ASSESSING POLICY BARRIERS TO EFFECTIVE PUBLIC HEALTH RESPONSE TO THE H1N1 INFLUENZA PANDEMIC

-- Colorado Report --

Meeting Overview

The Colorado Department of Public Health and Environment (CDPHE) scheduled the ASTHO-sponsored *Assessing Policy Barriers To Effective Public Health Response To The H1N1 Influenza Pandemic Project* After Action Meeting on Monday, April 26, 2010. This meeting served as a means for identifying and assessing key policy barriers, both legal and non-legal, to effective public health response to the recent H1N1 influenza pandemic.

Colorado's After Action Meeting was hosted at the CDPHE Department Operations Center in Denver, CO. The meeting was five-hours in length, scheduled from noon to 5:00pm to enable participants outside of the Denver metropolitan area to travel during the morning hours. Participants were given the option to participate in person or via video and audio conferencing. Lunch was provided for all in-person participants. The meeting agenda is also attached. Invited participants represented a broad range of stakeholder interests, including state and local public health, cross-sector agencies such as education, law enforcement, and emergency management; health care providers; and community and faith based organizations. A list of participants is attached. The general public was not invited to this meeting, as CDPHE was provided with less than one month to organize this event.

This event is part of a larger H1N1 after action review in the state of Colorado. A final statewide after action report (AAR) will be available in the Summer/Fall 2010.

After Action Review Outcomes

Surveillance, Epidemiology, and Laboratory Services

Over the summer, many local public health departments were able to work with their school districts and colleges to implement policies and procedures for capturing ILI-related illness and surveillance data. Unfortunately, not all school districts throughout the state were cooperative. There is no mandate at the Federal or state level to implement key public health practices within the school system. Data on ILI absences was valuable in predicting the status of the current H1N1 outbreak within the community. Schools and colleges need to be full partners with public health not only to assist in decisions surrounding school closures but also for setting up mass vaccination clinics within the community. School surveillance activities will be continued in Colorado due to the success of H1N1 ILI school-based surveillance.

Recommendations:

- Continue to develop ongoing relationships at the state and federal level between public health and educational institutions. CDC, HHS and US Department of Education should be communicating on how to better partner for routine and emergency disease surveillance.
- Federal agencies should also better support their state and local counterparts in these efforts, for example the U.S. Department of Education should loosen grant restrictions that interfere with collaboration with public health and that hinder reporting requirements.

Hospital partners reported that it was not difficult to manage in-patient H1N1 cases, but it was difficult to manage patients in the emergency department (ED). Many patients wanted to be tested for H1N1, even when they did not meet the testing criteria. Patients who were denied confirmatory testing would often return to the ED multiple times demanding to be tested, often because their employer required that they have a doctor's note verifying illness before they could be granted leave from work and/or to return to work. Employees should not need confirmation of a widespread illness in order to receive permission from the workplace to stay home due to illness or the illness of a family member. Schools saw an increase in the number of sick kids returning to school after one or two days due to parents who were unable or unwilling to take time off of work to care for their sick children.

Recommendations:

- Continue to work with private organizations to change corporate culture – employees should be encouraged to stay home when they are sick and HR policies should not require documentation from a physician confirming H1N1 or other widespread illnesses.
- Provide Federal support for low-income families to stay home when kids are sick.
- State and locals should continue to communicate with the business community and share public health guidance and recommendations.
- Department of Education, in partnership with state and local public health, should work more closely with the private sector to provide information on school closures and other school issues that potentially impact parents/private sector employees.

State and National Vaccination Campaign

There are a large number of military/active duty personnel in El Paso County. State and local health departments were told that the DOD would be vaccinating their own personnel; however the DOD did not receive vaccine in time to vaccinate their personnel prior

to or during the peak of the outbreak. The El Paso County Health Department could vaccinate dependents of active duty personnel, but not active duty personnel themselves– including those that were pregnant or had other high-risk conditions.

Recommendations:

- DOD needs to provide vaccine to all military personnel as promised in a timely fashion or enable state or local health departments to vaccinate military personnel with financial and operational support from DOD.

All healthcare providers who administered H1N1 vaccine were required to pre-register. Pre-registration was available online and accounted for the majority of enrollees. The CDC minimum vaccine shipment of 100 doses required CDPHE to turn many providers away that otherwise would have been able to provide vaccine in their smaller practices. This type of logistical requirement caused problems for states with rural and frontier counties.

Recommendations:

- In the future, we ask CDC to be more flexible with vaccine shipment allocations.

Due to issues with vaccine development, CDC over-promised and under-delivered vaccine allocations at the beginning of the influenza season. CDC continued to revise their vaccine allocations and these revisions continued to be miscalculated. The constant revisions in vaccine allocation undermined local mass vaccination efforts, as the amount of vaccine to arrive in the state each week was always unknown. As a result, many mass clinics were cancelled at the last minute. At the beginning of the outbreak, people who did not fit into one of the limited priority groups were turned away and were unable to receive H1N1 vaccine. Once vaccine was available in large quantities, the number of cases in Colorado began to decline and the general public was no longer interested in getting vaccinated. We ended up throwing out vaccine. This created credibility issues for both state and local public health.

Recommendations:

- CDC needs to provide better projections on vaccine availability, demanding better estimates from vaccine manufacturers.
- Federal government and vaccine producers need to implement new/non-egg based vaccine production technology.
- Vaccine manufacturers need to be held accountable for their estimated vaccine production.
- In the future, CDC should under-promise and over-produce, not the other way around.

Per CDC guidance, CDPHE mandated that all local public health departments enforce the priority groups- only vaccinating those in a priority group before vaccinating members of the general population. However, due to the wide variations in population between urban and rural counties, many rural counties were able to vaccinate everyone who fell into a priority group quickly, and therefore moved to vaccinating the general public much sooner than those more populated, larger counties in the state. Residents throughout the state who did not fit into a priority group were confused as to why they could be vaccinated in a neighboring county and not their own.

Recommendations:

- CDC should be more specific in defining priority groups so state and local public health departments can more easily justify the transition to vaccinating the general public.
- CDPHE should continue to enhance communications surrounding priority group issues during future events.
- CDPHE should continue to support local public health decisions on how to best meet the needs of their populations, ensuring that the highest risk are vaccinated and that vaccine is provided to as many people as possible.

CDC recalled vaccine during the outbreak due to degrading vaccine, quality, expiration dates, etc. When the public hears the word ‘recall’, they believe something is wrong; that the vaccine is dangerous. The use of the word ‘recall’ can lead to people refusing to be vaccinated due to misinformation.

Recommendations:

- CDC should never use the word ‘recall’ in association with vaccine unless there is a clear safety issue.

The varying amounts of formulations, presentations and amounts of vaccine shipped to hospitals caused logistical issues and confusion among providers. FluMist was the first vaccine presentation available for healthcare workers. In the past, healthcare workers were told that if they were vaccinated with FluMist, they could possibly transmit live virus to patients; therefore, many healthcare workers were not willing to be vaccinated with FluMist during H1N1. Many hospitals sent the FluMist presentation back without vaccinating their healthcare workers.

Recommendations:

- CDC needed to provide more specific information on FluMist and other intranasal presentations for healthcare workers.
- Directives to vaccinate healthcare workers should come out from the Federal level and not from the state, local or facility level.

The quality of the Federal vaccine supplies were adequate, however the type of supplies sent in each shipment did not always correspond to the type of vaccine shipped along with it. The type of supplies changed from shipment to shipment. Local public health departments tried to make logistical decisions based on the materials received in prior shipments, but were unable to do so because the Federal supply shipments contained inconsistent materials. Local public health departments had to backfill missing or inappropriate supplies with their own resources.

Recommendations:

- All vaccine kits should contain the same supplies throughout the response. CDC should keep vaccine materials consistent in each shipment.
- CDC should give states and locals the option to order supplies separate from the vaccine.
- All tracking numbers on vaccine shipments should be timely and correct.
- Send more yellow vaccination cards in future shipments.

Colorado has drafted several Draft Executive Orders to be implemented during a declared emergency – these orders expand public health authority to improve response. A few of these Draft Executive Orders delegate authority for vaccination to healthcare practitioners, such as EMS providers, that do not have this responsibility under their normal scope of practice. Colorado did not declare a state emergency and did not implement any of the Draft Executive Orders. CDPHE and local public health agencies agreed that vaccinator-staffing shortages could be addressed on a case-by-case basis. At no time during the outbreak were additional vaccinators requested. There are still questions at the local level about who can be given the authority to vaccinate. Local health departments are still looking for clear legal guidance from CDPHE or the Attorney General's Office on the regulations regarding liability and workman's compensation for the use of volunteers. Training and workshops addressing state/local legal issues have been provided, but locals want specific guidance signed by the AG or CDPHE's legal counsel. During H1N1, different parties read the same regulations regarding the use of EMTs in different ways.

Recommendations:

- CDPHE will continue to provide the existing legal guidelines defining what different classes (EMT-B, EMT-I, etc.) of EMT's can do under specific circumstances during a declared vs. non-declared disaster.
- CDPHE will work with legal council to determine if a Point of Dispensing (POD) can be defined as a medical facility.

<u>Medical Care and Countermeasures</u> (e.g., PPE, antivirals)

During a national event (such as a pandemic) that requires the distribution of SNS material, the Colorado Governor's Office of Homeland Security (GOHS) would like to know if Federal resources can be used to pay for the transportation and security of vaccine or other Federal assets.

Recommendations:

- Use Colorado National Guard staff, paid for by Federal funds, to increase surge capacity for law enforcement during large national events requiring the distribution of SNS assets.

A lack of consistent Federal guidance on the use of PPE caused a great deal of confusion for state and local personnel. Federal guidance on the use of N-95 respirators was not provided soon enough and varying Federal agencies (NIOSH and OSHA) provided conflicting information. Colorado disagreed with OSHA on the use of N-95 respirators and fit-testing for hospital personnel. CDC continued to send varying models and types of respirators. It is not possible to fit-test all staff on a new respirator model during the middle of an outbreak, not only due to a lack of time and staffing to do the fit testing, but because the new supplies sent from Federal stockpiles were depleted just from having to re-fit test hospital staff that were required to wear the PPE according to Federal guidance. Federal recommendations on who needs to wear the N-95 should be released earlier and the risks of not wearing an N-95 respirator in a hospital setting need to be more clearly defined. Many healthcare workers did not understand why surgical masks were acceptable for seasonal influenza, but not for H1N1. Hospitals started following guidance provided by their own infection control departments instead of referring to inconsistent Federal guidance. Healthcare workers also had a hard time wearing N-95 respirators for long periods of time.

Recommendations:

- CDC needs to ensure that states have access to full list of N-95 and other respirators that are stockpiled to ensure that personnel are fit-tested on the models that may be sent during a large-scale disease outbreak.
- States need clarification whether OSHA will penalize hospitals and other institutions that follow their states' worker protection recommendations if those recommendations conflict with NIOSH recommendations or with other federal guidance for worker safety.
- It would be preferable for PPE recommendations to come from state health departments based on Federal guidance.
- Federal research needs to focus on providing a better alternative to current N-95 respirator models – these need to be easier for healthcare workers to wear for longer periods of time. In the meantime, N-95s with the exhalation valve may be a better resource.
- Various healthcare providers, including EMS, need to enhance their current level of PPE stockpiles, including those for N-95 respirators.
- Clarify the relationship between NIOSH recommendations and OSHA safety requirements and well as interaction between federal guidance and state regulations.
- Clarify guidance for worker safety practices if official recommendations cannot be met (e.g., if the supply of N95 masks is inadequate)

CDPHE developed the state's SNS request without local input as a proactive attempt at getting access to our state allotment of PPE and antivirals before the fall H1N1 outbreak. HHS requires that all state requests for SNS resources be reviewed by the HHS director. During an emergency event, timely response is of the utmost importance and cannot be achieved with this type of top-down policy. As

a result, CDPHE did not receive an answer to our initial request for SNS assets until two months after the peak of H1N1 ended in the state of Colorado, by which time, we no longer needed additional resources.
Recommendations:
- CDPHE should develop a local advisory group that can be called upon during an emergency to obtain input from local health departments and to assist in communicating state response efforts to our local counterparts.
- HHS should change their policy for approving state requests for SNS assets during an emergency event.

Community Mitigation Measures
CDC guidance during the first phase of H1N1 was inconsistent, especially in regards to school closure.
Recommendations:
- CDC should provide consistent guidance and version control (see comments under communication section)

Hospital visitor restrictions varied from hospital to hospital. Hospitals would have liked to have these policies be consistent and recommendations come from the state. These restrictions were also difficult to enforce without state guidance. Child welfare issues were also an issue at some hospitals as some parents left their children unattended in waiting rooms if they were not allowed to visit patients.
Recommendations:
- Hospital visitor restrictions need to be more clearly communicated to the public as early as possible to ensure that children are left at home
- Hospital visitor restrictions should be consistent statewide – guidelines should be provided by CDPHE during future outbreaks.

Communication/Coordination
CDC communication during the first phase of H1N1 was overwhelming, including information sent via the Health Alert Network (HAN). Much of this information was repetitive, and revisions of past guidance were not clearly labeled. HAN recipients did not know what information was new, what had been revised and what was already sent in prior email communications. The coordination of information was massively improved from Spring to Fall, in large part because of a COHealth Google Group implemented at the state level. This was developed to ensure that healthcare workers only received H1N1 updates once a day rather than each time a Federal HAN was issued (multiple times a day during the Spring response). It was difficult for local healthcare providers and health departments to keep up with recommendations and the volume of communications issued at the Federal, state and local level.
Recommendations:
- CDC should summarize their revisions to HAN communications and guidance in bullets, clearly outlining changes made.
- CDC should post a version number on every guidance document.
- CDPHE should continue to consolidate Federal guidance for state and local partners during future large-scale events to ensure state and local partners are not overwhelmed by Federal communications and to ensure that state and local communications are also being received.

Local media often monitors and uses information directly from the CDC website without using state or local information. CDC is looked to as the ultimate authority on these large public health issues and critical state and local information can be overlooked or disregarded if CDC's messages conflict with, or don't include, key state/local talking points. In the future, state agencies need to be more proactive in summarizing Federal information and including state-specific information relevant to the current situation. Talking points should be systematically provided to all participating public information officers. The state needs to be looked to as the buffer between interpreting Federal guidance and providing consistent messaging to local communities.
Recommendations:
- CDC should include a statement in all press releases that individuals and media go to their state and/or local health department to receive specific regional and local public health information
- CDPHE should take all CDC information and translate it so that it mirrors state guidance – state and locals need to ensure that communications are consistent.

Federal agencies conducted too many conference calls on topics related to H1N1. The information provided was inconsistent and audiences were pre-selected so people were getting different information.
Recommendations:
- Reduce the number of conference calls.
- Ensure that the same information is provided on all calls – make conference call notes available to everyone by posting these notes on a public website for everyone involved in the response effort to see.
- Keep conference call times and days consistent.

Workforce, Capacity and Infrastructure Issues
Many healthcare workers expressed concern that there was limited numbers of personnel in their facilities that chose to be vaccinated against H1N1. Our hospital partners questioned whether mandating vaccination in this situation would work, as other vaccines (MMR) are mandated in order to work in a healthcare setting.

Recommendations:
- During future pandemics, the Federal government should mandate that influenza vaccination be required of all healthcare practitioners.

Maintaining public health and hospital staffing during the peak of the H1N1 outbreak was a challenge. In general, the use of volunteers at the local level was effective; however, state and local public health found that they could not use volunteer staff as effectively for fulfilling key public health roles. Individuals with an intricate knowledge of the Colorado public health system should have filled these roles internally.

Recommendations:
- The use of volunteers needs to be restricted to non-critical public health roles

Surge capacity for hospitals continues to be an issue, as hospitals do not want to divert their staff to off-site facilities. Staffing continues to be the biggest barrier to alternate care facility planning. The solution may be to surge as much as possible in the hospital where staff capacity already exists in addition to using retired medical personnel and students. In rural areas, they are encouraging people to stay at home and creating guidance to this effect. Hospital personnel also stated that credentialing continues to be an issue as well as Joint Commission issues surrounding EMTALA laws and the restricted roles of staff during an emergency.

Recommendations:
- Need to resolve the missing reference to "EMTALA" in the President's Declaration of National Emergency.
- Need to re-evaluate roles for volunteers and contractors during an emergency event, clearly defining those roles for public health staff vs. volunteers and ensuring the proper staffing is available for emergency response needs.
- Local healthcare coalitions need to look at using retired medical personnel as well as medical and nursing students for surge staffing.
- All critical players—employees and contractors—need to have VPN access established in advance. This ensures that business operations continue in the event that employees can not be in the office, e.g. poor weather conditions, sickness, etc.

All Colorado Volunteer Mobilizer (CVM) [Colorado's ESAR-VHP system] volunteers must pass a Colorado Bureau of Investigation (CBI) background check before they are allowed in the system, however, the CBI background check is limited to illegal activity conducted in the state of Colorado. Many partners were not comfortable using CVM volunteers as their criminal history outside of Colorado is unknown. This has lead to limited use and enrollment in CVM. State volunteer databases need a higher level of background checks providing national data, not just state and local information.

Recommendations:
- Conduct Federal background checks for all ESAR-VHP volunteers. This should be done by HHS – states can not afford to conduct these background checks using current funds.

<u>Incident Command and Authority Issues</u>

CDPHE did not implement a formal ICS structure in response to the H1N1 event, although many local health departments in Colorado did. Many local public health agencies in Colorado have been using ICS to conduct activities related to seasonal influenza for years now to meet state and Federal requirements. CDC also did not show any signs of formally using ICS to respond to this event. Each CDPHE program was compartmentalized based on how the CDC was organized. Local health departments use ICS now, not only because it is federally mandated, but also because the system works. ICS is not a training issue, it is a culture issue, and must be used for daily response, not just during large-scale outbreaks.

Recommendations:
- CDPHE needs to implement ICS in a more formal way
- CDC needs to use ICS and make formal ICS positions and Incident Action Plans (IAPs) available to states for review

Disaster declarations posed several state and local issues which made it apparent that public health emergencies should be classified differently. Public health emergencies tend to emerge slowly and require a longer period of response. This is why it can be difficult to determine when to declare an emergency, establish ICS, etc. There needs to be a formal response that does not trigger the full disaster declaration, but addresses public health specific issues. Since the Colorado Division of Emergency Management (DEM) cannot stand up the state emergency operations center (EOC) until the Governor declares a state emergency, Colorado needs a better process for activating the state EOC without an emergency declaration. Several counties received pressure from their partners to declare a local disaster to free up additional resources. As the case mortality rate was not unlike that of seasonal influenza, state and local health departments did not see the need to formally declare a state or local disaster.

Recommendations:
- Colorado needs to implement more flexible disaster declarations to account for public health response.
- Change current policies to enable the Colorado DEM to activate the State EOC and free up additional state and local resources without the Governor declaring an official state of emergency.
- The Federal government needs to clarify the implications of alternative types of federal emergency declarations.