

CONSTELLA



G R O U P SM

Assisting States to Plan for Pandemic Influenza

A White Paper

December, 2006

TABLE OF CONTENTS

EFFECTIVE PLANNING IS CRITICAL 1

SUGGESTED CHANGES TO STATE PANDEMIC PLANS SHOULD BE CONSIDERED 1

ACTION MUST BE TAKEN NOW 3

IMMEDIATE NEXT STEPS NEED TO OCCUR QUICKLY 4

ASSISTING STATES TO PLAN FOR PANDEMIC INFLUENZA

EFFECTIVE PLANNING IS CRITICAL

A highly pathogenic pandemic influenza has the potential to cause many more deaths, more widespread disability, and greater economic loss than either the terrorist attacks of September 11 or Hurricane Katrina. Potentially, 1% of the US population could die, and up to 10% could become severely ill, within a very short period. The widespread effects will prevent most mutual aid and communities will be less able to rely on receiving relief from external sources. Further, the effects are expected to be protracted, with several waves of infections over a several month period. As efforts to contain the outbreak are implemented, schools will likely to be closed, and certain types of businesses may cease to function or be greatly curtailed.

This scenario highlights the importance of early planning and effective preparation. To that end, the Congress and the US Department of Health and Human Services have provided funds for the development of detailed State Pandemic Plans and initial implementation steps. This current federal work adds to ongoing efforts by CDC and the Health Resources and Services Administration to prepare the Nation for potential bioterrorist attacks.

In an actual pandemic, particularly a highly pathogenic one, *community and personal survival will very likely depend upon whether the local Pandemic Plans actually work*. There will be little time to make major adjustments to the plans once the pandemic begins. Hence, it is essential to work with states now to assist them in their efforts to further develop their plans and to aid in developing and enhancing local plans. It is also essential to provide related technical assistance to ensure that the plans and the related implementation steps are as effective as possible when they are actually needed.

SUGGESTED CHANGES TO STATE PANDEMIC PLANS SHOULD BE CONSIDERED

All 50 States, the District of Columbia, and the territories of Guam and Palau have published pandemic influenza plans on the Federal pandemic influenza preparedness site, <http://www.pandemicflu.gov>. Most plans were prepared by State departments of public health, and were last updated between Spring 2005 and August 2006 (approximately half are labeled “draft”). They vary in length from 11 pages to over 400 pages with multiple appendices. A longer plan is not necessarily a better plan, but the variability in the length is reflective of similar variability in the content and depth.

Constella Group has reviewed a sampling of these plans as of August 2006.

Although the state plans have much strength, and some have exemplary elements, we offer the following general suggestions for enhancement:

- 1. Plans should extend beyond the health aspects of the State response.** The health and medical response to a pandemic depends upon community infrastructure (i.e., electricity, communications, water, sewage and garbage disposal, the Internet, food and gasoline distribution, and others). The secondary effects of a pandemic will also be found in the distribution systems for healthcare items not directly and specifically related to the

pandemic influenza response, such as thermometers and over-the-counter medications, as transportation and manufacturing are both likely to be hindered. While many plans are explicitly identified as appendices to broader documents such as the state emergency response plans, it is not clear that the necessary planning and coordination are underway to ensure that all affected agencies are considering the distinct differences between planning for a discrete disaster or even a regional catastrophe, and planning for scenarios that affect the national infrastructure. Where the health department is designated as the lead agency for pandemic influenza planning, does it have the responsibility to take the lead in ensuring that the broader coordination takes place?

2. **The impact estimates that support the planning assumptions should be explicitly documented.** Precisely what to expect in morbidity and mortality of the pandemic is not known; however, history of previous pandemics provides a basis for critical planning assumptions. CDC has made a software program, *Flu Surge*, available to local jurisdictions as an aid for estimating the impact of pandemic influenza upon their healthcare facilities. The software uses the experience from the 1968 and 1918 pandemics as its baseline. We suggest that the States also use this program or similar software to identify and support their planning assumptions. Planners need clearly defined estimates of morbidity and mortality to adequately assess the viability of plans for medications, medical and laboratory surge capacity, mortuary services, and other critical needs.
3. **Continuity of government should be addressed.** It is important to address the need for continuity of operations and business for State and local governments during a pandemic. Similarly, coordination among the multiple agencies and organizations needs to be planned systematically. Work done now to identify critical and vulnerable government services will serve the public well and ease decision making that will be necessary when the event occurs. For example, how will the State infrastructure support increased demand on Medicaid systems? Or, will staff be available to support essential state data center operations?
4. **Business activities should be considered.** Virtually all larger businesses have corporate health plans and many also support employee and family assistance programs. The State Pandemic Plans should address this aspect of the health infrastructure. Similarly, the plans should incorporate other business activities (e.g., transportation capacity) or resources (e.g., virtual call centers, distribution facilities) that can facilitate plan implementation.
5. **State plans should be coordinated with local governments and their health departments, and guidance should be offered to assist them in their planning.** Because of the anticipated scope of a pandemic, most communities would need to rely on local resources. Coordination between State and local planning activities needs to be explicitly addressed, and local governments given clear guidance as to what resources they can expect from the State. Continual communication is needed between State planners and local planning agencies to ensure that plans and implementation steps are evolving in parallel.

6. **Major health and social services should be included.** State plans should address specifically the need for continued mental health and substance use services (see the Constella Group White Paper on this topic) and social services. Social services plans should consider the potential expansion of services for children neglected or orphaned because of the pandemic, and identify alternatives to common safety-net services such as congregate shelters for homeless persons, community meals for impoverished persons, and school lunch programs. This might include Meals on Wheels, family foster care and expansion of in-home services and permanency planning, and others.
7. **Communication plans should be broadened.** Most pandemic influenza plans anticipate communication among health personnel, and sometimes communication with the media about the scope of the pandemic, the need to wash hands and avoid close contact, etc. To adequately support the response to a pandemic communication strategies should consider the importance of meta-communication to avoid panic in the population and what planning needs be done now with the media to forestall that occurrence. Plans should address health workforce communication and management, both of which will be extremely difficult in a pandemic. Finally, plans should consider the diverse communications requirements of the special language needs of select populations, including undocumented residents.
8. **Mortuary services should be explicitly considered.** If death rates approach predictions, most mortuary services will be quickly overwhelmed. While not an immediate health threat, the accumulation of bodies will have significant psychosocial impacts. The appropriate agency plans within each State should address this eventuality.
9. **The plans should include ongoing implementation activities.** Actions that are being accomplished now, and need to be reviewed regularly, need to be addressed in the general plans. Ongoing preparation will enhance the effectiveness of future actions when they are actually needed and may actually forestall future problems.

ACTION MUST BE TAKEN NOW

The extremely adverse effects that can be experienced as a result of a pandemic require the States to begin now to enhance both State and local pandemic planning and initial implementation steps. Key steps will include:

1. **Conduct a Detailed Review of All State Pandemic Planning.** A team of expert reviewers should develop a template to aid in the review of State pandemic planning. Using the template, this same team can review individual State Pandemic Plans along with applicable overarching planning documents (e.g., state emergency operations plans or public health emergency response plans), and provide guidance on the observed opportunities for improvement. This work should be a high priority, since the initial guidance provided to the States did not address many of the suggestions noted here. The review should be conducted by the same team of experts, in much the same way that the National Institutes of Health conduct an external peer review. The panel must have Federal, State, and local representatives. Specific recommendations should be noted for each plan with results communicated to the subject State. If critical best or promising practices are found in particular plans, these findings should be communicated to all States.

2. **Create a Model Plan and Implementation Guidance.** Findings from the review of the State Pandemic Plans can be the basis for a model plan for all States. Equally important, States need specific guidance to assist in implementing the preliminary steps of their plans. If done well, this guidance can serve as a roadmap for the implementation steps. The plan reviews and the model plan should explicitly recognize the need to modify any model to meet individual state and local circumstances.
3. **Convene Focus Groups of States to Discuss Barriers and Solutions to Implementation Issues.** Four focus groups of State and select local representatives from various disciplines should be convened to review plans and implementation components in a systematic manner. From this review, barriers can be summarized in each implementation area and solutions identified. We recommend that the focus groups be organized regionally to encourage continued interstate collaboration following the reviews.
4. **Provide State-Specific Technical Assistance.** It is likely that some barriers will be State-specific and not amenable to solution through the focus groups. To address these situations, technical assistance on plan and implementation steps should be provided to individual States on a request basis.
5. **Reconvene the Focus Groups Periodically to Share Updates to Plans and Implementation Steps.** With the exact timing and nature of the anticipated pandemic being uncertain, the focus groups should reconvene on a periodic basis (every 6 months is recommended) to share information on the specific actions each is taking to update State and local Pandemic Plans and modification of implementation steps. Such information will be valuable to all the States within the regional group. Rotating the host requirements for the meetings will let states share their best practice implementation steps.

IMMEDIATE NEXT STEPS NEED TO OCCUR QUICKLY

Constella Group plans to share this white paper with a focus group of States to be convened in September 2006. This focus group will review and refine this White Paper, as well as discuss suggestions for improvements to current State Pandemic Plans.

The authors would like to acknowledge the contributions of C. Lee Smith, Director, Public Health Emergency Preparedness, Georgia Department of Human Resources.