

Engaging Community Sectors in Pandemic Influenza Preparedness

Category:

Business community and private sector involvement

Community Description:

Tulsa County Metropolitan Statistical Area is the second most populated area in the State (~700,000 people) and is approximately 120 miles away from Oklahoma County which is the largest county in the State (~1,000,000). The land mass of Tulsa County is approximately 570 square miles. The demographic make-up of Tulsa County is 76% white, 11% black, 5% American Indian and Alaska Native, 4% Asian and other and 4% are two or more races. Tulsa County is one of eight Homeland Security Regions in the State. The County has eleven separate jurisdictions ranging from 563,000 people in the City of Tulsa, 75,000 in Broken Arrow, to 4,000 in Collinsville.

Public Health in Oklahoma is centralized with the Oklahoma State Department of Health (OSDH) in Oklahoma City having approximately 800 employees. The State of Oklahoma has 77 counties with 67 of these counties having County Health Departments. Two autonomous counties, Oklahoma County and Tulsa County are City-County Health Departments. Tulsa Health Department (THD) employs approximately 300 staff and Oklahoma City-County Health Department (OCCHD) employs approximately 275 staff.

The health care delivery system in Tulsa County includes one public health department and 8 private hospital systems. The healthcare system capabilities include: no level 1 trauma centers and two level 2 trauma centers, one pediatric trauma center, one burn center, 275 ICU beds, 88 long term care facilities and several mental health centers. The hospital emergency departments are routinely on divert due to typical weekend patients making the emergency capabilities limited. Tulsa contracts with a private emergency medical service provider, EMSA, which also conducts surveillance of chief complaints for paramedic runs in the area. In addition, Tulsa utilizes a Medical Emergency Response Center for coordinating with each individual hospital and rapid communication of an incident is relayed to terminals dedicated in the emergency department through EMS systems. Tulsa's Metropolitan Medical Response System maintains a cache of medical supplies to augment surge capacity and provides planning support for Mass Casualty plan development.

The Tulsa Health Department maintains three clinic locations within the community and three satellite centers. THD formed an Emergency Preparedness Division three years ago but have been working on emergency preparedness activities since 9/11/01. THD's Emergency Preparedness Division is centralized with one planner. The Division has fifteen staff with several

professional disciplines including; epidemiology, emergency response, volunteer coordination, communication, exercise/training, pan flu and technical specialties coordinated by the division manager. Work assignments are derived from CDC and State funded grant goals. Critical tasks are accomplished through project developments originating as proposals from any and all the disciplines. Since 2001, THD has:

- developed an electronic syndromic surveillance system (TASSS) with all five major hospitals participating five years ago;
- participated in the statewide SNS exercise in 2005 resulting in a green rating for the State; and
- utilized the Incident Command System for seasonal Influenza Mass Vaccinations and reached thru-put levels exceeding 1,000/hr using a drive-thru model. This is an ongoing activity each year.

Planning Process:

THD receives CDC and state grants and guidance to maintain a safe and healthy community. The 2006 Pandemic Supplemental Grant as well as the Department of Health and Human Services Pandemic Influenza Plan encourages local health departments to assist the business community and private sector agencies in developing preparedness plans much like their own developed plans. The government developed checklists for numerous sectors of a community, but did not provide the means to accomplish the goals.

The THD developed a proposal to assist the business and private sectors with pandemic preparedness through a Community Pandemic Preparedness Project. Our planning committee determined that many businesses were familiar with Continuity of Operations Plans and that this would be a good approach to pandemic preparedness. Typically large businesses have well-developed emergency plans, more resources and are more open to protecting their ongoing operations. It was determined that providing information to businesses about pandemic influenza preparedness should be targeted and the impact it would have on their ability or inability to continue business as usual.

The planning committee determined that the community sectors should be divided by discipline; therefore workshops targeting businesses, schools and health care facilities were designed and provided separately. For example, the planning committee targeted large businesses and critical service providers in the community. To assist in identifying these businesses, THD worked with the local chambers of commerce, who maintain lists of by size within the community. Large businesses were defined as those with greater than 500 employees (many had over 1,000 employees) while critical service providers were defined as businesses providing essential services that dramatically impact the community if unavailable (ex. Electric company, gas company, phone companies, etc.). The same rationale was done for schools and healthcare facilities.

Narrative:

Pandemic preparedness is difficult to plan for due to the magnitude and scope of such an event. In addition, it is difficult to project the level of impact as well as the measures likely to be the most effective. The public perceptions of a pandemic are derived from the media which have created layers of misconceptions leading to fear and ultimately disconnection of individual empowerment.

THD recognizes the limitations for all communities to respond and minimize the effects of a pandemic. Creating partnerships and providing awareness through educational forums is a primary objective of the THD pandemic plan. Business partnerships in public health are viewed as new territory with high potential for successful relationships. THD wanted to ensure that the partnership development through this project included multiple benefits for the businesses and significant steps towards mitigating a pandemic. The benefits needed to be tangible and measurable; therefore, providing them with the resources to develop a plan and providing continued guidance, work-site educational materials and presentations, and exercise involvement were key to solidifying the relationship.

The community pandemic preparedness project includes three phases of involvement: Plan Development Workshops, Plan Implementation, and Lessons Learned and Improvement Plan Workshops. The phases allow the participants to select their level of involvement based on their abilities and allowing each to learn how to meet the unique needs of planning for a pandemic.

PHASE I: Plan Development

Plan development workshops were filled to capacity and the response was overwhelming. One objective for these workshops was to reach as many people as possible with information on how they can prepare for a pandemic as individuals. A strong emphasis of the workshop encouraged employers to provide education opportunities to employees regarding pandemic preparedness such as the checklist for families and individuals. Over 80 of Tulsa's largest employers participated representing over 60,000 employees (almost 10% of the total population). Survey results from the participants indicated 99% of individuals will share the information learned from these workshops with others.

Another objective for these workshops was ensuring businesses understood a pandemic and had the necessary resources to develop a plan. Participants responded that 60% had not started a plan, 25% had an outline and only 3% stated they had completed the plan.

Developing useful products that participants could utilize and better understand how to prepare for a pandemic was another primary objective this was done by providing application based resources. Each participant was provided the following;

- Workbook - containing all of the workshop information
- Templates (in Word format) - burned to a CD
- Overview presentation - differentiating seasonal flu, bird flu, and a pandemic
- Instructional guides – how to develop a plan
- Examples of infection control - tissues, hand sanitizer, disinfectant wipes, and disposable thermometers
- References - links to websites when available
- Tabletop exercise - modifiable to their specific business.

PHASE II: Plan Implementation

Plan implementation began five months after Phase I and was dependent upon the success of the workshops. Participants were asked in the workshop survey, “Would you be willing to participate in activating components of your plan in the upcoming flu season?” of which 77% responded yes. The planning group used the results to identify candidates for the implementation phase and selected those representing each sector which had well developed plans.

The objectives for the implementation phase were to initiate various components such as communications, employee education, public health measures, policies and surveillance involving a business, school, or healthcare plan during various stages of the influenza season. A brief description of each is provided below.

- **Communications**

All communications are sent via e-mail as weekly updates, advisories, or alerts depending upon the level of severity of flu activity. For example, as the first cases were identified nationally, notification and recommendations were sent out to the sentinel partners to begin encouraging employees to get their flu shots. Once cases began to show up in Oklahoma, notification and recommendations included posting good hygiene signs, providing hygiene products, enhancing disinfection, etc.

- **Employee Education**

Presentations and resources were provided to businesses and schools regarding the pandemic flu vs. seasonal flu vs. avian flu.

- **Public Health Measures**

Businesses and schools were provided ‘Don’t Bug Me’ materials in addition to other hygiene related materials to educate staff/students. In addition, these entities were given recommendations to ensure infection control measures were encouraged in the workplace such as tissues, hand sanitizers and other housekeeping items.

- **Policies**

THD provided technical support to businesses and schools in developing policies to address pandemic preparedness such as sick policies work from home policies, surveillance and infection control measures. This support is currently ongoing.

- **Surveillance**

Surveillance provides the business or school with an indication of how the flu may be impacting their operation. Businesses and schools were encouraged to evaluate absenteeism and report these absences on a weekly basis to THD. Rapid flu tests were distributed to a select group of businesses and universities that maintain occupational or health service centers to aid in community surveillance for initial flu cases. Positive rapid tests are forwarded to the Laboratory Response Network (LRN) for confirmation and sub-typing allowing us to evaluate the gaps in providing the enhanced capability pre-pandemic.

The conclusion of Phase II will likely occur sometime in the middle of March, as the flu season begins to wind down. Participants will be asked to respond to a short survey asking how well certain components of their plan were implemented and what additional items were needed to be successful.

PHASE III: Lessons Learned & Improvement Plan Workshops

In this phase, THD will invite all participants from the project to conduct open forums with the Phase II participants sharing the successes and challenges of implementing their plan components. Each will have the opportunity to discuss what measures may have been the most effective and which measures presented the most challenges. Participants from each sector will be asked questions regarding the planning and implementation phases. A report will be generated highlighting the most effective measures and providing recommendations to how plans could be improved. The current status regarding avian influenza will be provided and new developments for pandemic preparedness will also be discussed at this time.

In conclusion, advice to other local health departments undertaking similar efforts would include; utilize the chambers of commerce, insurance agencies, and city organizations to identify good partners. Provide tangible resources that each participant can take away and find application for. Maintain contact through communications such as e-mail groups, newsletters, and provide additional training opportunities. Offer opportunities for their employees to be involved in exercises as volunteers and include them as resources. Finally, be forthcoming with information (if you don't know the answer- follow up with a contact where they can get the answer), be honest (don't be afraid to address the scarier aspects of a disaster such as death) and to the point (time is money so don't waste their time with useless information), as all of these points will add credibility to your efforts.