

# NACCHO

National Association of County & City Health Officials

*NACCHO Annual 2009 Conference  
H1N1 Roundtable Session*

**Orlando, Florida  
July 30, 2009**

This was a moderated discussion of one hour's duration. We were able to ask six questions of the attendees about their experiences during the Spring 2009 outbreak of the H1N1 pandemic flu. These questions sparked the following conversation between the attendees.

**What were your LHD's greatest successes?**

- Southeast Idaho—We had done our plans, exercises, drills, how to activate EOC and standing that all up went very smoothly, allowed us to quickly ramp up
- Rockland County, NY: Had an established system for engaging school nurses; had ability to communicate on a daily basis; HAN worked well
- Allegan County, Southwest MI: Health Alert system worked well—maybe too well because there was an overload of information
- Sedgwick County, KS: ICS structure worked well. Been through dozens of levels of training but I couldn't have told you what a planning chief did until now. It was applied like a tabletop could never do but it really worked. There were still some gaps, but it was still helpful.
- Colorado Springs: Partnerships that we'd developed over the past few years. One simple phone call and they were all there to help.
- Oklahoma City: Developed new community partners; developed situation report that ended up going to over 100 people.
- South Central Idaho: Interim guidance often new every day. Was helpful to have those and then at the end of the day have the NACCHO-ASTHO daily call notes.
- (Speaker unknown): The 3-4 years ago doing exercises for pan flu planning was very useful. Was able to engage well with state and CDC
- Region 3 HHS regional office (Phil, PA): Opportunity to convene state and local health officers and could send information up to HHS so we knew what was going right and what not
- Cambridge, MA: Scale of H1N1 was a good-sized public health emergency that was a perfect opportunity to manage as a teaching and learning experience—learn what was not in place and what we could count on that was in place
- Carson City, NV: An SNS requesting procedure was set up with the hospital
- Rockland County, NY: Went to school superintendents to be on the same page for school closure
- Small LHD in OH: Was impressed to see changes come in a fluid way and that there was transparency in the fluid nature of the guidance. Understood that changes would be coming and that it was okay. Fluid progression of information

that worked very well. People were not upset that this wasn't what you said yesterday. The antiviral distribution worked well.

- Kent County, MI: We have been setting up an antiviral distribution center for 2 years so when antivirals from SNS came in, it was out to the community in a couple of hours.
- Indianapolis, IN: Have a scientific advisory committee from hospitals, schools, etc. and they came within 24 hours with recommendations and local guidance. Great communication with state HD on daily basis, via calls with school superintendent daily, super confident LHD staff that were incredible.

#### **What were your LHD's greatest frustrations?**

- Sedgwick, KS: ICS completely ignores politics. Needs to leave room for the experts. To say you are the IC or the operations chief doesn't preclude the county manager from demanding this. ICS has doesn't take into account need for subject matter expertise. Need to have some content expertise in chief positions (e.g. fire expertise in a fire event). Need a constant update of information. Needed one person doing nothing but monitoring for situational awareness and reading information
- Boston, MA: Didn't see H1N1 as an incident—this is months and months of work and didn't see ICS as appropriate for such an ongoing demand. Agreed the content expertise is important. Not enough emphasis of ICS structure on utilizing non-traditional partners—schools, business, etc. Didn't feel there was a lot about building community-based teams
- Fort Collins, CO: Obvious in retrospect, when came to guidance on school closures from 2007—spent a lot of time with school boards on what to do when and value of proactive school closures—things fell apart. Need measurable triggers.
- Tri-County, CO: 20<sup>th</sup> century communications for 21<sup>st</sup> century between higher ups and LHDs. Hard to keep track of which conference calls are out there and which ones I needed to be on. A problem in the heat of moment.
- Speaker unknown (again): Guidance on submission of specimens for diagnosis H1N1 were contradictory, but maybe that is because there was still so much unknown about the virus
- Gloucester, MA: (host agent for 15 cities and towns): Struggled with PPE recommendations, different than what was stockpiled, none were fit-tested—disconnect with recommendations and got conflicting guidance from the state

and CDC. Instructed to do fit tests with emergency services personnel when they weren't even recommended for N-95

- Indianapolis, IN: Recommendations to be fit-tested but how many N-95s will you have. Hospitals ran out so it didn't make practical sense. Different agencies had different recommendations—who do you follow. Vulnerable populations wanted to get their kids tested for H1N1 and wanted to get prophylactic anti-virals—couldn't afford it. Hospitals tell them to go to the health department. Doctors kept posing questions to CDC.
- Rockland County, NY: Messaging—county was in same news cycle as NYC so when NYC schools closed, locals wanted to close—variation in messaging from NYC and state. Need time for key public health messages to stick. To this day, people still think H1N1 is a death sentence and still want to get tested.

#### **How were the different levels of government helpful to you?**

- Indianapolis, IN: Media would try to play locals and states off each other; so locals and the state health commissioner agreed on joint and consistent basis for recommendations. Served us well but needed to have daily communication between state and locals to ensure messages were the same. Daily communication between states and locals was excellent. We did not coordinate messages directly with CDC – relied on state to do that. There were delays. Feds would release how many cases we had so media was calling us before we had that information. We can't look prepared if we don't find out about it first.
- Clark County (and area counties), WA: Deeper appreciation for ICS 400 coordination between states and local—we're a border county could do a better of cross jurisdictional coordination
- Utah: State talked to media daily, we didn't give the same messages—only gave information that was different and communicated that to the state. Had a daily conference call between locals and the state. State would provide an embargoed copy of info/talking points 1 hour before the call. Tried not to share information that wasn't coming from the state first. ICS worked well. Our locality has a chamber of commerce county-wide— we would correct the state report and email to every business in the county and made sure to aware them that things can change daily and had great cooperation from all the businesses
- Fort Collins, CO: Also had daily conference calls with the state. Notes from CDC/ASTHO/NACCHO calls were extremely helpful; we got more information from those notes than what we got from the state health department

### **How could different levels of government be more helpful?**

- Indianapolis, IN: A federal group or national organization should have web board for LHDs to post ideas for how we're tackling problems, questions to peers, examples of letters to schools, others; cheat sheets to post and find. We were sharing information with neighboring counties, but it would be helpful to share information on a national level.
- Sedgwick, KS: Not clear what PHER funding is for and not for, how much the state will keep or not keep; can't charge admin fee b/c giving you this money, but big moat from state about how much money trickles down; we'll get 25% if we are lucky
- MA SACCHO rep: PHER—locals are getting 32% but that's not a majority of the money. Because no concurrence is required, we are held hostage by this
- Utah—Able to get 65% to get to locals and 82% of this (PHER) money. Aiming for 80% in the next stream of funding. State is not giving one shot. Needs to be put in the guidance
- Boston: We are getting very little of that money, even though we have the most healthcare workers and are usually hardest hit in much of the country in the spring. Even though we have a good relationship with the state, we are still concerned that locals weren't consulted. Removed from relationship with the commissioner/state it's their requirements, need money for infrastructure and in absence of guidance from CDC we will be stuck with inability to do what we need to do.
- (Speaker unknown): Federal people need to help us; we need to be involved in discussions for how this money will be used from day 1 and that is not happening
- Rockland County, NY: Attended ASTHO/CDC meeting in Atlanta a few weeks ago RE: H1N1 lessons learned. Everyone at ASTHO meeting acknowledged that locals are where the rubber meets road but money is not filtered down... local, local, local but we are not at the table with enough power to commend what should be done, even though we know what is needed
- Speaker Unknown: It's a manpower issue—we do not have the workforce to this
- Bradford County, FL: Agrees with the workforce point—unrealistic to think the private sector will give one vaccine if they are going to be reimbursed but you ask LHDs to do this
- (Speaker unknown): Will want us to keep track of vaccine you give to citizens re: side effects—that's an issue; what are the strings/cables to this money?

- Rockland County, NY: CDC did say that they may have a mechanism in place if you need workforce. They can provide staff support through GSA contracts or public health service workforce avenues. This is if the LHD cannot hire someone based on their own restraints.
- Jack Herrmann, NACCHO: This is a concept that CDC is looking at; they understand ability to hire and ramp up is very challenging—one option is to use federal workforce that CDC has access to and are looking at the option of offering states and locals the option of contracting or requesting this workforce through CDC.
- Region 3 HHS Director (Phil, PA): Various agencies (FEMA) have contracts with 8 entities that include additional personnel for disasters
- Chicago, IL: Has discussed contracting with mass vaccinators—one issue with calling in a mass vaccinator is that you can only do so much. We don't have extra people laying around. They are taking the same people who are working at 3-5 different agencies. Vaccinate 160 million people in the same time period. Mass vaccinators and the health department are trying to draw staffing support from the same pool of people in the area. There aren't people sitting in the closet that aren't doing anything. They will be working. Can't bring people from other regions since they all need to vaccinate.
- Washington County, OR: Flexibility would be a good key (e.g. locals could hire staff through CDC GSA contracts or use the \$\$ to hire directly). If we could get money from the state down to locals, some counties could hire staff. I'd prefer staff than a federal person. Others would feel differently.
- Napa County, CA: PHER grant issues demonstrate problem. If it weren't for NACCHO minutes, we wouldn't know that there would be a separate round of the PHER funding. Totally separate pot of money for implementation. I can see CDC saying it's not appropriated we can't say it in public but NACCHO letting locals know that it's in the works helps us.
- South Central Idaho: We get very little info from the state. If it wasn't for NACCHO's email blast, we wouldn't have a clue of what was coming down and what it was to be used for. We have needed to get info from another state or go around our state and get it directly from CDC. We wouldn't have a clue—we don't know what the state is getting; heard 50%, but don't even know 50% of what. Hope that this money is tracked and earmarked only for H1N1—concerned that states will want to use this to fill other gaps.

- Carson City, NV: Did have conference call between states and locals and all did send in local narrative applications for how we'd spend the money. Clark County gets 70% of the money.
- Boston, MA: Everyone is watching us for this next round. We are getting set up on this. NACCHO must take a role in helping us negotiate with our state health departments. There is no one to help us and communicating the workforce shortages. We do not have the workforce. I am very concerned.

**How could NACCHO have been more helpful in the spring, or come this autumn, what would you like from NACCHO?**

- (Speaker unknown): NACCHO did a great job but want to echo need for advocacy. Highlights some long-standing issues. We are not at the table equally for decisions that are getting made. Is that because there are fewer states? That governors have more authority? It's not just the funding decisions but logistical issues. Advisory groups that are filled with state people. Summit was mostly states. Information flow – assumption that states are representing well the interests of the locals. Even though the states that mean well, it is really hard for local interests to have equal weight. Huge plea that we get better access to resources but also for local presentation during planning.
- Boston MA: Absence of data about what happened in local communities in the spring. Not sure how CDC was collecting that, but needs to share info in more granular detail. Can NACCHO broker exchange of local surveillance data and what we should be looking for in the fall. Articles in MMWR but beyond that a repository for local data that can be shared among all of us. I want to know what happened between Dallas and Ft. Worth re school closings.
- Indianapolis, IN: Need to make it clear that although the states are representing us they don't know what they don't know. Can't just be NY, Chicago, LA that can be at the table. What can work in my jurisdiction won't work in a smaller community. Need a way for NACCHO to do an analysis of what % of those PHER dollars should be coming to LHDs. Not enough to say "more." Need science-based mechanisms that shows the bare minimum that should be coming to LHDs. They are crazy if they think I can get private physicians to vaccinate without admin costs.
- Clive Brown (DGMQ): CDC works through CSTE mainly. NY, LA, SF included through that mix. Assume that each state is doing with locals what is done with states. How do we do that with locals without bypassing the state?

- (Speaker unknown): Include states and locals at the same table. For all cooperative agreements, include concurrence. Removing concurrence language from PHER was a big issue.
- Jack Herrmann, NACCHO: NACCHO has been having many locals writing in re: how this is going. Majority of LHDs writing in are on the significant percentage of what they are receiving. We are monitoring and tracking. There is a wide range of locals getting \$ (versus those who are not). In almost daily discussions with DSLR and are updating them on where these state and local.
- Tri-County, CO: Communication that is occurring from CDC to states—negotiate with CDC to get director's reports
- Region 3 HHS regional office (Phil, PA): Our office is one of the 10 regional offices. Since we are in the field, we broker what happens at the state and local level what happens to federal level; NACCHO can work more closely with HHS regional offices
- Rockland County, NY: Mechanism in place to have local representatives at each of the significant calls—just to ensure that NACCHO continues it and keeps local interests at the forefront. Doesn't have to be 3,000 people on a conference call. Can be done and shown that it can work.
- Jack Herrmann, NACCHO: Clarification on PHER funding—next installment is for implementation purposes. Budget for 2009-2010, there is language that requires matching and raised with the state and state said it would need to be matched at the local level. Match requirement for PHEP is congressionally mandated and CDC does not have the authority to change it. They are working on changing that requirement and a change takes an act of Congress. That is why the PHER was developed - it does not have a match and is a mechanism to get a bolus of money out quickly. There is mechanism at NACCHO to get local input. We did raise the concurrence issue for PHER funding. Many of workgroup members are speaking out on behalf of you on guidance documents, review of grant language, etc. Next time nominations come up for workgroups, please consider replying. They are the individuals that are first tapped. Talked with CDC about using PHER as a test of not having concurrence.
- Speaker unknown: Put concurrence language into the second round of funding.

### **How can peers be helpful to each other?**

- Sedgwick, KS: NACCHO should develop a wiki—takes no skills to read and it's easy to post—don't need to arbitrate or review. Would be really easy to post

tools that way. Also need to provide some mechanism for LHDs to post resources/tools themselves.

- Jack Herrmann, NACCHO: Communication will be a challenge. We are committed to over communicating. Understand that a deluge of information can be difficult. As we attempt to push information out, if it is not helpful to you, then just delete it. Also trying to over sample health departments to get feedback on documents and give feedback in 24 hours.