EPI-LOG

Communicable Disease and Epidemiology News

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Planning the Local Healthcare System Response to an Influenza Pandemic

The King County Healthcare System Pandemic Influenza Task Force held a meeting on March 10, 2005 in Seattle to discuss the local healthcare system response to an influenza pandemic. Members of the Task Force include local, state, and federal public health staff, along with representatives from King County hospitals and large outpatient healthcare organizations (including administrators, safety and emergency preparedness officers, infection control practitioners, nurses, and physicians), and professional societies active in King County.

The goals of the task force are to:

- Improve the effectiveness of the local healthcare system response to pandemic influenza in order to limit mortality and morbidity
- Facilitate coordination and collaboration among healthcare system stakeholders, and between healthcare systems and Public Health

The objectives of this meeting were to:

1. Provide a forum where healthcare system stakeholders can share pandemic influenza preparedness information
2. Make recommendations to guide both healthcare system and Public Health pandemic influenza planning
3. Prioritize pandemic influenza preparedness issues that should be addressed by healthcare systems

The following topics, as they would relate to a public health emergency, such as an influenza pandemic, were explored:

- The legal authority of the Local Health Jurisdiction Health Officer
- Mass fatality management
- Decision making and coordination
- Communication
- Triage, including screening and surge capacity

Recommendations

The following are recommendations that were made by the Task Force as a result of this meeting:

1. Public Health will take the lead role in coordinating community healthcare system response during a pandemic emergency. This will be facilitated by prompt consultation with King County healthcare system leadership to inform decision making on healthcare system responses such as “temporary reorganization of healthcare delivery services”, (e.g., canceling elective admissions or surgeries), and activation of off-site screening/triage centers.

2. Public Health will continue to use e-mail, listservs, and broadcast fax distribution lists to reach healthcare facility and outpatient administrators and clinical staff, safety officers, and emergency preparedness staff. Public Health will work with King County healthcare facilities and local professional societies to increase the number of healthcare professionals receiving Public Health messages.

3. The King County Medical Society has agreed to take a lead role, in collaboration with other medical professional organizations, to facilitate establishment of a volunteer physician network to respond in public health emergencies. The first issue to be addressed is liability protection for physician volunteers.

4. The Task Force will continue to discuss the best options for planning and implementing community-based triage/screening to minimize the number of patients who do not need hospital care from seeking care at, and overwhelming, the hospitals.

In pandemic influenza planning, triage/screening refers to:

- identifying persons with potential influenza infection;
- separating these persons from others to prevent transmission of infection;
- identifying and treating non-influenza illnesses that do not require hospital care, and;
- referral of patients to a hospital or other appropriate venue for additional evaluation or treatment when necessary.

Options for community-based triage/screening include locations on-site at healthcare facilities, off-site but in close proximity to healthcare facilities, and other community locations. There was consensus that hospitals and outpatient facilities will need to have increased on-site triage/screening capacity regardless of the existence of potential new community-based facilities, as many patients will present to their usual source of medical care during an emergency.

Conclusion

Planning for the healthcare system response to a Public Health emergency, including pandemic influenza requires active engagement of all local healthcare facilities and many professional organizations. The Task Force will continue to meet to assess progress and promote healthcare system preparedness. All healthcare professionals are encouraged to review the "Planning Guidance for Health Care System."(Annex 2) in the national Pandemic Influenza Response and Preparedness Plan, online at: www.hhs.gov/nvpo/pandemicplan/.

New Meningococcal Vaccine

On Jan. 17, the Food and Drug Administration approved meningococcal polysaccharide diphtheria toxoid conjugate vaccine (Menactra®, made by Sanofi Pasteur, a division of the Sanofi-Aventis Group) for protection against meningococcal disease in adolescents and adults aged 11 to 55 years. This vaccine provides improved protection against the same four serogroups of *Neisseria meningitidis* (A, C, Y and W-135) as the existing meningococcal polysaccharide vaccine, (Menomune®, made by Sanofi Pasteur). Benefits of the conjugate vaccine are increased duration of protection, induction of immunologic memory, booster responses, and, potentially, reduction in nasopharyngeal meningococcal carriage.

On February 10th, 2005, the Advisory Committee on Immunization Practices (ACIP) recommended that the following groups receive Menactra:

- Children 11 to 12 years of age
- Teens entering high school
- College freshman living in dormitories

In addition, the committee recommended that teens entering high school be vaccinated for the next two to three years in order to facilitate a rapid reduction of disease.

Approximately 300 people in the U.S. die annually from meningococcal disease. Of the 195 cases reported in King County since 1995, 99 (51 percent) were caused by *Neisseria meningitidis* serogroup C, W135, or Y, which are covered by currently available vaccines. There were no infections due to serogroup A, a strain common in sub-Saharan Africa, identified in King County during that period. Eighty-four cases (43 percent) were caused by serogroup B, a strain not covered by either vaccine.

Reported Meningococcal Disease Cases in King County by Age, 1995 to 2004

Age in Years	All Cases	All Deaths	Infections due to serogroups C, Y and W135*	
			Cases	Deaths
<1	29	3	6	0
1 to 10	35	2	13	2
11 to 24	50	6	22	3
25 to 35	19	3	15	2
36 to 45	15	1	11	0
46 to 55	16	2	9	1
56 to 65	8	0	4	0
>65	23	3	19	2
Total	**195**	**20**	**99**	**12**

**Neisseria meningiditis* serogroups A, C, Y and W135 are those covered by currently available vaccines; there were no infections due to serogroup A (which is common in sub-Saharan Africa) identified in King County between 1995 and 2004.

Disease Reporting

AIDS/HIV ..... (206) 296-4645
STDs ..... (206) 731-3954
TB ..... (206) 731-4579
All Other Notifiable Communicable Diseases (24 hours a day) .... (206) 296-4774
Automated reporting line for conditions not immediately notifiable ..... (206) 296-4782

Hotlines

Communicable Disease ..... (206) 296-4949
HIV/STD ..... (206) 205-STDS

Public Health-Seattle & King County Online Resources

Home Page: www.metrokc.gov/health/
The *EPI-LOG*: www.metrokc.gov/health/providers
Communicable Disease listserv (PHSKC INFO-X) at: mailman.u.washington.edu/mailman/listinfo/phskc-info-x

Reported Cases of Selected Diseases, Seattle & King County 2005

	Cases Reported in March		Cases Reported Through March	
	2005	2004	2005	2004
Campylobacteriosis	32	17	65	48
Cryptosporidiosis	10	3	22	6
Chlamydial infections	643	520	1,504	1,310
Enterohemorrhagic *E. coli* (non-O157)	0	0	0	0
***E. coli* O157: H7**	3	0	6	0
Giardiasis	9	12	28	35
Gonorrhea	191	104	395	314
***Haemophilus influenzae* (cases <6 years of age)**	0	1	0	1
Hepatitis A	1	0	6	2
Hepatitis B (acute)	2	5	4	12
Hepatitis B (chronic)	39	80	119	116
Hepatitis C (acute)	0	1	3	1
Hepatitis C (chronic, confirmed/probable)	67	146	256	321
Hepatitis C (chronic, possible)	55	39	108	93
Herpes, genital (primary)	86	63	185	177
HIV and AIDS (includes only AIDS cases not previously reported as HIV)	37	54	116	119
Measles	0	0	0	0
Meningococcal Disease	2	1	8	6
Mumps	1	0	1	0
Pertussis	28	28	48	71
Rubella	0	0	1	0
Rubella, congenital	0	0	0	0
Salmonellosis	19	12	55	36
Shigellosis	5	4	13	23
Syphilis	10	8	51	19
Syphilis, congenital	0	0	0	0
Syphilis, late	14	7	25	22
Tuberculosis	15	7	28	27

The *Epi-Log* is available in alternate formats upon request.

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