provide information to lessen the unnecessary health and economic impacts of disease on the state.
- Assist in the public information aspects of behavioral health support activities.

**Summary of Activities by Pandemic Period**

This section summarizes communication activities during each pandemic phase. For a complete list of activities, see Tab A-1, *Communications Checklist by Pandemic Phase*. For a definition of the pandemic phases, see section 1.2, *World Health Organization Pandemic Phases*. Many of the activities described in Attachment I, *Behavioral Health Support* overlap with other communication activities and are not repeated here.

**Interpandemic/Early Pandemic Alert (Phases 1-3)**

- Ensure that appropriate policies, procedures and mechanisms are in place for a coordinated public information response at the federal, state and local levels. Messages at this phase will focus on preparedness activities for state and local public health, hospitals, businesses, individuals and families, community organizations and schools.
- Prepare communication and educational materials about pandemic flu for distribution to health care providers, other emergency responders, the media, and the public.
- Participate in communication planning and exercises.
Pandemic Alert (Phases 4-5)

- Notify local health departments and hospitals of the pandemic alert phase.
- Activate the Joint Information System.
- Prepare fact sheets on the emergent novel influenza virus and methods of diagnosis.

Pandemic (Phase 6)

- Activate the Public Health Joint Information Center at a level consistent with the proximity of outbreaks to Oregon communities.
- Increase information flow to local health departments, medical providers and other partners and stakeholders.
- Focus messages on infection control measures, the numbers of new cases or deaths, and the availability and prioritization of treatment.

Post-pandemic

- Deactivate the Joint Information System when the Agency Operations Center has suspended operations and ended the Incident Command System.
- Evaluate the public information response and incorporate needed changes into plans.

Active Issues

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<th>Issue</th>
<th>Recommendation</th>
<th>Anticipated Completion</th>
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<td>Public Information Hotline and Communications Surge Capacity</td>
<td>Evaluate communication surge capacity within state and local government; identify and train 60 additional staff to serve in a public health Joint Information Center (JIC)</td>
<td>September 2006</td>
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<tr>
<td>Telephone surge capacity in the Portland State Office Building</td>
<td>Redraft standard operating procedures, train call takers (included in public information surge capacity, above) and conduct drills for a hotline of 12 incoming lines</td>
<td>July 2006</td>
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<tr>
<td>Efficient web-posting of rapidly changing health information</td>
<td>Evaluate and test alternatives to current DHS website</td>
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# Tabs

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<td>A-1</td>
<td>Communications Checklist by Pandemic Phase</td>
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<td>A-2</td>
<td>2005-2006 Influenza Season, Pandemic Influenza Planning and Avian Influenza Communication Plan</td>
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<td>A-3</td>
<td>2005-2006 Influenza Season Communication Tools</td>
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<td>A-4</td>
<td>Templates for Flu Vaccine Talking Points</td>
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<td>Pandemic Influenza Communication Tools</td>
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<td>A-6</td>
<td>Avian Influenza Communication Tools</td>
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<td>A-7</td>
<td>Use of Antiviral Drugs Fact Sheet</td>
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<td>A-8</td>
<td>Antiviral Drug Side Effects Fact Sheet</td>
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<td>A-9</td>
<td>Normal Flu Season FAQ</td>
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<td>A-10</td>
<td>Flu Vaccine/Antiviral Adverse Event Communication Plan</td>
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<td>A-11</td>
<td>Isolation and Quarantine Fact Sheet</td>
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<td>A-12</td>
<td>Templates for communications to health care workers concerning prioritization of vaccine distribution, appropriate use of antiviral meds and reporting of adverse events</td>
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Attachment B: Surveillance

Surveillance for new subtypes of influenza will determine the start and end of an influenza pandemic in Oregon, and will help define groups at high risk for complications. Prompt detection of the first cases of a new influenza subtype may provide opportunities to slow spread even if the pandemic cannot be prevented. Surveillance data are vital to other state activities such as health care planning, vaccine and antiviral use, and recommendations about community control measures.

During pandemic Phases 3-5, laboratory testing of ill citizens will detect the arrival of a pandemic influenza subtype in Oregon. During Phase 6, laboratory efforts will focus on confirming infection as a part of systematic surveillance and in identifying viral evolution and the frequency of drug resistance. New reporting requirements and systems will be needed to monitor hospitalizations related to the pandemic. The enumeration of deaths and hospitalizations will provide a measure of the magnitude and intensity of the outbreak. Existing systems for tracking annual influenza and influenza deaths will be enhanced to respond to the anticipated surge in reports and the need for timely data during a pandemic.

Assumptions

- Continuity of vital records reporting will be a priority for Oregon and its counties.
- Hospital information systems (or designated individuals in small facilities) will be able to report daily a list of admissions, discharges, diagnoses and deaths.
- Alternative sites of care, if in use, will not be the main focus of disease surveillance.

Objectives

- Detect the onset of a pandemic in Oregon.
- Measure the number of deaths from respiratory illness (all causes) during a pandemic.
- Measure the number of individuals requiring hospitalization during a pandemic.
- Define the groups at highest risk for infection, hospitalization and death during a pandemic.
Authorities

<table>
<thead>
<tr>
<th>Oregon Revised Statute</th>
<th>Title</th>
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<tbody>
<tr>
<td>431.110</td>
<td>General powers of Department of Human Services</td>
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<tr>
<td>431.550</td>
<td>Authority of Department of Human Services to collect information from local public health administrators</td>
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<tr>
<td>432.005 to 432.337</td>
<td>Vital statistics</td>
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<td>433.001 to 433.012</td>
<td>Reportable diseases; duty to report; effect of failure to report; rules; investigation and control measures</td>
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<tr>
<td>333-001-0000</td>
<td>DHS Public Health; notice of proposed rule</td>
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<td>333-003-0030</td>
<td>Public Health Preparedness; impending health crisis; new reporting requirements</td>
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<tr>
<td>333-003-0050</td>
<td>Public Health Preparedness; impending health crisis; access to individually identifiable information</td>
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<td>333-011-0072</td>
<td>Death Registration</td>
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<tr>
<td>333-018-0000 to 0020</td>
<td>Disease Reporting</td>
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<tr>
<td>333-019-0000 to 0015</td>
<td>Investigation and Control of Diseases</td>
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</tbody>
</table>

Summary of Activities by Pandemic Period

This section describes surveillance activities during each pandemic phase (see section 1.2, World Health Organization Pandemic Phases).

Interpandemic/Early Pandemic Alert (Phases 1-3)

Oregon conducts routine surveillance for influenza and influenza-like illness (ILI) by a variety of methods throughout the year.

Annual Influenza Surveillance

**Sentinel Provider Network.** This network, which is supported by the CDC and facilitated by Oregon State Public Health (OSPH), consists of health care providers located throughout Oregon who voluntarily report on a weekly basis the total number of patients seen and the number of those patients with influenza-like illness (defined as fever ≥100.0°F or 37.8°C plus cough or sore throat, in the absence of a known cause other than influenza). Results are tabulated and disseminated by email and Web site posting weekly.
**Laboratory Surveillance.** A network of contributing laboratories report viral culture results year-round. During the October-to-May influenza season, this information is tabulated and distributed weekly.

**Kaiser Permanente Northwest Respiratory Illness.** The Center for Health Research of Kaiser Permanente Northwest and the DHS Acute and Communicable Disease Prevention program (ACDP) collaborate to track hospital admissions and out-patient visits related to acute respiratory illness.

Kaiser Permanente Northwest provides health care for 340,000 Oregonians and another 130,000 people living in southwest Washington. Because health plan members avoid out-of-pocket expenses by seeking their health care at a Kaiser facility, rates of illness calculated from Kaiser records closely approximate population-based incidence. The Kaiser electronic medical record makes analysis of this data possible shortly after it is collected. Rates of illness are calculated using International Classification of Diseases, 9th Edition (ICD-9) codes 460-466 (upper respiratory infection) and 480-487 (pneumonia and influenza) for outpatient visits and codes 480-487 for hospitalization.

**City of Portland Pneumonia and Influenza Mortality.** The city of Portland, through the effort of Multnomah County vital records, reports deaths from “pneumonia and influenza” to the CDC weekly. In the current system there is a delay of at least 1 week in this reporting. ACDP monitors these reports via the CDC website.

**Pediatric (<18 years) Influenza Hospitalization (Statewide).** Laboratory-confirmed influenza hospitalization in those under 18 years old, statewide, is reported to ACDP as a project of the CDC-funded Emerging Infections Program.

**Adult Influenza Hospitalization (Portland Metro Area).** Laboratory-confirmed influenza hospitalization in those over 18 years old, in the Portland metropolitan area only (Clackamas, Multnomah and Washington counties) is reported to ACDP as a project of the CDC-funded Emerging Infections Program.

**Novel Influenza Surveillance**

ACDP tracks novel influenza as defined by current CDC case definitions (clinical and epidemiologic criteria) by providing laboratory testing for influenza H1, H3, H5, and H7 at the Oregon State Public Health Laboratory and by providing technical guidance on criteria for testing and infection control.

**Avian Influenza Surveillance**

ACDP, the Oregon Department of Agriculture and the Oregon Department of Fish and Wildlife partner to develop and update plans and protocols to track influenza in domestic and wild birds. A worker-protection plan has also been developed to ensure the safety of those involved in the surveillance or disposal of dead birds.
Pandemic Alert (Phases 4-5)

Once human-to-human spread of a new strain of influenza is confirmed elsewhere, surveillance for its appearance in Oregon will intensify, and monitoring systems for the expected pandemic will be activated and tested. In anticipation of pandemic Phase 6, the existing death reporting system will be modified to enable provisional reporting of pneumonia and influenza deaths within 1 week of occurrence. In addition, new rules for reporting hospitalization for acute respiratory illness will be finalized and tested. During this period the Acute and Communicable Disease Prevention program will:

- Continue routine surveillance activities described for Phases 1-3.
- Update case definitions for suspect novel influenza based on CDC guidance.
- Intensify novel influenza surveillance among returning travelers and health-care workers in collaboration with CDC Global Migration and Quarantine, ports of entry, local health departments and clinicians.
- Finalize plans for changing influenza and respiratory illness reporting requirements.
- Expand pneumonia and influenza death reporting statewide:
  - Evaluate timeliness and specificity of death certificate data.
  - Evaluate methods for shortening delays in reporting.
  - Test systems for analyzing cause of death from death certificate.
  - Begin production of weekly pneumonia and influenza death report.
- Test statewide respiratory hospitalization reporting system:
  - Distribute new reporting rules to hospitals.
  - Test reporting using existing hospital information systems.
  - Test hospital reporting using state or local public health staff placed in facilities to enter data directly into the eSentinel Web-based reporting system.
- Test statewide hospital capacity monitoring system (HospCap) for monitoring staffed beds and critical supplies.

Pandemic (Phase 6)

During this phase surveillance will be focused on timely and accurate enumeration of severe illness and death from influenza.

- Finalize requirements for laboratory, hospital, and vital records reporting:
  - Laboratories will report confirmed novel influenza cases.
  - Hospitals will report presumptive and confirmed novel influenza admissions.
  - Vital records will report all deaths (any cause) and deaths caused by pneumonia and influenza.
- Optimize sentinel clinician reporting to the CDC.
- Monitor and share hospital capacity data.
**Active Issues**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small sentinel provider system</td>
<td>Expand the number of participating providers to at least 30 by the 2006-07 influenza season</td>
<td>By October 2006</td>
</tr>
<tr>
<td>Delays in death reporting</td>
<td>Evaluate progress in implementation of electronic death registration system</td>
<td>Evaluate June 2006 and decide whether to pursue electronic or paper-based system for real-time death reporting</td>
</tr>
<tr>
<td>Hospital reporting of acute respiratory disease admissions</td>
<td>Develop case definitions. Identify pilot hospital or health system to test reporting. Expand pilot reporting focusing on state population centers and geographical diversity</td>
<td>Pilot reporting from one hospital system by the end of 2006, expand further in 2007</td>
</tr>
<tr>
<td>Determine role of Hospital Capacity Web site in surveillance</td>
<td>Evaluate Web site during exercises for pandemic influenza</td>
<td>November 2006</td>
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</tbody>
</table>

**Tabs**

<table>
<thead>
<tr>
<th>Tab Number</th>
<th>Tab Title</th>
<th>Status</th>
<th>Anticipated Completion Date</th>
</tr>
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<tbody>
<tr>
<td>B-1</td>
<td>Evaluation of Hospital Capacity Web site for pandemic influenza surveillance</td>
<td>Initiated, not completed</td>
<td>July 2006</td>
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<tr>
<td>B-2</td>
<td>Protocol for death surveillance for pandemic influenza</td>
<td>Initiated, not completed</td>
<td>June 2006</td>
</tr>
<tr>
<td>B-3</td>
<td>Case Report form and investigative guideline for novel influenza pandemic Phase 3-5</td>
<td>Not completed</td>
<td>Draft May 2006; Final July 2006</td>
</tr>
<tr>
<td>B-4</td>
<td>Proposed reporting rules for pandemic influenza</td>
<td>Not Completed</td>
<td>March 2006</td>
</tr>
<tr>
<td>B-5</td>
<td>Sample data use agreements for hospitals</td>
<td>Not Completed</td>
<td>June 2006</td>
</tr>
</tbody>
</table>
Attachment C: Laboratory Diagnostics

Laboratory testing will identify the arrival of a novel strain of influenza in Oregon. The Oregon State Public Health Laboratory (OSPHL) will obtain test reagents from the Centers for Disease Control and Prevention (CDC) as available, to detect new strains of influenza. The largest volume of and greatest urgency for testing will likely occur just before and immediately after the arrival of a new strain. If a new influenza strain becomes widespread, OSPHL focus may shift to monitoring for antigenic drift and detection of antiviral resistance mutations.

Assumptions

- RT-PCR (reverse transcriptase polymerase chain reaction) testing will be the primary method for detecting a new strain of influenza.
- Using real-time RT-PCR methods, a maximum of 200-250 specimens per day, 5 days per week for 4 weeks, can be analyzed. Subsequent capacity will depend upon reagent availability.
- RT-PCR testing capacity can be maintained even if up to 50% of the trained staff is incapacitated.

Objectives

- Detect new strains of influenza in Oregon patients.
- Rapidly communicate influenza testing results to requesting clinicians, especially during pandemic Phases 3-5. (During Phase 6 lab priorities will be reassessed.)
- Rapidly communicate results to local, state and federal health officials.
- Request and validate new assays as available from the CDC.
- Assure on-going participation in the WHO/CDC laboratory network

Authorities

<table>
<thead>
<tr>
<th>Oregon Revised Statute</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>431.310</td>
<td>Bacteriological and other examinations and newborn screening by state laboratory; rules; fees</td>
</tr>
<tr>
<td>433.012</td>
<td>Department to provide laboratory examination</td>
</tr>
</tbody>
</table>

Summary of Activities by Pandemic Period

This section describes laboratory activities during each pandemic phase (see section 1.2, World Health Organization Pandemic Phases).
Interpandemic/Early Pandemic Alert (Phases 1-3)

- Perform seasonal influenza laboratory surveillance by viral culture; submit a subset of isolates for antigenic characterization to the CDC.
- Obtain reagents and validate influenza RT-PCR testing for novel strains.
- Develop plans for laboratory personnel, equipment and reagent surge capacity.
- Develop novel influenza testing criteria and communication plans in collaboration with the state Acute and Communicable Disease Prevention program (ACDP) including:
  - Case definition for patients needing testing.
  - Standard operating procedures for on-call epidemiologists.
  - CD Summary newsletter to clinicians explaining testing availability.
  - Media plan for reporting positive results.

Pandemic Alert (Phases 4-5)

- Implement plans to confirm positive tests for novel influenza from other labs.
- Finalize and test plans for personnel, equipment and reagent surge capacity.
- Educate staff on up-to-date safety, personal protective equipment, and vaccine recommendations.
- Develop respiratory illness surveillance plan for staff who handle specimens.
- Designate essential pandemic response laboratory workers for antiviral and vaccine priority groups.
- Revise novel influenza testing criteria and communication in collaboration with ACDP including:
  - Case definition for patients needing testing.
  - Standard operating procedures for on-call epidemiologists.
  - CD Summary to clinicians explaining testing availability.
  - Media plan for reporting positive results.

Pandemic (Phase 6)

- Continue RT-PCR testing; anticipate maximum volume.
- Forward specimens to the CDC as requested.
- Collaborate with the ACDP and the CDC on changing lab focus from detection to other needs such as:
  - Detecting antigenic drift.
  - Detecting antiviral resistance mutations.
  - Monitoring vaccine effectiveness.
  - Validating testing done in other laboratories.
## Active Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional automated extraction equipment is needed</td>
<td>Identify funding, estimated cost $156,000</td>
<td>End of 2006</td>
</tr>
<tr>
<td>Funding and feasibility of reagent stockpiling</td>
<td>Identify funding to stock enough reagents for 4000 tests, estimated cost $160,000</td>
<td>End of 2006</td>
</tr>
<tr>
<td>Exercise of lab capacity and epidemiology for pandemic flu testing</td>
<td>Hold an exercise on lab capacity and communication with epidemiology section</td>
<td>Before November 2006 full scale exercise</td>
</tr>
</tbody>
</table>

## Tabs

<table>
<thead>
<tr>
<th>Tab Number</th>
<th>Tab</th>
<th>Status</th>
<th>Anticipated Completion Date</th>
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<tbody>
<tr>
<td>C-1</td>
<td>ORS and OAR for laboratories</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>C-2</td>
<td>CD Summary Dec 27, 2005- Avian Influenza Testing</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>C-3</td>
<td>ACDP-OSPHEL SOP for Avian Influenza (AI) testing</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>C-4</td>
<td>AI testing algorithm</td>
<td>Completed</td>
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</tr>
</tbody>
</table>
Attachment D: Hospital Health Care Planning

Guidance on hospital planning is provided in the federal HHS Pandemic Influenza Plan, Supplement 3, Healthcare Planning. Attachment D is under active development and will focus on areas in which Oregon State Public Health (OSPH) will directly interact with and support hospitals and health care systems.

Topics include:
- Hospital surge capacity and altered standards of care.
- Alternative sites of hospital care.
- Mortuary surge capacity
- Hospital-based surveillance for acute respiratory illness.
- Oregon State Public Health Laboratory support for influenza testing.
- Distribution of vaccine and antiviral drugs to hospitals.
- Process for hospitals to make resource requests during an emergency.
- Training of clinical and non-clinical hospital staff around pandemic influenza.
- Coordination of communication.
Attachment E: Vaccine Distribution and Use

Vaccination is a fundamental influenza prevention strategy during routine influenza seasons. The federal government is supporting the development of human vaccines against novel influenza subtypes, such as H5N1, and the development of methods that would speed the availability of vaccine in a pandemic, but neither effort is complete. If a pandemic occurs prior to the adoption of new production techniques, vaccine for a novel virus is unlikely to be available for 4-6 months after the virus strain is identified, and even then the amount of supplies on hand will be less than needed to meet demand. This attachment outlines Oregon State Public Health (OSPH) activities for vaccine distribution and use based on pandemic phase and the amount of available vaccine.

Assumptions

- Vaccine for a pandemic influenza strain will not be available until at least WHO pandemic Phase 6; widespread availability may not occur until many months after the onset of a pandemic.
- U.S.-based vaccine production capacity is 3 to 5 million 15µg doses per week; Oregon receives 1.3% of that amount.
- At full production capacity, Oregon will receive about 50,000 doses per week; vaccination of the entire Oregon population would require approximately 19 months.
- Oregon Department of Human Services (DHS) maintains a vaccine depot.
- Oregon DHS does not have a statewide mechanism for tracking the supply and distribution of vaccines in both the private and public health sectors.
- Oregon DHS does not have the legal authority to break purchasing agreements between vaccine producers and buyers.
- Legislation prohibits the sharing of individual-level ALERT adult immunization registry data except in the case of a catastrophic public health threat.
- Public providers submit vaccine adverse events reports (VAERS) to DHS.
- Private providers do not currently submit VAERS reports to DHS and may need training if reports are required during a pandemic.
- The federal government may stockpile vaccine for influenza strains with pandemic potential.
- The CDC has developed vaccine priority group recommendations (the federal HHS Pandemic Influenza Plan, Supplement 6, Vaccine Distribution and Use); these recommendations may change over time.

Objectives

- Ensure equitable, effective and timely distribution of vaccine.
- Estimate the number of Oregonians, by county, within each CDC priority group.
- Assist counties with the brokering of vaccine (Tab E-5).
- Track vaccine adverse event reports.
Authorities

<table>
<thead>
<tr>
<th>Oregon Revised Statute</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>433.040</td>
<td>Vaccine Education and Prioritization Plan (VEPP)</td>
</tr>
<tr>
<td>433.090 to 433.104</td>
<td>Immunization Registry and Tracking System</td>
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</table>

<table>
<thead>
<tr>
<th>Oregon Administrative Rule</th>
<th>Title</th>
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</thead>
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<tr>
<td>333-048-0010</td>
<td>VEPP – Definitions</td>
</tr>
<tr>
<td>333-048-0020</td>
<td>VEPP – Plan Development</td>
</tr>
<tr>
<td>333-048-0030</td>
<td>VEPP – Penalties</td>
</tr>
<tr>
<td>855-041-0500 to 855-041-0520</td>
<td>Administration of Vaccine by Pharmacists</td>
</tr>
</tbody>
</table>

Summary of Activities by Pandemic Period

This section describes vaccine distribution and use during each pandemic phase (see section 1.2, World Health Organization Pandemic Phases).

Interpandemic/Early Pandemic Alert (Phases 1-3)

Note: These activities assume that a vaccine is not available during Phases 1-3.

- Work to improve routine influenza and pneumococcal vaccination coverage rates.
- Collaborate with the Oregon Adult Immunization Coalition (OAIC) and Oregon Partnership to Immunization Children (OPIC) on educational activities to enhance the public’s confidence in vaccines.
- Formalize the process of enumerating Advisory Committee on Immunization Practices (ACIP)/National Vaccine Advisory Committee (NVAC) priority populations across the state.
- Review the process needed to enact the Oregon Vaccine Education and Prioritization Plan (VEPP).
- Develop a vaccine allocation and distribution plan (Tab E-3) through discussions with the Immunization Program Advisory Team (IPAT) and other Immunization Program partners.
- Work with OAIC, OPIC, IPAT and other DHS partners to identify channels for accessing priority populations.
- Maintain communications for DHS with the National Immunization Program (NIP) and vaccine manufacturers.
- Conduct an assessment to determine the feasibility of having DHS and local health departments (LHDs) track vaccine supply and distribution, monitor unused vaccine
supply, and administer vaccine (including 2nd dose) in the public and private sectors, per the federal HHS Pandemic Influenza Plan.

- Receive and review VAERS reports under the routine procedures.
- Determine whether a state-level VAERS tracking database should be developed for rapid assessment of adverse reactions.
- Decide with IPAT and the Oregon Medical Association (OMA) whether vaccine adverse reactions should be reported to DHS.
- Exercise vaccine allocation and distribution plans with state and LHD partners through tabletop, functional and full-scale exercises (Tabs E-1, E-2).
- Develop and exercise a standardized Point of Dispensing (POD) plan with LHDs.
- Formalize existing procedures for brokering unused vaccine (Tab E-5).

**Pandemic Alert (Phases 4-5)**

**Note:** These activities assume that a vaccine is not available during Phases 4 and 5.

- Continue activities outlined in Phases 1-3, as necessary.
- Convene IPAT and other partners to review and revise, as necessary, the VEPP and vaccine allocation and distribution plan (Tab E-3).
- Review procedures for delivery and storage of vaccine in the Oregon DHS vaccine depot, including memorandum of understanding (MOU) with Kaiser about the use of their facilities to store additional vaccine.
- Teach private sector providers how to report vaccine adverse events if VAERS reports will be required from the private sector. Provide such instruction through Immunization Program health educators, direct lines of communication with providers or utilize LHDs to forward the information to providers.
- Assign Immunization Program staff to track activities for use in preparing an after-action report.

**Pandemic (Phase 6)**

**Vaccine is Available (< 50,000 Doses Per Week)**

- Ascertain the availability of vaccine from the CDC and manufacturers through routine Immunization Program channels of communication with the CDC.
- Distribute vaccine as outlined in Tabs E-1, E-2 and E-3.
- Administer pre-pandemic stockpiled vaccine as directed by the CDC.
- Assist LHDs with the brokering of vaccine, as necessary (Tab E-5).
- Implement plan for delivery and storage of vaccine to the DHS vaccine depot and DHS/Kaiser MOU on additional storage, if necessary.
- Distribute materials about vaccine delivery protocols and procedures to LHDs and providers through routine Immunization Program communication channels and/or the Oregon DHS fax alert system.
- Begin vaccination of priority populations through health care providers, LHDs and other immunization partners.
March 30, 2006

- Initiate the monitoring, distribution, and tracking of statewide vaccine supply by DHS and the local health departments, as described above.
- Update providers and other partners about the production, distribution and administration of vaccine through routine Immunization Program communication channels and/or the Oregon DHS fax alert system.
- Conduct surveillance for side effects of the novel influenza vaccine by reviewing VAERS reports on a weekly basis.
- Provide technical assistance to counties on the standardized POD plan.

**Vaccine is Available (>50,000 Doses Per Week)**

- Distribute vaccine as outlined in Tabs E-1, E-2 and E-3.
- The Immunization Program, the Acute and Communicable Disease Prevention program (ACDP), and IPAT will modify recommendations on vaccinating priority groups to reflect availability of vaccine and epidemiological data as outlined in the Vaccine Education and Prioritization Plan.
- Phase in vaccination for non-priority groups after the priority groups have been vaccinated at sufficient levels.
- Provide technical assistance to counties on the standardized POD plan.
- Continue to monitor vaccine supply, distribution and administration if these activities have been implemented per the assessment conducted under during Phase 3.
- Continue to assist LHDs with the brokering of vaccine, as necessary.
- Update partners about the production, distribution and use of vaccine through routine Immunization Program channels of communication and/or the Oregon DHS fax alert system.
- Continue to conduct surveillance for side effects of the novel influenza vaccine by reviewing VAERS reports on a weekly basis.
- Participate in special studies as requested by CDC.

**Postpandemic**

- Return to interpandemic phase activities.
- Write an after-action report on vaccine distribution and use during the pandemic period.
## Active Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>No registry for tracking adult immunization exists</td>
<td>Feasibility study to be completed and legislation proposed to use existing ALERT child immunization registry or to develop a new tracking mechanism</td>
<td>2007 Oregon legislative session</td>
</tr>
<tr>
<td>No tracking of vaccine from commercial distributors</td>
<td>Federal officials are urged to address the issue of states’ access to commercial data</td>
<td>On-going</td>
</tr>
<tr>
<td>Vaccine Prioritization Process</td>
<td>Use national recommendations and local epidemiology to develop Oregon recommendations through a unified public health decision making process including state and local health officials plus other stakeholders</td>
<td>On-going</td>
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</tbody>
</table>
## Tabs

<table>
<thead>
<tr>
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<th>Tab Title</th>
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</thead>
<tbody>
<tr>
<td>E-1</td>
<td>SOP 4.1.1 Storage, Security and Transportation of Vaccine and/or Antiviral Medications</td>
<td>Complete</td>
<td>N/A</td>
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<tr>
<td>E-2</td>
<td>Functional SOP 2.1.5 SNS Inventory Control</td>
<td>Complete</td>
<td>N/A</td>
</tr>
<tr>
<td>E-3</td>
<td>SOP 4.1.2 Vaccine Allocation and Distribution</td>
<td>Under Development</td>
<td>June 2006</td>
</tr>
<tr>
<td>E-4</td>
<td>SOP 4.1.3 Vaccine Adverse Events Reporting System (VAERS)</td>
<td>Under Development</td>
<td>April 2006</td>
</tr>
<tr>
<td>E-5</td>
<td>SOP 4.1.4 Brokering Unused Vaccine</td>
<td>Under Development</td>
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<tr>
<td>E-6</td>
<td>Local SNS/Mass Prophylaxis Plan template</td>
<td>Under Development</td>
<td>May 2006</td>
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<tr>
<td>E-7</td>
<td>Vaccine Education and Prioritization Plan (VEPP)</td>
<td>Complete</td>
<td>N/A</td>
</tr>
<tr>
<td>E-8</td>
<td>VAERS form</td>
<td>Complete</td>
<td>N/A</td>
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<tr>
<td>E-9</td>
<td>MOU with Kaiser – Additional Storage Space for Vaccines</td>
<td>Complete</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Attachment F: Antiviral Drug Distribution and Use

An effective vaccine is not expected to be available at the onset of an influenza pandemic, making treatment or prophylaxis with antiviral agents a potentially important strategy to decrease complications and possibly limit transmission to close contacts. There are four FDA-approved influenza antiviral agents:

- Amantadine and rimantadine are similar drugs in the class known as “Adamantanes.” As of March 2006, these agents are not in use because of widespread resistance. Their value in a future pandemic is uncertain.
- Oral oseltamivir (Tamiflu®) and inhaled zanamivir (Relenza®) are known as “Neuraminidase inhibitors” (see the federal HHS Pandemic Influenza Plan, Supplements S7, S17, and S18 for descriptions and dosage schedules). As of March 2006 the influenza antiviral component of the U.S. Strategic National Stockpile (SNS) consists primarily of oseltamivir with a small fraction of zanamivir on order. Oseltamivir has proven, but modest, value in decreasing antibiotic use and hospitalization following influenza infection; it has the greatest impact if given within 1-2 days of illness onset. The value of neuraminidase inhibitors in the setting of a pandemic with a new strain of influenza is also unknown.

Prophylaxis versus Treatment

Influenza antivirals can be used for prophylaxis or treatment:

- **Prophylaxis** uses an influenza antiviral drug to prevent infection in a susceptible individual. The drug must be given for the entire duration of possible exposure.
- **Treatment** with influenza antiviral drugs is used to both shorten the duration and limit complications of an established infection. Treatment is most effective if started within the first 48 hours of illness.

The proposed U.S. strategy for antiviral agents in a pandemic emphasizes *treatment* over *prophylaxis*; this makes the most efficient use of the existing national stockpile of oseltamivir.

Priority Groups

Two expert committees convened by the U.S. Department of Health and Human Services (HSS) developed a list, size and definitions of priority groups to guide distribution of oseltamivir during a pandemic. Table F-1 is based on the 11 antiviral priority groups as described in the federal HHS Pandemic Influenza Plan which made several assumptions about how many people in each priority group would become ill (35%) and how many of these would present for treatment within 48 hours (75%). The table F-1 follows those assumptions in calculating the number of courses required to treat the priority groups in Oregon. The federal SNS currently contains enough oseltamivir to provide treatment for the top 3 priority groups. In March 2006, HHS announced substantial additional purchases of influenza antivirals for the SNS which will extend expected treatment to other priority groups, but the delivery date is unknown.
Table F-1: Estimated size of Influenza Antiviral Priority Groups in Oregon

<table>
<thead>
<tr>
<th>Priority Group (treatment or prophylaxis)</th>
<th>Oseltamivir courses required</th>
<th>Cumulative courses required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Hospitalized patients (treatment)</td>
<td>8,400</td>
<td>8,400*</td>
</tr>
<tr>
<td>2 Ill health care workers with direct patient care (treatment)</td>
<td>31,200</td>
<td>39,600*</td>
</tr>
<tr>
<td>3 Highest risk outpatients (treatment)</td>
<td>9100</td>
<td>48,700*</td>
</tr>
<tr>
<td>4 Pandemic responders (treatment)</td>
<td>11,700</td>
<td>60,400*</td>
</tr>
<tr>
<td>5 Increased risk outpatients (treatment)</td>
<td>291,200</td>
<td>351,600</td>
</tr>
<tr>
<td>6 Outbreak response, post-exposure (prophylaxis)</td>
<td>26,000</td>
<td>377,600</td>
</tr>
<tr>
<td>7 Select health care workers (prophylaxis)</td>
<td>62,400</td>
<td>440,000</td>
</tr>
<tr>
<td>8 Pandemic societal responders (treatment)</td>
<td>35,100</td>
<td>475,100</td>
</tr>
<tr>
<td>9 Other outpatients (treatment)</td>
<td>614,900</td>
<td>1,090,000</td>
</tr>
<tr>
<td>10 Highest risk outpatients (prophylaxis)</td>
<td>130,000</td>
<td>1,220,000</td>
</tr>
<tr>
<td>11 Other health care workers (prophylaxis)</td>
<td>416,000</td>
<td>1,636,000</td>
</tr>
</tbody>
</table>

*Currently available from the SNS

Assumptions

- Oregon antiviral distribution will be based on the recommendations of the federal advisory groups (National Vaccine Advisory Council and Advisory Committee on Immunization Practice) as outlined in the federal HHS Pandemic Influenza Plan.
- Oregon influenza antiviral planning is based on impact of the moderate scenario as defined by HHS. In a more severe scenario, the current antiviral supply would only cover a fraction of those in priority group 1 (hospitalized patients).
- Amantadine and Rimantadine will not be used because resistance rapidly develops.
- Oseltamivir (Tamiflu®) will be the antiviral of choice; it is an oral drug, available as pills and powder; it will decrease morbidity if used within 48 hours of illness onset.
- The Oregon State Pharmaceutical Cache of at least 3,000 courses of oseltamivir will be available.
- As of 2005, hospital and retail pharmacy supplies of influenza antivirals are small (0-10 treatment courses per pharmacy).
- As of March 2006, Oregon has decided not allocate state funds to purchase additional antiviral drugs.
- As of March 2006, the U.S. SNS contains approximately 5.5 million treatment courses of oseltamivir. We estimate the Oregon share of this as 1.3% (Oregon proportion of U.S. population) or 71,000 treatment courses. This amount may increase substantially during 2006.
The SNS stockpile of 72,000 oseltamivir treatment courses is adequate for the top 4 priority groups in Oregon in the moderate scenario (hospitalized patients, ill health care workers with direct patient contact, and highest risk outpatients). See Table F-1.

During pandemic Phases 4 and 5, more detailed information on supply and efficacy of influenza antivirals for the anticipated pandemic strain will become available.

Influenza antivirals will be distributed to hospitals at the onset of pandemic Phase 6.

**Objectives**

- Provide treatment and prophylaxis recommendations to hospitals, clinicians, and the public.
- Ensure prompt, efficient distribution of influenza antivirals from the SNS to those in the top priority groups as supplies allow.
- Track outcomes and adverse events in those receiving influenza antivirals.

**Authorities**

<table>
<thead>
<tr>
<th>Oregon Revised Statute/Oregon Administrative Rule</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORS 433.040</td>
<td>Vaccine Education and Prioritization Plan (VEPP)</td>
</tr>
<tr>
<td>OAR 333-048</td>
<td>Vaccine Education and Prioritization Plan</td>
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</table>

**Summary of Activities by Pandemic Phase**

This section describes activities related to influenza antivirals during each pandemic phase (see section 1.2, *World Health Organization Pandemic Phases*).

**Interpandemic/Early Pandemic Alert (Phases 1-3)**

During Phases 1-3, suspected human cases of novel influenza in Oregon are most likely to occur in the following populations:

- Sick travelers returning from a country with novel influenza cases in birds and humans.
- People who handle wild or domestic birds if a novel influenza strain is present in Oregon.

If a novel influenza strain is suspected in a human patient:

- The Oregon State Public Health Laboratory (OSPHL) will expedite RT-PCR (reverse transcriptase polymerase chain reaction) testing on human clinical specimens.
- While awaiting test results, the ill person will receive oseltamivir treatment; exposed close contacts and health care workers providing direct patient care will receive oseltamivir prophylaxis.
If hospital and retail pharmacy supplies of oseltamivir are inadequate, the drug will be released from the Oregon State Pharmaceutical Cache. The decision to use oseltamivir from the cache will be made by Oregon State Public Health (OSPH) Director in consultation with the CDC. If the state pharmaceutical cache is inadequate, additional oseltamivir from the SNS will be requested. In the setting of high-pathogenicity avian influenza (AI) in wild or domestic birds, the Oregon Avian Influenza Worker Protection Plan (see Tab F-4) will guide antiviral distribution to prevent illness in exposed people. All those receiving antivirals will be:
  - Screened for underlying illness and contraindications prior to distribution of drug (see Tab F-8).
  - Monitored for adverse events. Any adverse events will be reported to FDA through MedWatch (www.fda.gov/medwatch/).

**Pandemic Alert (Phases 4-5)**

When human to human transmission of a new influenza strain is occurring, OSPH will:
- Develop detailed distribution plans with key partners such as hospitals and health systems, and health care professional organizations.
- If cases are present in Oregon, consult with CDC regarding the use of influenza antivirals to limit further spread.
- Treat cases if disease is present in Oregon and provide prophylaxis to close contacts and health care workers as described above using Oregon and SNS stockpiles.
- Exercise the process for making decisions about antiviral prioritization through the Pandemic Influenza Coordinating Committee (PICC), with input from other stakeholders as needed.
- Develop and disseminate criteria for stockpiled influenza antiviral use in Phases 4 and 5 based on the most up-to-date clinical and epidemiological information.
- Request and distribute the Oregon portion of the SNS antiviral stockpile if available along with criteria for use prior to Phase 6.

**Pandemic (Phase 6)**

The top two priority groups for antiviral use are hospitalized influenza patients and ill health care workers with direct patient care roles. Distribution to these two groups will be through hospital pharmacies; quick distribution to the other priority groups is less straightforward. Because oseltamivir has never been in widespread use in the United States, reporting of unanticipated and rare side effects will be encouraged. In this phase OSPH will:
- Request, stage, and store influenza antivirals from the SNS (see Tab F-5)
- Distribute antivirals to hospitals and other facilities, such as skilled nursing facilities, providing hospital-level care for influenza patients (priority group 1).
• Distribute antivirals to hospital employee health or occupational medicine clinics to facilitate prompt treatment of health care workers who provide direct patient care (priority group 2).
• Develop and distribute criteria for treatment of “highest risk” outpatients (priority group 3) and “pandemic responders” (priority group 4) in accordance with national guidelines.
• Make further decisions about other antiviral prioritization issues through the PICC. State epidemiologists will make recommendations to this group based on up-to-date data on risk factors for severe disease, efficacy of treatment and feasibility of distribution.
• Inform clinicians to report any adverse events to the FDA through MedWatch (www.fda.gov/medwatch/report/hcp.htm).

Active Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Unknown efficacy of oselatamivir against pandemic strain</td>
<td>Continue to monitor efficacy and antiviral data</td>
<td>ongoing</td>
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<tr>
<td>Distribution mechanism to “highest risk outpatients” is not yet defined</td>
<td>Analyze access of this group to medical care. Determine options for drug distribution with health care systems and pharmacies</td>
<td>end of 2006</td>
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<tr>
<td>Priority group 4, pandemic responders is poorly defined</td>
<td>Assess state pandemic response, discuss with CDC</td>
<td>end of 2006</td>
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</table>

Tabs

<table>
<thead>
<tr>
<th>Tab Number</th>
<th>Tab Title</th>
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<tr>
<td>F-1</td>
<td>HHS/NVAC Appendix D, Vaccine and Antiviral Prioritization</td>
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<td>N/A</td>
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<td>F-2</td>
<td>HHS Supplement 7, Antivirals</td>
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<td>F-3</td>
<td>Text of Vaccine Education and Prioritization Plan Statute and Administrative Rule</td>
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<tr>
<td>F-4</td>
<td>AI Worker Protection Plan</td>
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<td>F-5</td>
<td>SNS Plan (Oregon Emergency Plan Annex F, Functional Appendix 2)</td>
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<tr>
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<td>Tab Title</td>
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<tr>
<td>F-6</td>
<td>Spreadsheets detailing Oregon priority group size for different pandemic scenarios</td>
<td>Completed</td>
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<tr>
<td>F-7</td>
<td>Process for hospitals to obtain state controlled antivirals for patients and staff.</td>
<td>Not Completed</td>
<td>September 2006</td>
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<td>F-8</td>
<td>Standing Order for Antiviral Prophylaxis</td>
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<td>N/A</td>
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<td>F-9</td>
<td>Influenza Antiviral Summary</td>
<td>Completed</td>
<td>N/A</td>
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<tr>
<td>F-10</td>
<td>Current case definitions for novel influenza virus testing, <em>CD Summary</em> Dec 27, 2005</td>
<td>Completed</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Attachment G: Community Disease Control and Prevention

During the early days and weeks of an influenza pandemic (WHO Pandemic Phase 6), public health measures, such as isolation, quarantine, or closing of public places, may be the only means available to slow the spread of disease. Any delay in the peak of influenza activity will be valuable to dampen the peak demand on the health care system; delay could also permit more time for a vaccine to become available. Unfortunately, public health measures may have limited effect on the course of an influenza outbreak given the typically short incubation period, non-specific symptoms, and the ability of this virus to spread from an individual even before the onset of illness.

Assumptions

• Oregon will not have an adequate supply of vaccine in the early phases of a pandemic.
• To be effective, public health measures will be implemented during the early stages of a pandemic.
• Voluntary measures will be emphasized over mandatory measures.
• Existing Oregon laws are adequate for anticipated control measures.
• Key partners, such as the health care industry and the media, will assist with the implementation of community disease control efforts.
• Community control measures will not prevent the introduction of influenza into Oregon.
• The Oregon State Public Health (OSPH) Director with guidance from the Pandemic Influenza Coordinating Committee (PICC) will make recommendations to elected officials about implementing community control measures.
• Local authorities have the resources to publicize the anticipated measures.

Objectives

• To minimize the impact of pandemic influenza on Oregon
• To decrease contact between infected and non-infected individuals.
• To reduce the probability that exposure will cause infection when contact occurs.
• To minimize social and economic consequences while slowing the spread of influenza.
Authorities

<table>
<thead>
<tr>
<th>Oregon Revised Statute</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>401.055 to 401.155</td>
<td>Relating to emergencies (Governor’s powers)</td>
</tr>
<tr>
<td>431.110 to 431.195</td>
<td>Enforcement of Health Laws and Rules</td>
</tr>
<tr>
<td>431.440</td>
<td>Public health administrators have police powers</td>
</tr>
<tr>
<td>433.001 to 433.012</td>
<td>Reportable diseases</td>
</tr>
<tr>
<td>433.019 to 433.035</td>
<td>Procedure to impose public health measures; enforcement</td>
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<tr>
<td>433.040</td>
<td>Vaccine Education and Prioritization Plan</td>
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<tr>
<td>433.104</td>
<td>Use of immunization registry for potential catastrophic disease threat</td>
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<tr>
<td>433.106</td>
<td>Power to impose public health measures</td>
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<tr>
<td>433.407 to 433.423</td>
<td>Procedure where workers exposed to infectious disease</td>
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<tr>
<td>433.441 to 433.452</td>
<td>Impending public health crises</td>
</tr>
</tbody>
</table>

Summary of Activities by Pandemic Period

This section describes community control activities during each pandemic phase (see section 1.2, World Health Organization Pandemic Phases).

Interpandemic/Early Pandemic Alert (Phases 1-3)

Until human-to-human spread of H5N1 or another novel influenza virus is confirmed, community disease control activities will be limited to planning and routine activities to prevent influenza as follows:

- Continue annual public health disease control measures, including:
  - Promote influenza and pneumococcal vaccination.
  - Recommend hygienic practices (hand washing and “cover your cough”).
  - Recommend ill individuals stay at home to avoid exposure of others.
  - Recommend standard emergency preparedness measures, such as keeping adequate food, water, and essential medicines in case of a need to avoid exposure.
- Convene an advisory committee of representatives from the community to work with the OSPH Director to create and periodically review suggested public health disease control measures for pandemic Phase 6.
- Plan and exercise for potential isolation and quarantine measures, including providing for basic life support requirements such as food, water and medical supplies.

Pandemic Alert (Phases 4-5)

Once human-to-human spread of a new strain of influenza is confirmed elsewhere, public health activities in Oregon will intensify. These activities include the following:
• Provide travel advisories for areas where the novel influenza strain has been confirmed. (See Attachment H)
• Aggressively promote prevention activities previously described and add recommendations that advise the public to:
  o Limit the exposure of vulnerable individuals (infants, elderly, immunocompromised people) to others as much as possible.
  o Avoid unnecessary visits to hospitals, emergency rooms and urgent care clinics.
• Encourage telecommuting and development of telecommuting options.
• Encourage individuals to self-quarantine if they have been in an affected area or exposed to persons with flu-like symptoms.
• Convene the PICC and community representatives to review options and develop a prioritized list of public health disease control measures, both voluntary and mandatory, that could be employed during pandemic Phase 6; public input will be obtained before Pandemic Phase 6.

Pandemic (Phase 6)

• Once a human-to-human transmission of a novel strain of influenza has been confirmed anywhere in the world, health promotion activities will become more aggressive, and direct public health disease control measures will be considered and possibly employed.
• Provide travel advisories for areas where the novel influenza strain has been confirmed (see Attachment H).
• Support mass vaccination clinics if effective vaccine is available.
• Consider implementing, on a voluntary basis, the following community disease control measures:
  o Isolation of symptomatic individuals or groups.
  o Quarantine of individuals or groups exposed to symptomatic persons.
  o Cancellation of large group meetings.
  o School closures.
  o Snow days.
  o Closures of places where large groups congregate (e.g., malls, theaters, clubs, etc.).
• With local health departments and emergency management agencies, provide for basic life support requirements (food, water, necessary medical supplies, etc.) for individuals who are isolated or quarantined as a result of public health measures.
## Active Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process for making recommendations and decisions around involuntary measures</td>
<td>Convene PICC and elected officials to develop and exercise process</td>
<td></td>
</tr>
<tr>
<td>Do existing public health laws provide adequate authority for imposing involuntary measures?</td>
<td>Formal review of public health statutes</td>
<td>Completed by end of 2006</td>
</tr>
<tr>
<td>Should masks be recommended for use in public?</td>
<td>Obtain guidance from CDC regarding national recommendations; prepare a media releases</td>
<td>Review and update annually</td>
</tr>
</tbody>
</table>
Attachment H: Managing Travel-Related Risk of Disease Transmission

Influenza has a short incubation period (1 to 3 days) and is easily spread from person to person. Some people infected with influenza shed virus up to one day prior to onset of symptoms. If an influenza pandemic begins outside of the United States, screening of inbound international travelers may slow importation of the virus into Oregon. If a pandemic begins or is occurring in the United States, screening of outbound international travelers may slow spread to other countries. Screening of travelers on domestic flights may slow the spread of pandemic influenza within the United States if it is not yet widespread throughout the country.

Restriction of international and interstate travel is a federal responsibility. Federal agencies likely to be involved include CDC, U.S. Customs Border Protection, U.S. Immigration and Naturalization Service, and the Federal Aviation Administration. Oregon State Public Health (OSPH) will coordinate with these agencies and local partners in developing and implementing strategies that may be used to limit importation of pandemic influenza. OSPH will coordinate with state and local partners in developing and implementing travel-related strategies that may limit spread within Oregon.

Assumptions

- Oregon has four ports of entry (Astoria, Coos Bay, Newport and Portland).
- Port of Portland is the only Oregon airport with direct inbound international flights.
- Direct international flights to and from Portland International Airport are limited.
- Most Oregon-bound international passengers will clear U.S. customs at points of entry outside of Oregon.
- An influenza pandemic will not begin in Oregon.

Objectives

- Slow importation of pandemic influenza into Oregon via infected travelers.
- Slow spread of pandemic influenza within the United States via infected travelers.
- Slow spread of pandemic influenza within Oregon via infected travelers.
Authorities

<table>
<thead>
<tr>
<th>Oregon Revised Statute</th>
<th>Title</th>
</tr>
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<tbody>
<tr>
<td>431.110 to 431.150</td>
<td>General powers of Department of Human Services; enforcement of health laws generally</td>
</tr>
<tr>
<td>433.001</td>
<td>Disease and condition control, definitions</td>
</tr>
<tr>
<td>433.006</td>
<td>Investigation and control measures</td>
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<tr>
<td>433.019</td>
<td>Procedure to impose public health measure; enforcement</td>
</tr>
<tr>
<td>433.022</td>
<td>Taking subject into custody; information to subject; notice to court; court order; duration of custody</td>
</tr>
<tr>
<td>433.035</td>
<td>Examination of certain persons prior to imposition of public health measure</td>
</tr>
<tr>
<td>433.106 to 433.220</td>
<td>Power to impose public health measures</td>
</tr>
<tr>
<td>433.441 to 433.452</td>
<td>Impending public health crises</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oregon Administrative Rule</th>
<th>Title</th>
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<tbody>
<tr>
<td>333-003-0010 to 0080</td>
<td>Public Health Preparedness; impending public health crisis</td>
</tr>
</tbody>
</table>

Summary of Activities by Pandemic Period

This section describes managing travel activities during each pandemic phase (see section 1.2, World Health Organization Pandemic Phases).

Interpandemic/Early Pandemic Alert (Phases 1-3)

Phases 1-3 offer the opportunity for advanced planning and coordination with response partners:
- Convene an advisory committee of community members to develop and review suggested travel-related disease control measures to be employed during an influenza pandemic.
- Assist counties with ports of entry in developing protocols for managing ill arriving passengers of airplanes or ships where none exist (see Tab H-2).
- Participate in exercises of these protocols and procedures with federal, state and local partners.
- Assist local health authorities in dissemination of CDC health information to travelers (In the News, Outbreak Notices, Travel Health Precautions, Travel Health Warnings).
- Collaborate with CDC Quarantine station and local health authorities to develop protocols and procedures for the management of ill arriving passengers meeting the
clinical and epidemiologic criteria for infection with a novel strain of influenza (see Tab H-1).
• Consult with the CDC on the management of contacts of ill travelers. During Phase 3, this will be done on a case-by-case basis and will be based on the following factors:
  ○ The likelihood that the suspected case is ill due to novel influenza.
  ○ The likelihood of human-to-human transmission, based on the transmissibility of the virus during this phase.
  ○ The feasibility of tracing and monitoring contacts.
• Strategies might include:
  ○ Health monitoring of contacts without restriction of activities.
  ○ Quarantine at home or designated facility (only if there is a high probability that the ill passenger is infected with novel influenza and transmissibility between humans).
  ○ Antiviral prophylaxis or treatment.

Pandemic Alert (Phases 4-5)
• Continue the planning efforts as outlined above.
• Reevaluate clinical and epidemiological criteria for evaluation of suspected cases of novel influenza.
• Assist local health authorities in dissemination of CDC health information to travelers (In the News, Outbreak Notices, Travel Health Precautions, Travel Health Warnings).
• Collaborate with CDC Quarantine station and local health authorities to modify protocols and procedures for the management of ill arriving passengers as the pandemic alert phases change.
• Consult with CDC on the management of contacts of ill travelers. During Phases 4-5, this will be done on a case-by-case basis as described for Phases 1-3.

Pandemic (Phase 6)

During the First 4 Weeks
In the early stages of a pandemic, disease surveillance at ports of entry into the United States will intensify. OSPH will:
• Reevaluate clinical and epidemiological criteria for evaluation of suspected cases of novel influenza.
• Assist local health authorities in dissemination of CDC health information to travelers (Travel Health Precautions, Travel Health Warnings).
• Collaborate with CDC Quarantine station and local health authorities to enhance disease surveillance at ports of entry.
• Collaborate with CDC to reevaluate protocols and procedures for the management of ill arriving passengers. Strategies may include:
  ○ Provide guidance on infection control practices to airlines and ships.
  ○ Isolate ill passengers and quarantine contacts as necessary.
  ○ Collect information on all arriving passengers if notification is warranted.
During Subsequent Weeks

In the later stages of the pandemic there will be extensive and sustained transmission. Travel-related control strategies will depend on how widely the virus has spread within Oregon and the United States. OSPH will collaborate with the CDC and state and local partners to:

- Distribute travel health alert notices to passengers arriving from affected countries.
- Post travel alert notices in airports.
- Collect information on arriving passengers if notification is warranted.
- Evaluate other strategies that might include:
  - Cancellation of “non-essential” travel to/from affected countries.
  - Closure of mass transit systems.

If the level of influenza transmission in the United States is high, but most regions of the country have not yet been affected, OSPH will work with federal, state and local partners to develop strategies to slow introduction into Oregon. Strategies might include:

- Limiting or canceling nonessential travel to affected areas.
- Implementation of increased disease surveillance.
- Distribution of travel health alert notices on domestic flights.
- Isolation of arriving ill domestic flight passengers and quarantine of travel contacts using protocols for international travel.
- Closing mass transit systems.
- Closing interstate bus and train routes.

If the level of influenza transmission in Oregon is high, but most parts of the state have yet to be affected, OSPH will work with state and local partners to develop strategies to slow spread across the state. Strategies might include:

- Travel advisories to avoid affected areas of the state.
- Limiting intrastate bus, train and airline travel.

If the level of influenza transmission in the United States represents a high risk of exportation of disease, OSPH will work with federal, state and local partners to develop strategies to decrease this risk. Strategies might include:

- Distribution of travel health warnings to outbound passengers.
- Cancellation of “non-essential” travel to other countries.
- Implementation of pre-departure screening of outbound travelers.
# Active Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Identification of temporary and long-term quarantine facilities in counties with ports of entry</td>
<td>Plans for such facilities should be proportional to passenger traffic</td>
<td>End of 2006</td>
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<tr>
<td>Development of Memos Of Understanding (MOU) with hospitals near ports to facilitate isolation, evaluation and management of suspected influenza patients</td>
<td>Development needed</td>
<td>End of 2006</td>
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<tr>
<td>Development of MOUs with emergency medical services near ports of entry for on-site assessment and transport of suspected influenza patients</td>
<td>Development needed</td>
<td>End of 2006</td>
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# Tabs

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<td>SOP 4.1.6– Procedures for assessment of suspected human cases of novel influenza</td>
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<td>H-4</td>
<td>SOP 4.1.7 – Criteria for testing of suspected human cases of novel influenza</td>
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<td>H-5</td>
<td>SOP 4.1.8 – Procedures for dissemination of CDC travel notices to travelers’ clinics, local health departments, others.</td>
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</table>
Attachment I: Behavioral Health Support

During times of high stress, such as during an influenza pandemic, it is important to provide behavioral health support services to both the work force responding to the pandemic and to the general public, including people in isolation and quarantine. OSPH’s *Functional Appendix 7, Behavioral Health* will provide the baseline guidance for behavioral health responses. However, due to the potential length of an influenza pandemic, it is possible that behavioral health services will need to be different from those in a short term emergency.

**Workforce Support**

In this plan, workforce support primarily addresses the behavioral health needs of the response and essential service workers who will respond to an influenza pandemic, including:

- Health care workers who provide medical care to ill persons.
- Emergency field workers and other public health personnel who help control the spread of infection.
- First-responder and nongovernmental organizations whose employees assist affected groups.
- Essential service workers whose activities maintain normal functions in the community and minimize social disruption.
- Family members of all of these groups.

Workforce support activities for the Interpandemic and Pandemic Alert periods focus on the establishment of behavioral health informational materials and support services to help health care and other response and essential service workers and their families manage emotional stress during the response to an influenza pandemic.

**Public Support**

Activities related to the general public include:

- Increased surveillance for and treatment of behavioral health issues in the community as a result of increasing likelihood and increased spread of disease during the Pandemic period.
- Behavioral health support as strict public health measures are implemented, including potential isolation and quarantine.
- Preparation and distribution of informational materials for all Oregon citizens to help with personal, professional and family issues during a pandemic.

**Assumptions**

- The state Office of Mental Health and Addiction Services (OMHAS) will take the lead in the behavioral health emergency planning process.
• *Functional Appendix 7, Behavioral Health*, and its Standard Operating Procedures (SOPs) will provide the baseline guidance for behavioral health responses during an emergency and will be revised, if necessary, to reflect changing conditions during a pandemic.

**Objectives**

- Identify planning activities to be developed by OMHAS and OSPH during the pandemic alert periods.
- Identify response activities for OMHAS, OSPH, and other behavioral health organizations during the Pandemic period.
- Develop or identify informational products to assist response and essential service workers with personal, professional and family issues during a pandemic.
- Develop or identify informational products to support the general public, including people requiring isolation or quarantine, with personal, professional and family issues during a pandemic.
- Identify SOPs, checklists, position descriptions and other tools that may be required to implement the actions identified in this section.

**Summary of Activities by Pandemic Period**

This section describes support activities during each pandemic phase (see section 1.2, *World Health Organization Pandemic Phases*).

**Interpandemic/Early Pandemic Alert (Phases 1-3)**

The following activities relate to both response and essential service workers and public behavioral health support.

**Planning**

- Incorporate behavioral health support services into emergency preparedness planning for an influenza pandemic.
- Develop plans to support response and essential service workers during and following deployment in excess of those plans in *Functional Appendix 7, Behavioral Health*, since the deployment will likely be longer than for other emergencies.
- Develop a plan to manage offers of assistance and invited/uninvited volunteers.

**Identify and Develop or Access Resources**

- Identify community-based nongovernmental organizations to determine the types of psychological and social support services and training courses available in their jurisdictions.
- Establish public-sector links with private mental health resources such as the Red Cross and other national voluntary organizations active in disasters.
• Establish links to behavioral health professionals to assist in screening citizens for mental disorders, functional impairment, substance abuse, etc.
• OMHAS will aid Risk Communications staff in identifying or developing materials on behavioral health issues for distribution to response and essential service workers, their families and the public during an influenza pandemic.
• Ensure that OSPH can distribute behavioral health resources to the private and non-profit sectors.
• OMHAS will aid Risk Communications staff in developing messages that will enhance public support for and participation in voluntary isolation, quarantine and personal infection control measures.
• Office of Multicultural Health will aid Risk Communications staff in ensuring that different communities within the state (e.g., ethnic, racial, and religious groups; most vulnerable; special needs; language minorities) are identified and can be reached with appropriate behavioral health resources.
• Identify resources, such as culturally competent and multilingual providers, that could help in managing disaster services.

Train Behavioral Health and Related Professionals in Disaster Response Strategies

• Train behavioral health staff in hospitals, clinics, and related agencies in “psychological first aid” techniques to help people cope with grief, stress, exhaustion, anger, and fear during an emergency.
• Train non-behavioral health professionals (e.g., primary-care clinicians, safety and security personnel, community leaders, and staff of cultural- and faith-based organizations) in basic psychological first aid.

Pandemic Alert (Phases 4-5)

• Accelerate and intensify activities described in Interpandemic/Early Pandemic Alert (Phases 1-3).

Pandemic (Phase 6)

During the First 4 Weeks

For response and essential service workers:
• Identify rest and recuperation sites.
• Provide psychological and social support services for response and essential service workers and their families.

For the public:
• Provide confidential telephone support lines to be staffed by behavioral health professionals.
• Provide psychological first aid.

Hazard Appendix 4.1, Attachment I: Behavioral Health Support
• Provide behavioral health triage and assessments.
• Provide outreach and information dissemination.

For other partners:
• Provide technical assistance, consultation, and just-in-time training in psychological first aid.
• Provide medical, public health, and community partners with educational and training materials on the behavioral health aspects of the influenza pandemic.

**During Subsequent Weeks**

• Provide continued outreach, triage, and services.
• Monitor response and essential service workers for signs of chronic or severe psychological distress.
• Provide assistance in reintegration for workers who were deployed or isolated from work and family.

**Active Issues**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity of Operations Planning (COOP) for Oregon DHS is not completed yet. This process will eventually identify DHS staffing during an emergency.</td>
<td>Work with DHS COOP staff to help define behavioral health issues for pandemic influenza.</td>
<td>Complete in 2007.</td>
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**Tabs**

<table>
<thead>
<tr>
<th>Tab Number</th>
<th>Tab Title</th>
<th>Status</th>
<th>Anticipated Completion Date</th>
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</thead>
<tbody>
<tr>
<td>I-1</td>
<td>Behavioral Health Plan (Oregon Emergency Plan Annex F, Functional Appendix 7)</td>
<td>Completed</td>
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<tr>
<td>I-2</td>
<td>SOP 4.1.9 – Additional support for response and essential service workers for extended deployment</td>
<td>In process</td>
<td></td>
</tr>
</tbody>
</table>
Attachment J: Local Health Department Roles and Responsibilities

Local health departments (LHDs) play a very important role in all phases of a pandemic. In the early phases, they may be the first governmental agency notified of an unusual cluster of influenza-like illness (ILI) and will be responsible for coordinating surveillance and sending presumptive influenza samples to Oregon State Public Health (OSPH).

During a pandemic, LHDs will be responsible for coordinating and running mass prophylaxis clinics, possibly to vaccinate everyone in their county. These mass clinics are enormous undertakings and will require assembling volunteers and isolating the sick from the well. They will also require the coordination of security with law enforcement and resources with the local Emergency Operations Center (EOC).

During all planning and response phases, local health departments and OSPH will need to coordinate on the need for and distribution of resources, and thus all plans and exercises around pandemic flu must be integrated.

Assumptions

• LHDs will have the primary command, response, and coordination role for their counties during a pandemic.
• LHDs will have preparedness coordinators that will write pandemic influenza plans and design and run exercises.
• LHD staff will take all the relevant training for Incident Command System (ICS) and mass prophylaxis.
• LHDs will coordinate all emergency response activities with their local Emergency Manager.
• LHDs will participate in exercises, develop after-action reports, and promote continuous improvement for their plans and exercises.

Objectives

• Ensure coordination between LHDs and OSPH.
• Provide guidance to LHDs for pandemic flu planning.

Summary of Activities by Pandemic Period

This section describes local health department activities during each pandemic phase (see section 1.2, World Health Organization Pandemic Phases).
Interpandemic/Early Pandemic Alert (Phases 1-3)

Planning and Exercising:
- Identify key community partners and establish clear channels of communication.
- In collaboration with community partners, develop a pandemic influenza plan detailing how the LHD will respond at the various pandemic phases.
- Review the local pandemic influenza plan with the community.
- Routinely evaluate plans through exercises, assess readiness and address gaps.
- Review legal authorities of the health administrator.

Surveillance:
- Perform disease surveillance and community interventions in collaboration with the Acute and Communicable Disease Prevention program (ACDP).

Dispensing medications:
- Identify dispensing points for mass immunization and distribution of pharmaceuticals.
- Develop a system to identify priority populations for immunization and pharmaceuticals. Populations who meet anticipated high-risk criteria include health care workers, essential community workers, first responders, and those at high risk due to age or medical condition, including pregnancy.

Communications:
- Establish appropriate policies, procedures and mechanisms for risk communications that include all relevant partners.
- Develop communication strategies for at-risk, hard-to-reach populations within the county, and define the infrastructure needed to vaccinate these populations (such as homebound, homeless, poor, uninsured, non-English speaking, immigrants or isolated groups).
- Maintain and routinely test an on-call 24/7 and call-down protocol for sharing information about public health emergencies.
- Cooperate in strategies to assess and inform travelers about pandemic influenza risk, affected areas, prevention, signs/symptoms, and treatment.

Pandemic Alert (Phases 4-5)

Planning:
- In cooperation with local EOC, consider implementing an Incident Command System (ICS).
- Compile a specific list of health care workers (including volunteers) and institutions that will administer vaccines if needed.
- Review the availability of personnel, supplies, and materials for infection control and care of influenza patients with local hospitals, clinics, pharmacies and providers.
- With local hospitals, assess their capacity to care for patients with severe respiratory illness.
• Participate in process to determine, communicate, and implement community control measures.

Surveillance:
• Perform disease surveillance and community interventions in collaboration with ACDP.

Dispensing medications:
• Review the antiviral prophylaxis and treatment recommendations for health care workers and those who provide essential community services.
• Ensure that human resources, equipment, and plans for mass immunization clinics are in place.
• With local hospitals, assess their capacity to care for patients with severe respiratory illness.
• Vaccinate high-risk individuals if vaccine is available.

Communications:
• Maintain and routinely test an on-call 24/7 and call-down protocol for sharing information about public health emergencies.
• Cooperate in strategies to assess and inform travelers of pandemic influenza.

Pandemic (Phase 6)

Response:
• In cooperation with the local EOC, implement an Incident Command System (ICS).
• Communicate and implement community control measures as decided in Phase 4/5.
• Facilitate cooperation among all local involved parties (e.g., government officials, emergency responders, health experts, industry, and the public), including:
  o Help enlist and assign workers and volunteers to staff triage sites, immunization clinics, nontraditional care sites, and essential community service agencies.
  o Work with local hospitals and providers to determine if inpatient medical care in non-traditional settings is needed. If so, help equip and staff these other settings to provide hospital surge capacity.

Surveillance:
• Coordinate surveillance activities with ACDP, local hospitals and health care providers.

Dispensing medications:
• Coordinate the dispensing of pharmaceuticals and vaccines to the public, if and when available.

Communication:
• Inform the community of measures being taken to prevent the spread of pandemic influenza.
• Participate in the statewide Joint Information System.

## Active Issues

<table>
<thead>
<tr>
<th>Issue</th>
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<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>County and state implementation of Emergency Operations Centers will probably be inconsistent</td>
<td>Countywide and regional exercises focusing on Incident Command System (ICS) coordination and triggers for implementing ICS procedures</td>
<td>By end of 2006</td>
</tr>
<tr>
<td>LHD role at international ports of entry to the state needs clarification</td>
<td>Tabletops with Ports and federal agencies (e.g., Customs and Border Protection, CDC, etc.)</td>
<td>Tabletops completed at PDX (11/05) and Sector Portland Coast Guard (10/05); planned for Coastal Ports (June 2006)</td>
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<tr>
<td>LHD / State command needs clarification</td>
<td>Statewide exercises on ICS integration</td>
<td>By end of 2006</td>
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<tr>
<td>Process for deciding upon and implementing community control measures</td>
<td>Tabletop exercises of state and local health department leadership and pertinent elected officials</td>
<td>Ongoing</td>
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</table>

## Tabs

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<tbody>
<tr>
<td>J-1</td>
<td>LHD Pandemic Influenza Plan Template</td>
<td>In development</td>
<td>June 2006</td>
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</tbody>
</table>
Attachment K: Infection Control

This attachment, which is available as a link on the DHS Web site, is the federal HSS Pandemic Influenza Plan, Supplement 4, Infection Control, which Oregon is adopting in full to promote national consistency on this topic. See oregon.gov/DHS/ph/acd/flu/panflu.shtml.
Attachment L: Clinical Guidelines

This attachment, which is available as a link on the DHS Web site, is the federal HSS Pandemic Influenza Plan, Supplement 5, Clinical Guidelines, which Oregon is adopting in full to promote national consistency on this topic. See oregon.gov/DHS/ph/acd/flu/panflu.shtml.