

Pandemic Planning Advice from the Trenches – Turning National Guidance into Practical Local Plans

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Introduction

Good national and provincial/state pandemic plans support the development of practical local pandemic plans. My 20+ years involvement in national and international pandemic planning has been challenged in local planning in two sharply-contrasting settings:

- a small rural county with a population of 80,000;
- a large urban Region serving 1.2 million, characterized by rapid growth and many new immigrants.

There are many routes to successful planning but common sense underlies them all. Markers of success include developing positive working relationships across diverse sectors and organizations, nailing down roles and responsibilities, and identifying practical options for a response that is integrated across the spectrum of care and between the health and non-health sectors. Suggestions and examples of successful local planning follow.

Tips for Successful Local Planning

1. Use local history to educate and motivate

It's all there in the front pages of local papers from fall 1918.

A search through local archives will illustrate:

- examples of all components of the pandemic response - still remarkably appropriate;
- the interplay of science and politics e.g. my favourite headline – *Reeve takes matter into own hands – Board of Health fails to act* (when the local mayor closed schools against public health advice);
- implications of widespread illness on societal disruption, e.g. the death of the Chinese laundryman left an entire nearby town without their clothes for weeks; 4 of the 5 Stratford police officers were ill at same time;
- cemetery records which allow creation of local epidemic curves and mortality charts as teaching tools;
- quaint quotes and graphics to enliven your presentations.

I've used examples from the 1918 experience in Stratford for many health and lay audiences. The gravestone shown here of a young Stratford couple illustrates timing and age distribution and can lead to discussion of causes of mortality in pandemics and impact of deaths in young people.



Municipal leaders tell me this approach made things real and motivated their planning. Many Ontario medical officers of health have followed my lead using their own local history to spark local interest.

2. Provide Strong Public Health Leadership

A dynamic public health physician, such as the medical officer of health (MOH), is well placed to lead or coordinate pandemic planning efforts for a region, not just for public health but for the broader health sector and non-health sector. Their leadership skills, broad knowledge and expertise in many areas add credibility and value to this complex process. The successful leader understands how clinical care is delivered, as well as public health and government in general, and keeps current with influenza and pandemic planning initiatives.

Different models and degrees of leadership can succeed. For example, in the small rural county described, the MOH has led a multi-sector health emergency coordinating committee for almost 5 years, which recently published a county-wide pandemic plan. The MOH also participates in hospital planning and visits councils to encourage municipal planning.

In the large Region, the MOH sponsored a highly successful Health Leaders Forum last fall that adopted health emergency command and communications structures and tackled pandemic roles and responsibilities. The MOH has subsequently published a health sector pandemic plan and is chairing a working group to develop influenza assessment and treatment centres. A public health physician consultant has facilitated workshops for all long term care homes in the Region and for Regional commissioners and directors.

3. Clarify Your Goals and Assumptions

Canadian planning for vaccine and antiviral priorities has demonstrated the value of having agreed-upon national goals to guide pandemic response. Similarly the latest Canadian plan has added explicit assumptions about expected impact and response to promote consistency. It's just as important to reinforce and actually apply these goals and assumptions to local planning.

An exercise at the Health Leaders Forum brought out many unrealistic and competing assumptions by health care organizations about each others' services in the pandemic. Two examples:

- the hospitals and home care services expected to "decant" many patients to long term care homes, while the latter anticipated reduced service levels due to loss of part-time staff to hospitals;
- estimates of workplace absenteeism at the peak of the pandemic ranged from <10% to >50%.

Explicitly airing these assumptions has led to genuine dialogue and cross-sector planning efforts across the full spectrum of care. For example, the long term care sector in the Region has worked through which expectations can be met, which can be met with extra resources, and which are unrealistic.

4. Who's in Charge? Who does What?

Emergency and health planners come from different worlds and it can take considerable effort to understand each other. Adapting the emergency "command and control" structure for a prolonged health emergency is not easy. Municipal or typical emergency boundaries for planning may differ from health sector planning boundaries. There are overlap areas, like natural death surge planning, for which lead responsibility must be sorted out. Specific areas where municipalities can support the health sector (e.g. providing child care for health care workers, clinic sites, security or volunteers) should be identified.

Local solutions must be developed for command and communications in a pandemic. The two regions described have taken different approaches:

- the small county plans to work with an expanded Incident Management System (IMS) that has two arms, for the health sector and for the municipal sector. The MOH will be the overall Incident Commander and the health department's communication manager will lead the communication response.
- the large Region will keep its usual Emergency Control Group (which includes the MOH). However, the MOH will head a high level Health Sector Coordinating Committee. The health department will be responsible for health content of messages and communications with the health sector.

Clinical planning, especially for community care across a large jurisdiction, is a largely uncharted area. Involving family doctors and other community practitioners, and emphasizing the continuum of care (starting with self care) helps everyone to think creatively and take a "system" view.

5. Create Added Value

There are many spin-offs to pandemic planning, especially if key approaches are taken from the outset:

- reinforce the broader picture and think generically as much as possible, e.g. develop mass vaccination and mass medication distribution plans, an adaptable crisis communication plan;
- emphasize flexibility and adaptability to many situations;
- build on the value of new working relationships and collaborations; and
- integrate pandemic and seasonal flu planning.

Some examples of integration of seasonal and pandemic planning:

- the Regional health department is revamping its flu surveillance program, so it moves smoothly between pandemic phases and delivers more useful physician alerts;
- hospital and clinic activity indicators will be tested next flu season;
- new national antiviral guidelines will be promoted to physicians (so they gain familiarity with antiviral use while improving care of seasonal flu).

6. Produce a Written Plan

Some key steps in preparing plans are as follows:

- decide what kind of plan is needed (and it may be more than one) – e.g. integrated county or regional plan, health sector plan, public health plan;
- decide if these are stand-alone documents or annexes to existing emergency plans and whether they are public documents;
- if a health sector plan is produced, clarify expectations for individual organizations; consider providing sample plans or frameworks to help smaller organizations;
- assign some staff resources and a deadline;
- involve lots of people so they understand and take ownership;
- borrow and steal shamelessly – plans, frameworks, ideas – and share your ideas in turn;
- connect regularly with provincial/state and national planning bodies to clarify issues and identify needs for guidance or direction.

7. Create Opportunities to Practice Your Plan

Formal exercises can take various forms including orientation exercises, table-top exercises, drills and full scale exercises. Developing explicit goals will focus planning and lead to most useful local results.

The small county has integrated pandemic exercises into annual pandemic planning days for health and municipal leaders and into hospital exercises performed to meet accreditation standards. For example:

- two simple scenarios lead to municipal leaders' understanding of the impact on their services and ways they could support the health sector; one outcome has been an integrated volunteer planning project;
- a four-hospital exercise, involving student travelers infected with a severe mystery respiratory disease, tested hospital ability to integrate their response with each other and with public health.

Exercises do not have to be simulated events. Real-life operations or situations (e.g. outbreaks or environmental emergencies) may be used to test parts of a pandemic plan. Some examples:

- for practice, the small health department used their new and still unfamiliar IMS structure to organize and run the annual flu campaign;
- the large Region will use seasonal flu clinics to streamline their mass vaccination protocol and expand the use of volunteers.

Conclusions

Local pandemic planning is not easy but is important and valuable. Planning leads to new relationships and opportunities. It can improve seasonal flu programs and management of outbreaks and other incidents. It has driven emergency planning in many municipalities. While pandemic planning will never be complete, there is peace of mind that comes from knowing that we have prepared as well as we can.