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# Exercise Schedule

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<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>7:30 – 8:00 AM</td>
<td>Registration and Completion of Pre-Exercise Survey</td>
</tr>
<tr>
<td>8:00 – 8:20 AM</td>
<td>Welcome and Introduction&lt;br&gt;Introductions&lt;br&gt;Exercise Overview&lt;br&gt;Exercise Goal and Objectives</td>
</tr>
<tr>
<td>8:20 – 8:50 AM</td>
<td>Pandemic Influenza 101 and Introduction to the Los Angeles County Department of Public Health (LACDPH) Pandemic Influenza Preparedness and Response Plan&lt;br&gt;&lt;br&gt;Sadina Reynaldo, PhD&lt;br&gt;Assistant Director, Pandemic Influenza Preparedness Unit, LACDPH</td>
</tr>
<tr>
<td>8:50 – 9:10 AM</td>
<td>Myth Busters Uncut: Infectious Diseases&lt;br&gt;&lt;br&gt;Dr. Kim Uyeda, MD, MPH, FAAP&lt;br&gt;Director, Student Medical Services, Los Angeles Unified School District (LAUSD)</td>
</tr>
<tr>
<td>9:10 – 9:30 AM</td>
<td>LAUSD Emergency Management Infectious Disease Planning Efforts&lt;br&gt;&lt;br&gt;Bob Spears&lt;br&gt;Director, Emergency Services, LAUSD&lt;br&gt;Connie Moore, RN, BSN, MA&lt;br&gt;Director, District Nursing Services, LAUSD</td>
</tr>
<tr>
<td>9:30 – 9:40 AM</td>
<td>Overview: Schools’ Infectious Disease/Public Health Emergency Toolkit&lt;br&gt;&lt;br&gt;Victoria Hoe&lt;br&gt;Research &amp; Development Analyst, Medweb&lt;br&gt;Connie Moore, RN, BSN, MA&lt;br&gt;Director, District Nursing Services, LAUSD</td>
</tr>
<tr>
<td>9:40 – 9:50 AM</td>
<td>Break</td>
</tr>
<tr>
<td>9:50 – 9:55 AM</td>
<td>Module 1: Pandemic Outbreak Overseas&lt;br&gt;Scenario Briefing</td>
</tr>
<tr>
<td>9:55 – 10:00 AM</td>
<td>Facilitated Discussion&lt;br&gt;Feedback Session</td>
</tr>
<tr>
<td>10:10 – 10:20 AM</td>
<td>Facilitated Discussion&lt;br&gt;Feedback Session</td>
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<tr>
<td>10:20 – 10:25 AM</td>
<td>Module 2: Outbreak in the U.S.&lt;br&gt;Scenario Briefing</td>
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<tr>
<td>10:25 – 10:45 AM</td>
<td>Facilitated Discussion&lt;br&gt;Feedback Session</td>
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<td>10:45 – 11:00 AM</td>
<td>Facilitated Discussion&lt;br&gt;Feedback Session</td>
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<td>11:00 – 11:05 AM</td>
<td>Module 3: Reported Cases within LAUSD&lt;br&gt;Scenario Briefing</td>
</tr>
<tr>
<td>11:05 – 11:30 AM</td>
<td>Facilitated Discussion&lt;br&gt;Feedback Session</td>
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<tr>
<td>11:30 – 11:55 AM</td>
<td>Facilitated Discussion&lt;br&gt;Feedback Session</td>
</tr>
<tr>
<td>11:55 AM – 12:00 PM</td>
<td>Evaluations, Post-Exercise Survey and Closing Remarks</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Adjourn</td>
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Over the past several years, the Los Angeles County Department of Public Health (LACDPH) has engaged agencies and jurisdictions throughout the Los Angeles County Operational Area as partners in planning sessions, exercises, and improvement actions in order to enhance the ability of Los Angeles County, as a whole, to mitigate, prepare for, respond to, and recover from a pandemic or other large-scale infectious disease/public health emergency.

Continuing its community mitigation and containment outreach and planning efforts in 2008, the Schools’ Pandemic Influenza and Public Health Emergency Exercise Program is sponsored by LACDPH and is designed to 1) facilitate partnerships, communication and coordination among schools, school districts and LACDPH; and 2) to increase awareness of the issues regarding planning for and responding to an influenza pandemic or other public health emergency.

Influenza pandemics are rare, but periodic events. Three pandemics occurred in the previous century, the most infamous of which, the 1918 “Spanish Flu”, killed an estimated 40-50 million people worldwide. Because viruses are constantly mutating, it is inevitable that a pandemic or other large-scale disease outbreak will occur; particularly in today’s highly interconnected world. Preparedness and mitigation represent the keys to ensuring that any outbreak is as mild as possible. The recent emergence of the H5N1 influenza virus, or “Avian Flu”, has sparked public debate and spurred international preparedness efforts for pandemic influenza. Also, despite their low incidence of occurrence, other outbreaks have captured media attention—and the attention of parents nationwide—such as Methicillin-resistant Staphylococcus aureus (MRSA), a drug-resistant staph infection that can be serious, as well as Extensively Drug-resistant tuberculosis (XDR-TB), and Severe Acute Respiratory Syndrome (SARS). Still other diseases which have not yet been widely publicized remain threats and require continuous mitigation, surveillance and education.

As the second largest public school system in the United States and the second largest employer in Los Angeles County, the Los Angeles Unified School District (LAUSD) faces many unique challenges in planning for and responding to an influenza pandemic, MRSA or other public health emergency. This exercise series represents the next step in
the continuous emergency preparedness cycle for LACDPH, LAUSD and their constituent audiences.

The LAUSD Series of the Schools’ Pandemic Influenza and Public Health Emergency Exercise Program is funded by Grant Cooperative Agreement Number 5U90TP917012-08, awarded to LACDPH through the U.S. Department of Health and Human Services (HHS) Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness (PHEP) Cooperative Agreement in accordance with the Pandemic and All-Hazards Preparedness Act (PAHPA).

SCOPE

This exercise will focus on the roles of LACDPH, LAUSD and individual schools in mitigating, preparing for, and responding to, a potential influenza pandemic or other infectious disease outbreak. Discussion will be centered around the plans, processes, and relationships among agencies and schools and the capabilities and available resources of local agencies. The decision-making processes and the methods for mitigation, preparation and response are more important than minute details. The emphasis will be on coordination, integration of capabilities, and intra-/inter-agency communication.

Target audience members for this exercise include LACDPH Service Planning Area (SPA) representatives, LAUSD Local District Parent Ombudsmen, School Administrators, Nurse Administrators, and Local District Operations Coordinators.

PURPOSE

The purpose of this exercise is to provide participants an opportunity to assess current mitigation, preparedness and response concepts, plans, and capabilities for an influenza pandemic or other public health emergency in Los Angeles County. The exercise will focus on the policies and procedures that guide public health, schools and LAUSD in command and control coordination, critical decisions, notifications, and the integration of external assets necessary to save lives and protect public health and safety. The role of public information strategies will also be critical to the overall response effort.

TARGET CAPABILITIES

The National Planning Scenarios and the establishment of the National Preparedness Priorities have steered the focus of emergency management toward a capabilities-based planning approach. Capabilities-based planning takes an all-hazards approach to planning and preparation which builds capabilities that can be applied to a wide variety of incidents.
Capabilities-based planning allows jurisdictions to prepare for an array of realistic scenarios, including pandemic influenza, by identifying a baseline assessment of a jurisdiction’s prevention, protection, response and recovery efforts by comparing their current capabilities against the Target Capabilities List (TCL) and the critical tasks outlined in the Universal Task List (UTL). The capabilities listed below have been selected based on overarching exercise program goals and objectives, and have been cross-walked to the correlating CDC Preparedness Goals.

These U.S. Department of Homeland Security (DHS) Homeland Security Exercise and Evaluation Program (HSEEP) capabilities and CDC Preparedness Goals provide the foundation for development of each individual exercise along with exercise evaluation criteria in order to measure and validate performance of these capabilities and their associated critical tasks.

**CDC PREPAREDNESS AREAS**

- Prevent
- Detect and Report
- Investigate
- Control
- Improve

**CAPABILITIES**

- Health Intelligence Analysis and Production
- Community Preparedness and Participation
- Citizen Evacuation, Shelter-in-Place, Provide Social Distancing Measures or Close Schools
- Community Preparedness and Participation

**EXERCISE GOAL AND OBJECTIVES**

The exercise series goal and objectives identify in broad and general terms what is to be accomplished or evaluated during this series. The following exercise goal and objectives were derived from CDC grant program guidance. The exercise design objectives were further developed and finalized by the exercise planning team, comprised of LAUSD and LACDPH officials and contractor support staff.
LAUSD LOCAL DISTRICT EXERCISE SERIES GOAL
To enhance the ability of the Los Angeles Unified School District to mitigate, prepare for, and respond to an influenza pandemic or other public health emergency.

LAUSD LOCAL DISTRICT EXERCISE SERIES OBJECTIVES

- Familiarize participants with the specific roles, responsibilities and capabilities of LACDPH and LAUSD in managing the response to an influenza pandemic or other public health emergency.

- Discuss the issues, concerns and impact regarding potential social distancing measures and school closure/distance learning strategies.

- Present ideas, methodologies and materials regarding pandemic influenza and other public health emergencies to assist schools in educating children, parents, teachers, support staff, and administrators.

- Discuss the communicable disease surveillance and reporting process(s) for schools, particularly at locations where school nurses are not onsite.

EXERCISE STRUCTURE

This exercise employs a scenario-based format with informational presentations and facilitated discussions regarding resources, capabilities and limitations of Los Angeles County and LAUSD resources, and identification of issues and best practices. Participants should act in their real-life roles when considering the scenario as well as listening to other players, offering observations to the forum, and making strategic and tactical decisions. Facilitators will ensure that the scenario progresses at an appropriate pace and that all participants have an opportunity to contribute.

Participants will first be presented with a series of informational presentations. These presentations are designed to prepare participants for the discussion portion of the exercise by familiarizing them with applicable plans and agency capabilities. Following the informational presentations, participants will be presented with the exercise scenario. The scenario was developed to chronologically simulate a pandemic influenza event in three stages and incorporates the recently revised WHO pandemic influenza response guidelines. The modules will be presented as follows:

- **Module 1:** Pandemic Outbreak Overseas
- **Module 2:** Outbreak in the U.S.
- **Module 3:** Cases Identified within LAUSD
A series of questions and follow-up “scenario cookies” have been developed for the exercise facilitator to pose to participants. Questions are designed to promote discussion of various scenario elements represented in each exercise module.

Participants are encouraged to periodically migrate between groups to foster communication. A spokesperson from each group should be designated to present a synopsis of the group’s discussion at the conclusion of each module. Exercise facilitators will then moderate a discussion amongst participant groups to highlight key elements of each scenario module.

**ROLES AND RESPONSIBILITIES**

- **PARTICIPANTS** respond to the situation presented based on expert knowledge of response procedures, current plans and procedures in place in their community or agency, and insights derived from training.
- **OBSERVERS** support the discussion groups as they develop responses to the situation in the caucus sessions.
- **FACILITATORS/CONTROLLERS** provide situation updates and moderate discussions. They also provide additional information or resolve questions as required.

**ASSUMPTIONS AND ARTIFICIALITIES**

In any exercise, a number of assumptions and artificialities may be necessary to complete play in the time allotted, and to ensure the exercise objectives are met. During the exercise, the following apply:

- The scenario is based upon a pandemic influenza outbreak; however, the exercise is designed with an all-hazards approach, and can be applied to a wide variety of public health and other emergencies.
- The scenario begins in September of 2008 and continues through March of 2009.
- The scenario is plausible and events occur as they are presented.
- Participants will use existing assets in their discussion, but will also be free to discuss potentially new and creative out-of-the-box solutions and/or resources that may or may not be currently available.
**Exercise Ground Rules**

This is intended to be a safe, open environment. The problems and challenges are real and there is no "textbook" solution. The following exercise ground rules have been developed to ensure that the goals and objectives are met in a reasonable amount of time and the TTX runs smoothly:

1. Keep the exercise’s goals and objectives in mind throughout the exercise.
2. Treat the incidents within the scenario as real events, and play your appropriate role.
3. Participate openly and focus discussions on appropriate topics. Asking questions, sharing thoughts, and offering forward-looking, problem-solving suggestions are strongly encouraged.
4. For these discussions to be effective, participants must be sure to respect the observations, opinions, and perspectives of others. Varying viewpoints, and even disagreements are expected.
5. 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.
6. 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.
7. Make decisions using the information provided and your best judgment of how to proceed.
Evaluation is an essential element of a successful exercise and provides an objective assessment of the participants’ discussions. The goal of evaluation is to validate strengths and identify opportunities for improvement among participating organizations.

Evaluation criteria has been developed around CDC pandemic influenza planning goals, objectives and activities using methodologies consistent with the U.S. Department of Homeland Security (DHS), Federal Emergency Management Agency (FEMA), Homeland Security Exercise and Evaluation Program (HSEEP).

Material for exercise evaluation and post-exercise evaluation and improvement will come from five primary sources:

- Facilitator notes
- Participant discussion and issues recorded during the exercise
- Participant Feedback Sessions
- Participant Feedback Forms
- Plans, policies, procedures, resources and agreements

Following the exercise, this material will be compiled and analyzed. Recurring themes and major issues which arise will be identified and addressed in an After-Action Report (AAR) and Improvement Plan (IP).
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No one can predict when or where the next pandemic influenza outbreak will occur, but many agree it is not a matter of if but when.

An influenza pandemic is a global outbreak of disease that occurs when a new influenza A virus appears in the human population, causes serious illness, and then spreads easily from person-to-person worldwide. Pandemics are different from seasonal outbreaks of influenza. Seasonal outbreaks are caused by subtypes of influenza viruses that are already in existence among people, whereas pandemic outbreaks are caused by new subtypes that have never circulated among people before or that have not circulated among people for a long time. Past influenza pandemics have led to high levels of illness, death, social disruption and economic loss.

What scares experts dealing with H5N1 avian flu more than anything else is the possibility that the virus—virulent and deadly, but so far only contracted (e.g. “catchable”) from birds—might suddenly mutate into a form that is transmissible between humans. In 1997, an outbreak of the virus infected both domestic poultry and humans in Hong Kong leading to 18 hospitalizations and six deaths. Since then, other outbreaks of avian viruses (H9N2 in 1999, H7N2 in 2002, H7N7 in 2003, and H5N1 again in 2004) have occurred and have been found to directly infect people. The spread of H5N1 by migratory birds, which may be asymptotically infected, has lead to an increased geographical distribution of infection from Asia to Europe to Africa.

While no one can predict the timing or severity of the next influenza pandemic, public health officials agree that planning is essential. No one can accurately predict how many people an influenza pandemic might kill. The severity of disease and the number of infected, to include development of an effective vaccine, depend upon unknowable specifics about the virus. Under the best circumstances, assuming that the new virus causes mild disease, the
WHO estimates 2 million to 7.4 million deaths. Projections for a more virulent virus are much higher. The 1918 pandemic, the worst in modern day history, killed over 40 million people worldwide.

The World Health Organization (WHO) has been in Phase Three of the Pandemic Alert Period since November of 2005. In response, the U.S. has moved to Stage One of the Pandemic Influenza Federal Government Response and is developing and evaluating vaccines against two H5N1 avian viral strains.

BACKGROUND: PANDEMICS & SCHOOLS

Because of the unique features of a pandemic and the expected impact of such an event, advance planning across all sectors of society, including school systems, is critical.

School systems represent an important element in pandemic influenza preparedness and response for several reasons:

• **Schools are potential sites for the spread of disease, including influenza.** Because schools are locations where significant numbers of persons (students and staff) routinely assemble, schools are potential sites where disease may be acquired or spread. In addition, school children are primary transmitters of influenza to their community. Compared to adults, children are more likely to be infected with influenza each year and “shed” influenza virus longer and in larger quantities.

• **Schools are an information source for community residents.** Because of their established position within the community, schools serve as focal points for information exchange and service delivery.

• **Schools are sources of valuable resources for emergency response.** In addition to their instructional activities, schools possess a variety of important assets. Personnel resources include healthcare and mental health professionals, staff with multi-lingual capabilities, and information technology professionals. Additionally, many school bus systems are their jurisdiction’s largest transportation system. Similarly, school cafeterias may represent a significant proportion of the school community’s food services infrastructure.
• **Schools are sources of health monitoring information.** Because of their routine contact with a large proportion of the population, schools afford opportunities for monitoring the public’s health status. In California, school personnel are required to report to the local health department all suspected or diagnosed cases of reportable communicable disease. If there were indications of an approaching influenza pandemic, schools might be enlisted to monitor students or staff for influenza-like illness. Within LAUSD, this is done through District Nursing Services who then reports the information to LACDPH.

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**EXERCISE SCENARIO**

**LATE SEPTEMBER 2008**

The WHO announces that eight cases of human-to-human transmission of avian influenza A have been identified in Sumatra, Indonesia. In a press conference in Jakarta, WHO Director General Dr. Margaret Chan indicated that the findings were based on an analysis of a cluster of eight flu cases within an extended family in northern Sumatra.

“Using a computerized disease-transmission model that took into account the number of infected cases, the number of people potentially exposed, the viral incubation period and other parameters, our scientists, in concert with Indonesian epidemiologists, produced the first statistical confirmation that humans have contracted the disease from each other rather than birds.” Indonesian Health Minister Siti Fadillah Supari, also at the press conference, said “We understand the severity of this announcement and are working closely with WHO officials to ensure that every measure is taken to mitigate the spread of disease.”

Viral cultures collected from several of the initial patients are sent to the WHO Reference Laboratory where they are identified as type A H7N1, a subtype never before isolated in humans. It is further determined that the strain possesses characteristics similar to the severe strain that caused the 1918 pandemic. These results suggest that the vaccination, in its current form, is unlikely to prevent infection, but may reduce the severity of illness.

Reports indicate that the chain of infection began with a 37-year old woman who had been exposed to dead poultry and chicken feces, the presumed source of infection. She then passed the virus to her 10-year old nephew; on the basis of genetic sequencing data, WHO epidemiologists concluded that he then passed the virus to his father. Human-to-human transmission to five other relatives—all of whom had sustained close contact with sick family members prior to catching the virus—was also confirmed. All but
one family member died; a high but not atypical mortality rate for the strain. Of the 327 cases worldwide confirmed by the WHO, 199 have been fatal.

Working with the WHO, Indonesian authorities immediately begin to implement a containment strategy; however, experts indicate that it may be too late. Over the next several days, additional suspected cases are identified in Malaysia, Singapore and the Philippines. It is unknown at this time whether the additional cases are the result of human-to-human transmission.

The WHO moves to Phase Four within the pandemic alert level. (See Reference Graphic below for description of WHO Phases.) The WHO indicates it has approximately 300,000 courses of Tamiflu at its disposal for initial deployment and solicits donations from industrialized countries with their own Tamiflu stockpiles, publicly noting that inaction of even a few days can mean the difference between containing the virus and unleashing a pandemic. Following the WHO declaration, the Indonesian government asks the U.S. for vaccine and antiviral drugs.

<table>
<thead>
<tr>
<th>Inter-pandemic Period</th>
<th>Pandemic Alert Period</th>
<th>Pandemic Period</th>
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<tbody>
<tr>
<td><strong>Phase 1:</strong> No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.</td>
<td><strong>Phase 3:</strong> Human infection(s) with a new subtype but no human-to-human spread, or at most, rare instances of spread to a close contact.</td>
<td><strong>Phase 6:</strong> Increased and sustained transmission in general population.</td>
</tr>
<tr>
<td><strong>Phase 2:</strong> No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease. The distinction between phases 1 and 2 is based on the risk of human infection or disease resulting from circulating strains in animals. The distinction is based on various factors and their relative importance according to current scientific knowledge. Factors may include pathogenicity in animals and humans, occurrence in domesticated animals and livestock or only in wildlife, whether the virus is enzootic or epizootic, geographically localized or widespread, and other scientific parameters.</td>
<td><strong>Phase 4:</strong> Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.</td>
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<tr>
<td><strong>Phase 5:</strong> Larger cluster(s) but human-to-human spread is still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk). The distinction among phases 3, 4, and 5 is based on an assessment of the risk of a pandemic. Various factors and their relative importance may be considered. Factors may include rate of transmission, geographical location and spread, severity of illness, presence of genes from human strains (if derived from an animal strain), and other scientific parameters.</td>
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**Phases summarized in 3 key questions:**
1. Is it imminent?
2. Is it here?
3. Is it passing person-to-person?
OCTOBER 2008

The U.S. Federal government transitions to Stage Two of their response and sends appropriate viral isolates to the U.S. Food and Drug Administration (FDA); the CDC begins work on producing a reference strain for vaccine production. Influenza vaccine manufacturers are placed on alert; however, it will be at least 3-6 months, perhaps more, before a vaccine will be available for distribution.

The novel influenza virus begins to make headlines worldwide and becomes the lead story on major news networks. In the U.S., influenza is the lead story for all major newspapers, television networks and cable news broadcasts. Key U.S. government officials are briefed on a daily basis as surveillance is intensified throughout Southeast Asia and the Pacific Rim.

Riots begin to occur in major cities throughout Southeast Asia while roaming mobs attack rural villages that the attackers perceive to be the source of the problem. Meanwhile, several other countries begin requesting antiviral drugs.

LATE OCTOBER 2008

Additional outbreaks of the illness are confirmed throughout Southeast Asia, and the average attack rate in these countries is 30%. Results of ongoing WHO investigations indicate extensive person-to-person transmission of the virus over at least four generations. The WHO has indicated that the bird-to-human transmission that occurred at the start of the pandemic has now mutated into multiple strains. One strain is the rapidly adaptive H7N1 strain which is efficiently transmitted human-to-human.

The WHO officially declares a transition to Phase Five. Accordingly, the U.S. Federal government moves to Federal Response Stage Three and prepares domestic containment and response mechanisms. Pre-pandemic vaccine and antiviral stockpiles are deployed as supplies allow. Across the country, hospitals examine their surge plans. In Los Angeles County, LACDPH coordinates with LAUSD and other school districts to review pandemic guidance documents, plans and strategies.

At this time, there are no known cases of the illness in the U.S. A vaccine is not yet available, and supplies of antiviral drugs are severely limited or absent in many countries.
LAUSD leadership schedules an impromptu conference call with key stakeholders to assess the situation, and to discuss the reinforcement of preparedness measures, such as proper hand washing and other healthy habits in light of the rapidly unfolding events.

<table>
<thead>
<tr>
<th></th>
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<th>U.S.</th>
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<tbody>
<tr>
<td>Hospitalized</td>
<td>1,090</td>
<td>0</td>
</tr>
<tr>
<td>Additional Suspected Cases</td>
<td>436</td>
<td>0</td>
</tr>
<tr>
<td>Total Deceased</td>
<td>381</td>
<td>0</td>
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</tbody>
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Reported Cases of Pandemic Influenza, in the U.S. as of November, 2008

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<tr>
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Reported Cases of Pandemic Influenza, in the U.S. as of November, 2008
Module 1 – Key Issues

Early – Mid October 2008

- Influenza virus type A H7N1 is identified in Indonesia.
- Eight cases are reported. All but one of the exposed have died.
- WHO moves to Phase Four within the Pandemic Alert Period.
- U.S. Federal Government Response Stage Two is declared.

Late October – Mid-November 2008

- The WHO confirms that human-to-human transmission is occurring over at least four generations of transmission.
- Additional outbreaks of the illness begin to appear throughout Southeast Asia at an average attack rate of 30%.
- The WHO officially declares the transition to Pandemic Alert Phase Five.
- The U.S. Federal Government Response transitions to Stage Three. Viral isolates are sent to the FDA to begin vaccine research and development.
- LACDPH coordinates with school districts throughout Los Angeles County to review their pandemic guidance, plans and strategies.
- Public anxiety continues to grow as news of the outbreak is released.
- LAUSD leadership schedules a call with key stakeholders to assess the situation and to reinforce preparedness measures, such as healthy habits.
- No known cases of human or animal illness are reported in the U.S.
1. How are you preparing students and staff for the possibility of a pandemic? What information is being disseminated at this time? How is it being disseminated? 🔵

2. Does your school have any unique features (e.g. special education centers or facilities, California Youth Authority, etc.) that need to be addressed?

3. Has a dissemination plan for communication with staff, students, and families, including lead spokespersons and links to other communication networks, been developed? How should this plan be enhanced at this time? 🔵

4. What systems are in place to maintain up-to-date communications with key public health and education stakeholders to provide regular updates as the pandemic unfolds? Are there redundant communication systems/channels that allow for the expedited transmission and receipt of information? What are they? What gaps exist? What can be done now to resolve these gaps?

5. As part of your Safe Schools Plan, is pandemic influenza/public health emergencies preparedness addressed? Does it tie in all relevant stakeholders in the district (e.g. lead emergency response agency, district administrators, local public health representatives, school health and mental health professionals, teachers, food services/cafeteria managers, facilities managers, other school staff, and parent representatives)? What can be done at this time to address gaps in current levels of preparedness? 🔵
6. Have the requirements of students with specific needs (e.g. low income students who rely on the school food service for daily meals, those in special facilities (e.g. juvenile justice facilities), as well as those who do not speak English at home), been incorporated into emergency plans? What more should be done to enhance these efforts?

7. How might the surveillance system for monitoring student absenteeism and/or illness be enhanced to better detect a pandemic or other infectious disease?

8. What should be done now to address provision of psychosocial support services for LAUSD staff, students and their families during and after a pandemic?

9. Have communication platforms (e.g. hotlines, telephone trees, dedicated websites, and local radio and/or TV stations) for communicating pandemic status and actions to school/school district staff, students, and families been developed and tested? What are they? How can these systems be enhanced?
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Module 2: Outbreak in the U.S.

**MID NOVEMBER 2008**

The WHO Director General declares a transition to Pandemic Period Phase Six and recommends that each country implement its pandemic plan. Meanwhile, influenza continues to spread throughout Southeast Asia. Public health authorities suspect and then confirm cases in India, as well as several coastal cities in East Africa. Epidemiological investigation of cases indicates that all age groups are infected. Laboratory tests reveal transmission occurs by respiratory secretions.

**DECEMBER 2008**

An unusually severe influenza cluster is identified in Miami, Florida, affecting otherwise young and healthy people. Laboratory tests are positive for influenza A; however, the subtype is not H1 or H3 by Hemagglutinin Inhibition test. Consequently, it is suspected to be a novel strain, and the isolates are referred urgently to a CDC collaborating center. Further analysis by the CDC confirms the causative agent for this outbreak is a pandemic strain.

Immediately, the U.S. government transitions to Stage Four of the federal response in an effort to contain the first cases identified domestically. Diagnostic reagents for the pandemic virus are deployed to all laboratories.

Thus far, five confirmed cases have been identified in Miami. All five individuals have been hospitalized, and two have died. Through investigation, four additional cases including mild respiratory illness in the neighbors and family of the confirmed cases are detected. One of these involves a family member from Boston who was visiting Miami, and has since returned home. All of the cases and contacts are being treated with antiviral medication, and are under isolation or self-confinement at home.
Additional human cases are reported throughout Europe and Africa, and in other parts of North America—namely Canada and Mexico. The outbreak has peaked in many parts of Indonesia. The overall rate of illness in affected areas ranges between 20% and 40%. In response to outbreaks in Paris, Brussels and London, the European Commission requests that member states urge their citizens to voluntarily cancel their travel plans within and outside the European Union (EU).

**JANUARY 2009**

Several U.S. cities and transportation hubs including Chicago, Philadelphia and New York City, begin to report cases; reaching as far west as Texas. In affected cities, decision makers and key community leaders at the local level, including school officials, emergency managers, and public health officials, are making decisions regarding limiting public gatherings and potential school closures. For parent/guardians maintaining employment during a school closure is a significant concern, and one not taken lightly by decision makers. Ford, Johnson & Johnson and other large companies announce the provision of telecommuting and alternative work schedules for employees to help manage the lack of childcare resources. The timing and duration of school closures for affected areas varies from city to city, and is made with epidemiological input from the U.S. Department of Health and Human Services (HHS) and logistical input from the U.S. Department of Education (ED), as well as State and local agencies on a case-by-case basis.

Emergency services in cities where cases have been identified are severely impacted. In many cases emergency managers are working with their local governments to rapidly expand and implement their continuity of operations (COOP) plans. The private and non-governmental sectors are also encouraged to implement their COOP plans; advice and counsel, to the extent possible, are given to those who have not been proactive and are now scrambling to put appropriate mitigation, control and continuity mechanisms in place.

Discussions continue to take place at the State and Federal levels with unions and professional associations of educators, administrators and school boards regarding the implications associated with a pandemic of this magnitude. Calls for national recommendations and guidance are made regarding the continued provision of Federal programs carried out at the State and local level (e.g. school lunch programs).
The national media continues to cover pandemic flu stories. The local press contacts LAUSD to inquire about what it, and its emergency management partners, are doing to prepare further; speculating that it will only be a matter of time before cases are identified in Los Angeles County. Signs of public concern are reaching new heights, fueled by media assertions of a lack of proper preparation.

Despite the fact that cases have not yet been identified in California, LAUSD officials continue to take a proactive stance, particularly with regard to information management. Informational letters are sent to parents regarding the unfolding events and LAUSD’s preparedness efforts. Teachers continue to remain vigilant—scanning their classrooms for children with flu-like symptoms and encouraging healthy habits such as proper hand washing and “cover your cough” public health maintenance steps.

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<thead>
<tr>
<th>Reported Cases of Pandemic Influenza, world-wide, as of January, 2009</th>
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<td>183,750,041</td>
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### Module 2 – Key Issues

#### Mid November – December 2008
- The WHO declares the transition to Pandemic Period Phase Six.
- A cluster of unusually severe influenza cases is identified in Miami.
- The U.S. Federal government officially transitions to Stage Four of the Federal Response.
- Several U.S. cities including Chicago, Philadelphia and Miami begin to report cases; reaching as far west as Texas.
- The national media continues to lead with pandemic flu stories, and signs of public concern and fear continue to grow.
- Additional human cases are reported throughout Southeast Asia, Europe, Africa and in other parts of North America.

#### January 2009
- In affected cities, decision makers and key community leaders at the local level, including school officials, emergency managers, and public health officials, are making decisions regarding limiting public gatherings and potential school closures.
- Local governments and private/non-government sector partners begin to implement their Continuity of Operations (COOP) plans.
- Discussions continue to take place at the State and Federal levels with unions and professional associations of educators, administrators and school boards regarding the implications associated with a pandemic of this magnitude.
- Calls for national recommendations and guidance are made regarding the continued provision of Federal programs carried out at the State and local level, such as school lunch programs.
- No known cases of illness are reported in the State of California.
1. Keeping the worst case scenario in mind, what steps will you take to prepare for school closures of potentially six-eight weeks? Who will lead this preparation effort? How will LAUSD ensure continuity of student learning and the continuity of core operations?

2. Discuss implementation of an order to close schools/dismiss students. In the event an order is issued, what steps will you take to carry out the order? Who is in charge of implementing the order at your school level? Is this person at each school or at another level of government? Have these people been identified?

3. What is each level of school governance that would be involved in preparing for a school closure, and what are their respective responsibilities? Have these people been designated in your jurisdiction?

4. What is the potential impact of a pandemic on student learning, school closings, and extracurricular activities?

5. What are the consequences of school closure for staff, teachers and parents? How can these consequences be addressed in advance?

6. Have you completed your school Continuity of Operations (COOP) plan? If not, what is your back-up plan? You have only one cafeteria manager, facilities manager and payroll clerk. If they are severely ill and cannot report to work, how would you handle essential office and school functions such as payroll, meals, and ongoing communication with students and parents?
7. What should be communicated to staff, students and families at this time? Who is in charge of this effort? What channels of communication can you use to provide regular updates to parents and staff on pandemic influenza and a potential school dismissal, to include children and families with specific needs?

8. What constituencies will you communicate with at this time? What are their roles? Are your mechanisms for communicating with them already in place?
EARLY FEBRUARY 2009

Pandemic influenza has now been confirmed in California, with over a dozen cases confirmed within LAUSD. The first case was identified at West Angeles Elementary School in Santa Monica, where a fifth grader was sent to the nurse’s office for flu-like symptoms. Following established procedures, the School Nurse began the notification and reporting process based upon the following:

A Public Health Emergency is proclaimed by the Los Angeles County Health Officer for the Los Angeles County Operational Area (LAC OA). The Los Angeles County Operational Area Emergency Operations Center (CEOC) is activated, and the State of California Regional EOC (REOC) and the State Operations Center (SOC) follow suit. The LAUSD EOC is activated and remains in constant contact with the City of Los Angeles. When called upon, the LAUSD EOC also responds to direct requests from the CEOC. A recommendation is issued to close all schools in California (public and private) for up to 12 weeks. All childcare programs are also recommended to be closed. The Governor issues a statement that staff and teachers will continue to be paid under the disaster proclamation.

State officials urge local school districts to work with State and Federal partners to consider the provision of distance education, school meals, and parent support networks. However, challenges to meeting these needs, such as staffing shortages (due to illness or childcare issues), lack of funding, and the logistics of developing
a distance learning curriculum and delivering it to students, are a significant obstacle. Communications between the California Department of Education (CDE) and the school districts, as well as the California Department of Public Health (CDPH) and LACDPH and other local public health jurisdictions, is expanded upon using existing structures and pre-existing relationships. Communications are being coordinated with the SOC and through the State Joint Information Center (JIC). Most recently, the following guidance was released with regard to school closures in California:

- Individual services, such as therapies, tutoring or other face-to-face interactions may be reduced or discontinued.

- Other services, such as meals, school projects/assignments, phone tutoring, use of the web for teaching activities may be modified during the pandemic period.

- Delivery of school lunches and other health-social service programs to children will need to be reevaluated to determine feasibility during the pandemic period.

- Methods for continuing learning during a school closure are recommended. This may include the use of local television and online classes, “educational packets” sent to students’ homes and the eventual use of transportation services to deliver assignments.

School superintendents are working with their respective school boards, school principals and directors of school programs, and drawing upon the expertise of their crisis managers, student support and/or health services team members. There is a concerted effort driven by LACDPH and the Los Angeles County Office of Education (LACOE) to facilitate communication and coordination among school districts throughout Los Angeles County.
MID-FEBRUARY 2009

Editorials in online and print media join the rest of the media chorus in speculating on the impact the pandemic will have on families and businesses, and the potential for a worldwide recession. Businesses express concern over their ability to maintain operations if they do not have enough staff; and employees are questioning their obligations to their employers. The high degree of uncertainty raises public anxiety and fear to a near panic pitch.

The U.S. Department of Homeland Security (DHS) raises the homeland security advisory system level to “Orange” or “high” due to the nation’s compromised situation. The outbreak continues to spread. It is projected that 35% of the Los Angeles County population will fall ill as a direct result of the pandemic strain. However, since persons can be infected and contagious 1-2 days before showing symptoms, there is no way to determine the actual numbers of those infected with the virus at this time.

MARCH 2009

Overall, about 2% of Americans infected with the H7N1 influenza illness die. Hospitals are overwhelmed and staff shortages limit capacity at the height of the outbreak. There are shortages of equipment and supplies at local hospitals, and they are unable to provide care for all who need it.

KTLA and KCAL-9 cover a growing internet protest started by parents of Benedict Spears High School who are concerned that following the deaths of two BSHS students that their children will be in danger when schools are back in session. They demand that public health and LAUSD officials come up with “viable sanitization alternatives” to ensure the school is “safe”, stating that “schools are not cleaned to any real standard, and LACDPH and LAUSD must do more to protect children and families.” Their children also chat about the closure, and their parents’ concerns, on MySpace and Facebook. Some even post videos of their angry parents on YouTube. The message and the protest spread quickly, fueling rumors and additional panic throughout the country.

Public Health Officials at LACDPH, in coordination with LAUSD Student Medical Services and District Nursing Services, and LACOE, respond to the spreading rumors using a number of traditional and new media resources. They reinforce the message that influenza viruses live on surfaces for a very short period of time—typically no more than 1-3 days and that since schools have been closed for a significant period of time, that despite being scary, there is no fact-based cause for concern. They stress again that the single most important prevention measure for individuals, families, schools and places of work is to practice good hygiene habits—to properly and more frequently wash hands (20 seconds with soap and warm water); to cover coughs appropriately (into sleeves); to monitor for symptoms and stay home from work/school if symptomatic; and if someone is sick at home, maintain a distance of a few feet from the infected person.
### Reported Cases of Pandemic Influenza, world-wide, as of March, 2009

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<th></th>
<th>Cases</th>
<th>Suspected Cases</th>
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<td>World</td>
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### Reported Cases of Pandemic Influenza, in the U.S. as of March, 2009

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### Reported Cases of Pandemic Influenza, in Los Angeles County, as of March, 2009

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<tr>
<td>Los Angeles County</td>
<td>95,172</td>
<td>10,575</td>
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# Module 3 – Key Issues

## February 2009
- Cases are identified within LAUSD.
- A Public Health Emergency is proclaimed by the Los Angeles County Health Officer.
- A recommendation is given by the State to close all schools in California—potentially up to 12 weeks; childcare programs are also recommended for closure. The recommendation provides provisions for teachers and staff to continue to be paid under the disaster declaration.
- State officials urge local school districts to work with State and Federal partners to consider the provision of distance education, school meals, and parent support networks.
- There is widespread speculation of a worldwide recession as businesses experience record high absentee rates and are unable to maintain their operations. Hospitals and healthcare facilities/providers are particularly hard hit.
- DHS raises the Homeland Security Advisory System to “Orange” due to the nation’s compromised situation.

## March 2009
- It is estimated that 2% of Americans infected with the H7N1 influenza illness have died or will die.
- Parents at Benedict Spears High School lead an internet protest following the deaths of two students. They demand that additional actions be taken by LACDPH and LAUSD officials to ensure the school is “safe” when schools reopen. The protest is intensified by their children’s postings about their parents’ concerns on MySpace, Facebook, and YouTube.
- News of the protest spreads quickly throughout the country, further fueling rumors and panic. Public fear and anxiety reach an all-time high.
BREAKOUT GROUP INSTRUCTIONS

1. You have 25 minutes to consider the questions in this module.
2. Participants are not required to address every assigned question. Your table facilitator will advise you of the questions your table has been assigned.
3. Elect a spokesperson for your group to discuss the group’s findings after each module.
4. Groups should work to identify any additional questions, critical issues or decisions they feel should be addressed at this time. Each participant should record their thoughts, issues and questions on the provided Participant Feedback and Evaluation Form.
5. Make decisions using the information provided and your best judgment of how to proceed.

1. What are your three most critical actions at this point? What challenges do you face? What are the gaps?

2. How would you implement a social distancing measure that recommends maintaining a distance of 3-feet between persons whenever possible? Consider classrooms, lunch and recess breaks, and extracurricular activities (athletics, school plays, field trips, etc.). What, if anything, can schools/school districts do to encourage children to not congregate elsewhere (e.g. malls, movies, friend’s house, parks, etc.)?

3. What are the consequences of school closure for students (ex. school lunch programs)? Are there alternative means for delivering services? If so, are there plans under development?

4. What other school-based services will be curtailed? Can any of these services be modified so that students are supported during a long-term closure?

5. What are the key services your school will need to continue to provide after students are dismissed? How will you plan to provide these?

6. Are there any other essential activities that need to continue during this period? If so, what are they?

7. If your school was designated as Point of Dispensing (POD, medication dispensing site), what are your primary concerns? What steps can LACDPH take during the preparedness phase to mitigate these concerns?