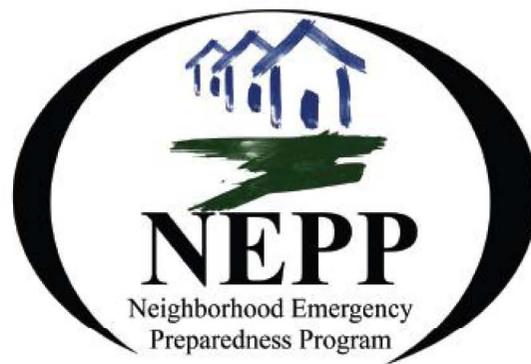


PANDEMIC PREPARATION



SITUATION MANUAL for **The Community & Neighborhood Emergency Preparedness Program**

WORKSHOP EXERCISE

PANDEMIC PREPARATION

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INTRODUCTION

In 1918-1919, a deadly influenza swept over the earth attacking 1/5 of the world's population and killing an estimated 650,000 people in the United States (U.S.), perhaps 30 million people worldwide.

In 1957, a second influenza pandemic – The Asian Flu -- killed nearly 70,000 people in the U.S. and millions across the world.

In 1968, the third pandemic of the 20th Century – the Hong Kong Flu -- killed 33,000 people in the U.S. Although it met the definition of a pandemic, the death rate from this virus was about the same as seasonal influenza.

In 1999, the World Health Organization (WHO) began tracking a strain of avian influenza (H5N1) that first appeared in Southeast Asia. Although human susceptibility and transmission of this disease is rare, the mortality rate has been as high as 80% among confirmed cases. Such a high death rate would likely increase if the disease suddenly mutated into a form that made humans more susceptible, but it deserves close watching and careful planning. So, pandemic response plans were written and tested and rewritten and retested and rewritten. . . all in preparation for the "Big One"- a deadly pandemic that would rival the 1918 Great Influenza.

In March 2009, while the eyes of WHO, US scientists, and epidemiologists continued to focus on Avian Influenza in Asia, a novel influenza virus originating in swine began infecting people in and around Mexico City - - sixty deaths were reported. The virus began spreading quickly, and everyone knew that it was just a matter of time before it made its way across the border into the US. With a sense of urgency and anxiety, health and emergency response planners began reviewing their pandemic plans.

The Centers of Disease Control and Prevention (CDC) confirmed the first case of H1N1 virus in the US on April 15, 2009. On April 17, there was a second confirmed case and more confirmed cases followed. The CDC activated its Emergency Operations Center (EOC) on April 22, 2009.

On April 26, the U.S. Government declared a Public Health Emergency to respond to the rising number of cases in disparate locations across the U.S. On April 30, the CDC began shipping antivirals and personal protective equipment to treat confirmed cases and their contacts to try to reduce virus spread. The Florida Emergency Operation Center (EOC) was activated to Level 2.

On May 1, 2009 Florida joined 19 other states that were tallying confirmed H1N1 virus cases as the State Surgeon General declared a Public Health Emergency and raised its Pandemic Alert to Level 5 – evidence of significant human-to-human transmission.

This H1N1 virus that came out of nowhere certainly taught us the need to build a flexible response into our county and state plans. This flexible response must include people-helping-people in communities and neighborhoods, if a pandemic quickly overcomes the ability of county and state resources to assist.

Purpose

Workshops can be used to build specific products (draft plan, policy), or test a new plan with canned scenarios.

Pandemic Preparation workshops provide an opportunity to evaluate the readiness of community and neighborhood emergency planning for self-care in a pandemic where there are limited outside support and resources available.

Scope

This workshop series is designed to contain elements from the U.S. Department of Homeland Security Target Capabilities List (TCL) under the Common Capability Planning and under Response Mission Capabilities:

- On-Site Incident Management
- Critical Resource Logistics and Distribution
- Volunteer Management and Donations
- Citizen Evacuation and Sheltering-in-Place
- Emergency Public Information and Warning
- Isolation and Quarantine
- Mass Care

This situation manual complies with the Homeland Security Exercise and Evaluation Program (HSEEP) terminology and guidelines for the conduct of a workshop. The **Pandemic Preparation Workshop** consists of three pandemic influenza scenario modules to be presented for discussion among community and neighborhood participants. The ideal situation is to provide the workshop in a facility with sufficient room to support a large number of participants, and provide room to organize the participants into groups for

separate breakout discussions. The breakout groups re-assemble to review their discussions with the whole group in a “hot wash” session at the end of each module.

Roles and Responsibilities

Participants. Community or neighborhood residents, neighborhood association representatives, neighborhood watch groups, citizen emergency response teams, churches, and local church leaders, schools, school principals or administrators, local health centers and clinics, small businesses owners and county emergency management and health department representatives could be invited to attend and participate in the workshop. Where they exist, current community or neighborhood plans should be reviewed and validated during the workshop. Where plans do not exist, the workshop should provide an opportunity to write an emergency and pandemic response plan. Participants should provide insights derived from past training and experiences and their knowledge of community or neighborhood composition and relationships.

Observers. Those who are not community or neighborhood residents may serve as technical specialists and observers; e.g., county emergency management or health department representatives. Observers may respond to questions, but they should not actively lead or participate in the facilitated discussion.

Facilitator. The facilitator(s) will initiate each scenario module and present a situation briefing to the workshop participants. The facilitator(s) will establish breakout groups and identify a participant recorder and spokesperson to present a discussion summary of key objective issues, conclusions, and recommendations at a Hot Wash following each module breakout session. The facilitator(s) will prepare and distribute the workshop after action report (AAR) within two weeks following the workshop.

Recorders. Selected participants will serve as discussion breakout session recorders. They will be present for the duration of the discussion sessions gathering data and writing notes about the players' responses in order to provide feedback for the breakout session exercise Hot Wash and AAR. Recorders should use the form at the end of this Situation Manual to record salient participant discussions. The recorder may also be selected as a spokesperson for his/her group.

Evaluators. The facilitator(s) may also appoint evaluators to assess the level of workshop participation, collect discussion forms, and record lessons learned that will improve future community or neighborhood workshops. These lessons learned will be provided to the facilitator(s) for incorporation into the AAR.

Design Objectives

Pandemic Preparation Workshop

Ground Rules

Workshop Site: Community or neighborhood meeting facility

Objectives:

- Provide an overview of the workshop purpose and mechanics
- Introduce discussion facilitator(s)
- Recruit breakout session recorders
- Provide for a Hot Wash summary at the end of each module

Intended Audience: Workshop participants (community planners and responders)

Pandemic Preparation Workshop

Session 1 Module 1

Workshop Site: Community or neighborhood meeting facility

Objectives:

Review Scenario Module 1 – Cases Rising. Discuss and recommend outcomes.

Intended Audience: Workshop participants (community planners and responders)

Pandemic Preparation Workshop

Session 2 Module 2

Workshop Site: Community or neighborhood meeting facility

Objectives:

Review Scenario Module 2 – Troubled Times. Discuss and recommend outcomes.

Intended Audience: Workshop participants (community planners and responders)

Pandemic Preparation Workshop

Session 3 Module 3

Workshop Site: Community or neighborhood meeting facility

Objectives:

Review Scenario Module 3 – Light at the End of the Tunnel. Discuss and recommend outcomes.

Intended Audience: Workshop participants (community planners and responders)

Workshop—Facilitated Discussion Format

The community or neighborhood leader will serve as workshop facilitator or appoint a workshop facilitator, discussion recorders, and evaluators.

Assumptions and Artificialities

In any workshop or exercise, assumptions and artificialities may be necessary to complete discussions in the time allotted. During the workshop, the following assumptions apply:

- Pandemic Planning Assumptions
 - Attack rate will be 30% or higher
 - Workplace and school absenteeism up to 40%
 - Half of ill will need and seek care
 - Virus spreads up to 2 days before symptoms
 - One sick person will make 2 others sick
 - Outbreaks 6-8 weeks
 - Multiple waves
- The scenario is plausible, and events occur as they are presented.
- There are no “hidden agendas” or trick questions.
- Breakout session facilitators will establish an internal schedule and priority for responding to scenario issues as needed because of time constraints.

Workshop Rules

There are no correct or predetermined solutions. Varying viewpoints, even disagreements, are expected. This is intended to be a **safe, open, stress-free environment.**

- Respond based on your knowledge of current plans and capabilities, and insights derived from training and experience.
- Your current position or local policies do not limit you. Make your best decision based on the circumstances presented.
- Decisions are not precedent-setting and may not reflect your organization's final position on a given issue. This is an opportunity to discuss and present multiple options and possible solutions.
- Issue identification is not as valuable as suggestions and recommended actions that could improve response and preparedness efforts. Problem-solving efforts should be the focus.

**ASSUME COOPERATION AND SUPPORT FROM
COUNTY RESPONDERS AND AGENCIES.**

SAMPLE WORKSHOP SCHEDULE

Pandemic Preparation

9:00 – 9:15	Workshop Introductions and Ground Rules
9:15 – 9:45	Scenario Module 1 Discussion
9:45 –10:00	Scenario Module 1 Hot Wash
10:00 –10:30	Scenario Module 2 Discussion
10:30 –10:45	Scenario Module 2 Hot Wash
10:45 –11:15	Scenario Module 3 Discussion
11:15 –11:30	Scenario Module 3 Hot Wash
11:30 –11:45	Wrap-up

BREAKOUT SESSION FACILITATOR GUIDE

The workshop facilitator will lead the Module Scenario discussions.

Module Scenarios advance a pandemic influenza second wave progression from week three through week six. As the scenarios build in complexity, the ability of the community and neighborhood to support its residents becomes more problematic. Existing plans and models should not limit discussions as “outside the box” considerations are brought to the table.

A summary of discussions should be recorded on the discussion form at the end of this situation manual. The facilitator(s) should reproduce copies of this form to ensure that there are sufficient forms for the scenario discussion reports for each breakout group.

Each module contains several issues. The facilitator(s) will keep the discussions from becoming focused on a single issue.

Where separate breakout sessions are held, the lead facilitator will call for all groups to reassemble in a central area for a Hot Wash to report a summary of their discussions to all participants. Typically, the group recorder will be asked to be the breakout session spokesperson.

The facilitator(s) should appoint one or more evaluators to gauge the overall level of workshop participation collect discussion forms, and assist in preparing an After Action Report (AAR).

MODULE 1 SCENARIO

Week 3 – Cases Rising

The current wave of pandemic influenza is now in its third week. Although fatalities have remained low, the virus has rapidly spread throughout Florida. All counties have been heavily impacted. Hospitals are overwhelmed and are requesting all but those in severe respiratory distress to remain home for self-care. Schools that remained officially open in the initial weeks are now closed due to high student and teacher absences.

Many businesses are also closed because of workers being ill or staying home to care for children and/or other sick family members.

Shipments of vaccine have been sporadic. The CHDs are continuing to urge voluntary isolation and quarantine - - staying home if symptomatic - - and practicing hygiene and infection control measures.

As county emergency services diminish, what actions can be taken at the community and neighborhood level to support those in need of care?

Discussion Considerations:

Is there an existing community or neighborhood emergency plan that includes supporting a pandemic or other widespread disease outbreak? If not, who should write one?

What are the boundaries of your community or neighborhood?

How many residences are there?

How many family residents? How many single residents? How many seniors? How many residents with special needs?

Is there a central list of community/neighborhood phone numbers that could be used to periodically check on people who are known to be ill and the status of residents who live alone?

How would the community or neighborhood identify homes with ill persons that need assistance? (e.g., colored ribbon on the mail box or front door handle.)

How many able retirees and others would volunteer to bring food and medicine to persons who are ill and self-isolating?

Are there community church groups who could be organized to support persons who are ill?

If needed, are there facilities (churches and schools), that could be used as local vaccination or anti-viral distribution points?

Are there persons who have recovered from the virus or have been vaccinated who are willing to provide support to others in the community or neighborhood?

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MODULE 2 SCENARIO

Week 4 – Troubled Times

Outages

The current wave of pandemic influenza is continuing. High worker absenteeism is beginning to affect local services adding to the misery of persons who are suffering with influenza symptoms.

There have been electrical outages in the community lasting several hours apparently due to utility workers, who maintain these systems being absent from work due to illness or serving as family caregivers to other family members.

Mrs. McWilliams lives alone. She is dependent on an electrical oxygen generator system. She has a cylinder of oxygen for emergency use, but she is concerned that a prolonged outage would leave her without Oxygen.

Discussion Considerations:

What can be done within the community or neighborhood to identify other electrical- dependent people and assist them in a prolonged outage occurrence?

Rising Crime

Crime is on the rise in the community. Some say it's because of reduced law enforcement support due to flu illnesses; others say that it's because juveniles are out of school due to closures. Many in the community/neighborhood have firearms. Some are concerned about their armed neighbors taking the law into their hands.

Discussion Considerations:

What can be done to reduce community/neighborhood concerns?

Church Deliveries

One of the churches in the community/neighborhood is offering home delivery of food and medications to those who have self-isolated/quarantined in their home, but the offer is only extended to members of their congregation. Many residents are complaining that they deserve the same service.

Discussion Considerations:

What can be done to bring these services to others?

MODULE 3 SCENARIO

Week 6 – Light at the End of the Tunnel

The H1N1 vaccine has become more available. The CHD and the Division of Emergency Management are polling communities and neighborhood associations to determine if they have local facilities available in which to provide vaccines to residents.

Discussion Considerations:

What type of facility would you look for as a vaccine distribution point?

Mr. and Mrs. Brooks are vehemently opposed to vaccination for religious reasons. They have been circulating a petition throughout the community/neighborhood to stop vaccine distribution at the local level. Many others are concerned because they have heard that preservatives used in the vaccine can cause autism in children. Many seniors, on the other hand, are angered because people over age 65 are not considered as an “at risk group” and are threatening to demand vaccination at the distribution point when it opens.

Discussion Considerations:

How would you address the vaccination issues that are being raised in your community/neighborhood?

DISCUSSION FORM

Discussion Session Recorder: _____

Participants: Attach a sign-in sheet. **Module Scenario:** _____

Main Discussion Points:

Conclusions:

Recommendations for Future Planning: