

TESTIMONY OF ROB FULTON, DIRECTOR OF PUBLIC HEALTH

SAINT PAUL – RAMSEY COUNTY DEPARTMENT OF PUBLIC HEALTH, SAINT PAUL, MN

MEMBER BRIEFING: LABOR, HHS, EDUCATION SUBCOMMITTEE

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My name is Rob Fulton and I'm the director of the Saint Paul – Ramsey County Department of Public Health. Ramsey County, MN is an urban county with a population of 517,000. Saint Paul, the capitol of Minnesota is the largest of the 17 cities in the county. Ramsey County has a diverse population with the highest poverty rate of any county in Minnesota. Saint Paul – Ramsey Public Health is a full service department providing specialty clinic services for TB, STDs, family planning and women's health as well as a large family home visiting program serving 1900 families a year. Our WIC program sees 19,500 women and children each month. We also provide environmental health services, solid waste management, correctional health, and community health promotion services. We have 320 staff to provide these services and budget in excess of \$52M.

We have been planning for a pandemic since the late 1990s. Federal funding to support our planning came shortly after the 9/11/01 event and the October, 2001 anthrax event. For example we developed a department initiative in partnership with John Hopkins School of Public Health called the "Roadmap to Preparedness" in which we committed to train as many of our staff as possible in emergency management systems and their potential resource roles in a public health emergency. We have used the resources of FEMA and their training courses and training events. For example, in fulfilling our obligation under the Public Health Emergency Planning funds, we conducted an exercise simulating a mass vaccination clinic on September 29 that involved more than 450 staff and volunteers.

The investment that the federal government has made in public health emergency planning and especially in the recent Public Health Emergency Response funding has been vital assistance to us in dealing with the current situation. I can assure you that local public health is well trained and ready to be the ground troops in dealing with H1N1 pandemic.

In late April of this year, when H1N1 first reached our community, one of the biggest tasks we faced was getting accurate and timely information to our community about the threat of H1N1. We immediately began providing the mitigation information to the residents of our county on how to avoid getting sick. Wash your hands, cover your cough, and stay home if you are sick, the same messages we gave in the 1918 pandemic are still the most effective messages today.

As the H1N1 flu returned this fall, it was important that we continue these messages until we could begin to vaccinate our residents. One important aspect of this communication is how to reach the many limited English proficient members of our community. Our department along with other local public health departments initiated a service called Emergency Community Health Outreach or ECHO. This now non-profit organization produces monthly health shows on our local public television in six different languages. They also have message lines in 12 different languages and a website with information in the same 12 languages.

The second major effort was to assure that as many of the appropriate clinics in Ramsey County applied to receive H1N1 vaccine. While we have large system clinics among our 218 clinics, we also have 63 unaffiliated clinics including our three Federally Qualified Health Centers, our Health Care for the Homeless clinics, five school districts and nine colleges with health services. A number of these clinics, such as obstetrical specialties and college health services don't routinely participate in the dispensing of vaccinations and needed our help to participate in the distribution system for H1N1 vaccine.

The Minnesota Department of Health has an excellent surveillance system and we use their information in our planning and tactical operations. However, it is the local public health systems responsibility to see that accurate information is provided to at risk populations, the general public, health care clinics, our elected officials and other partner agencies both inside and outside the county. We have done this by developing a variety of community pieces and enlisting our staff and community partners to get the word out on H1N1. Our community health promotion activities also include a website that is updated as often as daily, social media such as Twitter and an H1N1 blog, messaging to our community partners, and being accessible to the media to present current and accurate information.

As H1N1 vaccine became available, to us in small amounts our local public health department took on the responsibility of seeing that emergency medical service and other first responders not attached to hospitals received vaccine. One of the dilemmas was that the initial vaccine provided to us by the state was the weakened live virus vaccine commonly called flumist. This type of vaccine has some limitation such as maximum age. We uncovered some resistance in some of the first responders to receiving live virus. We conducted six vaccination clinics using our staff in both day and evening times in the past ten days to reach first responders. We also received a small amount of injectable vaccine and, along with the remaining live virus vaccine' have distributed this to many of the unaffiliated clinics in the county this past Friday and Monday. Our focus was on getting vaccine to those clinics that served high numbers of priority vaccination groups such as pregnant women and young children.

We have also become the distributor of anti-viral drugs. Minnesota has established a flu line that can help to diagnose flu symptoms and prescribe anti-virals to those persons who can best

use them. For persons who are uninsured or for those whose health insurance does not cover prescriptions, the prescriptions are sent to our department and these people can come and get the anti-virals without cost. We are also a local stockpile of these anti-virals that we will distribute to our local clinics as they need them. Another responsibility for local public health is to be the depository and distributor of personal protective equipment such as masks and respirators. These supplies are coming from the Strategic National Stockpile that was distributed in part to the state last spring.

So how do we do all of this? We set up our Incident command system last spring and reinitiated this system four weeks ago. This is the formal system of managing emergency situations that we have trained and exercised for over the past eight years. As of today, we have 135 of our 320 employees that have been assigned some duties for this situation. The challenge for local public health is that these folks have to give up doing their regular work in order to meet the needs of the H1N1 pandemic. We are preparing to initiate our Continuity of Operation Plan and determine what services we will suspend until this situation is over. Our county has a detailed COOP plan for dealing with a flu event and we are surveying the amount of sick leave that is being used by our staff.

We do have some concerns. The delays in delivery of H1N1 vaccine are causing disruptions to our plans to vaccinate as many persons as possible as quickly as possible. We are seeing increasing number of illness and hospitalizations and still have very limited supplies of vaccine. We know that the credibility of the entire public health system is in question due to the slow arrival of H1N1 vaccine. The demand for H1N1 vaccine is high right now. If it is slow in arriving, this demand may wane. We are anticipating some 7800 doses of vaccine to focus on school children 9 and under. Yet, we have over 20,000 children in this age category in schools. Our challenge is to distribute and vaccinate in a fair manner. So, we cannot meet what will be the high demand for vaccine in children.

Another issue is the delay in the delivery of seasonal flu vaccine. While this is not an immediate problem, it could become one if we don't see adequate supplies of seasonal vaccine by early December. Minnesota is proud that we have the highest rates of seasonal flu vaccination for persons over 65 in the country, but this will be more challenging to accomplish if the delays continue.

We are anticipating that we will be in the incident command system operations well into 2010. This will have a real impact on the delivery of our other important services. For example, we are planning to move from weekly to biweekly visits in our family home visiting program. We may also be reducing the frequency of our food, beverage, and lodging inspections as these staff are called up for duties in our command structure. We are very concerned should we have another emergency event such as a large scale food borne outbreak or a tuberculosis

outbreak that requires diverting staff. Local and state funding for public health has been impacted by the poor economy and we have just eliminated 5% of our staff to meet our 2010 budget goals. Wellness funding and family home visiting funding in the health care reform legislation will be very helpful to us.

In summary, local public health in the midst of the H1N1 pandemic, finds itself wearing many different hats. Many of the jobs we are asked to do are familiar tasks, but some are not. Local public health workers are putting in long hours and deeply committed to serving our communities. We are well trained, prepared, and willing to meet the many challenges that we are facing with H1N1 flu pandemic.