



PLANNING FOR A PANDEMIC

Findings and
Recommendations
from Ohio
Residents and
Stakeholders



Planning for a Pandemic: Findings and Recommendations from Ohio Residents and Stakeholders

The Ohio Pandemic Influenza Public Engagement Demonstration Project

Submitted:

By Susan Podziba & Associates and the Center for Public Health Practice at The Ohio State University's College of Public Health,
On behalf of the Ohio Department of Health,
To the Centers for Disease Control and Prevention
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This project was the result of a collaborative effort involving the following health jurisdictions...



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Executive Summary

The Ohio Department of Health (ODH) received a Pandemic Influenza Public Engagement Grant from the Centers for Disease Control and Prevention (CDC) to assist in the development of community containment plans, specifically related to non-pharmaceutical interventions that would be employed during an influenza pandemic. Ohio is one of six states in the nation that was selected to participate in this CDC Demonstration Project.

The Ohio Pandemic Influenza Public Engagement Demonstration Project sought to engage the general public and selected stakeholders in discussions about pending policy decisions related to social distancing strategies. The public engagement process was similar to those previously used by the CDC for pandemic influenza planning.

The project included two community-at-large public engagement meetings held in June 2009 in Franklin and Cuyahoga Counties, followed by stakeholder meetings in each locale about one month later. The meetings were designed with input from a Steering Committee, Jurisdictional Work Groups, Ohio Department of Health, The Ohio State University College of Public Health's Center for Public Health Practice (formerly the Office of Workforce Development), and Susan Podziba & Associates, a technical process consultant provided by CDC.

The public engagement meetings included a presentation on pandemic influenza, a context-setting scenario, facilitated small and large group discussions, and electronic polling.

For its public engagement meetings, Franklin County sought input on pending decisions related to the closure of schools, childcare facilities, and businesses such as malls and movie theaters, as well as cancellation or postponement of events such as graduations, weddings and funerals. Cuyahoga County sought to gain input related to how social distancing actions would impact faith-based communities.

In Franklin County, a series of recommendations was derived from the participant input across five themes:

- Guidelines for Social Distancing during a Pandemic;
- Education and Communication;
- Maintenance of Essential Functions and Services Provided by Schools;
- Assurance of Essential Services within the Communities; and
- Cooperation and Coordination Between Public Health and Other Community Entities.

In Cuyahoga County, a series of recommendations was derived from the participant input across four themes:

- Guidelines for Social Distancing during a Pandemic;
- Maintenance of Essential Services of Faith-Based Communities;
- Modifications for Worship Services and Life-Cycle/Special Events; and
- Cooperation and Coordination Between Public Health and the Faith-Based Community.

The recommendations are summarized below.

FRANKLIN COUNTY RECOMMENDATIONS

Guidelines for Social Distancing during a Pandemic

1. Create contingency plans that consider alternative gathering places and activities for children when schools are closed.
2. Issue recommendations that are conditional or phased in based on pandemic severity.
3. Include advice on modifications to practices as alternatives to closure or cancellation.
4. Maintain options that allow personal choices and responsibility.
5. Assure equitable services for vulnerable and isolated populations.
6. Assure equitable services across communities and populations that differ socio-economically.

Education and Communication

7. Use multiple and duplicative sources to provide education and information to the community.
8. Employ educational strategies that engage neighborhood and community-level networks.

Maintenance of Essential Functions and Services Provided by Schools

9. Work with education leaders to address concerns for interruptions to education during closures.
10. Work with providers and parents to assure that adequate childcare is available to families.
11. Work with school officials to ensure that social service needs are met during school closures.

Assurance of Essential Services within the Communities

12. Plan for essential business services to remain available.
13. Ensure that mental and behavioral health services are accessible.
14. Engage faith-based communities as providers of essential social services and emotional and spiritual support givers.

Cooperation and Coordination between Public Health and other Community Entities

15. Engage the business community in planning for business continuity, creating alternative work policies and practices for those who are ill or caring for ill family members, and as dissemination points for education.
16. Coordinate planning with other governmental entities, utilities, safety forces, and social service providers to assure they are prepared for increased demand.
17. Train and engage volunteers in response efforts.
18. Rely on stakeholder groups to disseminate information, share resources, and reinforce public health messages among populations they reach.

CUYAHOGA COUNTY RECOMMENDATIONS

Guidelines for Social Distancing during a Pandemic

1. Create guidelines not mandates.
2. Sustain separation of church and state.
3. Work with the faith-based community to develop the guidelines.
4. Include advice on closures and modifications within the guidelines.
5. Ensure implementation remains within the purview of the religious leadership.

Maintenance of Essential Services of Faith-Based Communities

6. Recognize and support continued delivery of faith-based social services that meet people's daily needs, for example, meals, food pantries, counseling, and shelter.
7. Provide specific guidance for reducing risk of infection.
8. Inform faith-based community leaders about alternatives for social services should their organizations become unable to provide them.

Modifications for Worship Services and Life-Cycle/Special Events

9. Work with the faith-based community to identify risks inherent in worship services and special events.
10. Develop tiered guidelines for modifications based on the severity of the pandemic.
11. Acknowledge and be sensitive to unique practices of different faiths.
12. Provide faith-based leadership with clear information to assist them in their decisions regarding modifications.

Cooperation and Coordination Between Public Health and the Faith-Based Community

13. Invite leaders of the faith-based community to assist in the development of the guidelines.
14. Provide religious leaders with accurate, timely information for distribution through their congregations and networks.
15. Provide education on pandemic influenza including strategies for preventing illness and flu care for oneself, family, and community members.
16. Rely on religious leaders for information regarding the impact of public health policies and guidelines within the community.
17. Consider the faith-based community as a resource for public health activities, for example, through the use of parish nurses and as sites for vaccination clinics.
18. Train individuals to serve as volunteers to assist within the community during a severe pandemic.

INTRODUCTION

The Ohio Department of Health (ODH) received a Pandemic Influenza Public Engagement Grant from the Centers for Disease Control and Prevention (CDC)¹ to support the development of community containment plans, specifically related to non-pharmaceutical interventions to be employed during an influenza pandemic.

The Ohio Pandemic Influenza Public Engagement Demonstration Project sought to engage the general public and selected stakeholders in discussions about pending policy decisions related to social distancing² strategies. Ohio is one of six states selected by CDC to participate in this national demonstration project.

The Ohio public engagement process was similar to those previously used by the Centers for Disease Control and Prevention for pandemic influenza planning. The project's purposes were to:

- Inform and assist state and local level decision-makers involved in pending values-oriented policy decisions related to non-pharmaceutical interventions (NPI) in pandemic influenza planning,
- Evaluate the effectiveness of engaging both the community-at-large and stakeholders in public health policy decisions surrounding NPI,
- Increase state and local capacity to effectively engage the public on policy choices in NPI,
- Empower citizens to participate effectively in public decision-making work regarding NPI, and
- Achieve results that enhance public trust in public health decisions regarding policy choices in NPI.

The Ohio Department of Health was the primary recipient of the cooperative agreement funding. The project period was September 30, 2008 through September 29, 2009. The Ohio State University College of Public Health's Center for Public Health Practice (formerly the Office of Workforce Development) worked with the local health jurisdictions in Franklin and Cuyahoga Counties to coordinate and implement the project. In addition to the grant, CDC also provided technical consultants for process support and neutral facilitation of the public and stakeholder meetings; in Ohio this role was filled by Susan Podziba & Associates (SP&A).

Two community-at-large public engagement meetings were held in Franklin and Cuyahoga Counties in June 2009 and were attended by approximately 116 people. Stakeholder meetings were held in each locale about one month later. The meetings were designed with input from a Steering Committee, Jurisdictional Work Groups,

¹ CDC is a component of the U.S. Department of Health and Human Services.

² Social distancing is defined as: increasing the physical space between individuals or infected populations with the aim of delaying spread of disease.

Ohio Department of Health, The Ohio State University College of Public Health's Center for Public Health Practice (CPHP), and SP&A.

For its public engagement meetings, Franklin County sought input on pending decisions related to the closure of schools, childcare facilities, and business such as malls and movie theaters, as well as cancellation or postponement of events such as graduation, weddings and funerals. Cuyahoga County sought to gain input related to how social distancing actions would impact faith-based communities.

The meetings included a presentation on pandemic influenza followed by facilitated small and large group discussions. Recommendations were prepared based on the participant input.

In Franklin County, a series of recommendations was derived from the participant input across five themes:

- Guidelines for Social Distancing during a Pandemic;
- Education and Communication;
- Maintenance of Essential Functions and Services Provided by Schools;
- Assurance of Essential Services within the Communities; and
- Cooperation and Coordination Between Public Health and Other Community Entities.

In Cuyahoga County, a series of recommendations was derived from the participant input across four themes:

- Guidelines for Social Distancing during a Pandemic;
- Maintenance of Essential Services of Faith-Based Communities;
- Modifications for Worship Services and Life-Cycle/Special Events; and
- Cooperation and Coordination Between Public Health and the Faith-Based Community.

The recommendations are presented below. They are followed by descriptions of the two communities involved in the project and the public engagement process, including its structure, planning, and implementation. The report concludes with lessons learned from the project.

RECOMMENDATIONS

FRANKLIN COUNTY RECOMMENDATIONS

Guidelines for Social Distancing during a Pandemic

1. Create contingency plans that consider alternative gathering places and activities for children when schools are closed.

Traditional alternative gathering locations such as libraries or recreation centers may be overwhelmed and informal child care systems may occur, creating concerns for the safety and wellbeing of children should schools be closed. Alternative care and entertainment activities should be pre-determined in conjunction with other community groups.

2. Issue recommendations that are conditional or phased in based on pandemic severity.

The value the public placed on personal choice and responsibility will likely impact adherence with social distancing recommendations. There was significant concern regarding economic consequences to families and businesses in the event of restrictions and closures. Parents may place their children at risk by opting to leave them alone while they work; others may take children to work, potentially disrupting the workplace or spreading the virus. Restrictive guidelines that are incremental in nature and based on the severity of the pandemic are recommended to increase compliance and minimize potential negative impacts.

3. Include advice on modifications to practices as alternatives to closure or cancellation.

Participants suggested modifications to typical practices in lieu of closures and cancellations. For instance, allowing mail order pharmacy services or drive through operations to remain active, broadcasting sporting events instead of entertaining live audiences, implementing social distancing and infection control strategies to help protect individuals that choose to participate, and increased sanitation at events were all suggested as measures that could be taken before closing events and operations entirely.

4. Maintain options that allow personal choices and responsibility.

Participants expressed a strong desire to make individual choices about social distancing as well as to take personal responsibility for preparing and responding to a pandemic. For example, some community members requested information to create a household response plan. Others offered actions that individuals and families could take to implement social distancing strategies, such as hanging a sign on the door of a home where residents are ill. There was an expressed reliance on family and neighbors for support. Furthermore, economic implications of cancelling

events such as weddings or sporting events may influence decisions about compliance with recommendations.

5. Assure equitable services for vulnerable and isolated populations.

Participants expressed concern for those in vulnerable population groups or among minority populations. Some distrust of government and vaccine safety was expressed at the community meeting, and this barrier will need to be overcome for social distancing strategies to have maximum impact. Definitive and clear interventions targeted to these individuals were urged. Engaging the leaders within the targeted populations to assure that issues are addressed across the collective public health response systems was recommended.

6. Assure equitable services across communities and populations that differ socio-economically.

Similar to a desire for equitable services for vulnerable and minority populations, the public was concerned about equity across geographic jurisdictions and socioeconomic groups. The perception was that suburbanites and “rich” people routinely get priority treatment. The respective jurisdictions should stress that the quality and timing of services and response are equal throughout the county and reach out to representatives from the communities of concern to engage them in early planning.

EXAMPLES OF PARTICIPANT COMMENTS:

- Need to provide parents solutions for kids other than electronics, - be active outside, family night, board games, card games, mental mind games, metro parks
- Unattended children/ “going where everyone else is”
- Gear decisions to prevent community spread – balance individual decision and community safety. Educate so we can decide. If it is really dangerous, public health can decide (like Level I, II, and III Snow Alert)
- Public health mandating closing of businesses takes onus away from employer
- Balance economy with need of public health – really, really think twice as impact incredibly significant
- If severe would want closures
- Begin with warning and precautions first – educate public on what to begin doing
- Why are we closing before we have to?? Individuals wear gloves and masks – no need for enforcement by public health
- Closures would impact increasing anxiety
- Closure would affect the health problem, but economic impact will be large
- Wedding – go on with just bride, groom, witnesses and clergy, party later on
- Wear gloves and masks instead of closing
- How people respond to the situation will be individual decision

- Needs to be personal decision and not dictated
- Make decision based on what is best for my family
- Not a systems responsibility, but personal responsibility – make aware
- Instead of government providing, INDIVIDUALS step in and help each other – mobilize and be resourceful and helpful to others
- Homeless – who cares for them? Many at risk everyday to become homeless
- Make certain ALL people get message – low hearing, illiterate, elderly, not able to understand, can't see. Are we doing a good job of getting the word out?

Education and Communication

7. Use multiple and duplicative sources to provide education and information to the community.

Education was suggested with high frequency as a way to limit disease, support personal responsibility, and protect individuals and families. A range of approaches is needed to reach the broadest of audiences who may have limited options; these include: radio, newspaper, cable, television, Internet, billboards, physicians' offices, churches, libraries, hospitals, and businesses. The information should reach vulnerable and diverse populations in language that is familiar to them. Messages should be direct, consistent, assuage fears, and ideally come from a credible, local source.

8. Employ educational strategies that engage neighborhood and community-level networks.

The community articulated an expectation for strong reliance on both formal and informal neighborhood groups during a pandemic. Officials should use community-level strategies and structures to deliver information regarding decisions that will impact citizens and to educate citizens.

EXAMPLES OF PARTICIPANT COMMENTS:

- Comes down to more information – wash hands, vaccine, when schools reopen
- Rural – local radio, newspaper, cable, no local TV
- Communication must be stepped up, using media. Let the community know how to help
- Make household/individual plan
- Check on neighbors – protect them with masks and hand washing
- Some communities will band together – but how?
- Neighbors helping neighbors – need to plan to work together

Maintenance of Essential Functions and Services Provided by Schools

9. Work with education leaders to address concerns for interruptions to education during closures.

There was considerable concern from both citizens-at-large and stakeholders regarding interruption to education and learning. Employing alternative educational methods to assure continuity in learning was desired, including use of cable networks, technology, and “on-demand” delivery. Equity in education for those who may not have technological capacity within the home should be addressed.

10. Work with providers and parents to assure that adequate childcare is available to families.

Both community members and stakeholders were concerned that children would be left alone at home or otherwise unsupervised if working parents were unable to identify alternate sources of childcare. While some parents would rely on extended family members to provide care; others suggested that impromptu neighborhood care arrangements would occur. Participants feared that children and youth would have access to illegal substances, engage in unhealthy practices, resort to disruptive behaviors, or be vulnerable without a safe place to go.

11. Work with school officials to ensure that social service needs are met during school closures.

Continuity in the provision of social services - such as meals, individualized care for special needs children, and after school programs – was important to participants. By working with school leaders, public health officials can assure that these needs continue to be met during a pandemic.

EXAMPLES OF PARTICIPANT COMMENTS:

- Children will miss out on learning – impacts education
- Learning and school day requirements required by law – what if affected by school closing?
- Use technology – “on demand” and local channels for child’s school work. This may help kids stay at home and engaged
- Sick kids shouldn’t be left alone at home – increased internet, kids accessing pornography, bad site
- What will we do with kids when we have to work?
- Concern – kids left at home by themselves. Safety – who is watching, kids vulnerable to sexual assault
- “Community” set up child care center (i.e. church, some moms in the neighborhood)
- Children caring for other/smaller children
- Impromptu daycares may pop up
- Possibility of neighbors sharing care of sick kids
- Teenagers – mischief, i.e. vandalism

- 70% of children won't have access to breakfast/lunch
- How would [MRDD] children receive the same care at home which school provides
- If no social services who and how can we get help? All becomes overwhelmed - where do we turn?

Assurance of Essential Services within the Communities

12. Plan for essential business services to remain available.

Maintenance of services and goods such as pharmaceuticals and food are considered essential and public health should work to assure that they remain available during a pandemic, either directly or through modified delivery mechanisms.

13. Ensure that mental and behavioral health services are accessible.

Loss of income, inadequate childcare options, caring for ill family members, and general disruption to family practices and routines are expected to create heightened anxiety during a pandemic. These new stressors could lead to depression, conflict, or family abuse. Public health practitioners should anticipate an increase in demand for mental and behavioral health services and plan collaboratively for continued provision and access to services.

14. Engage faith-based communities as providers of essential social services and emotional and spiritual support givers.

The role of faith communities as partners in providing for continuation of essential social services was acknowledged. Furthermore, the spiritual support offered by faith organizations was recognized as an important component of the recovery process.

EXAMPLES OF PARTICIPANT COMMENTS:

- We need grocery store, doctor
- Government must work with companies so don't turn off services
- Increase in mental health issues and drug use (suicide and depression)
- Increased stress/home tension
- More stress causes rise in abuse, family problems, parents forced to stay home, rise in crime
- Rise in risk of childcare abuse and neglect
- If you aren't sick and kids aren't sick, couldn't church be used as a safe place for kids?
- People look to church

Cooperation and Coordination between Public Health and other Community Entities

15. Engage the business community in planning for business continuity, creating alternative work policies and practices for those who are ill or caring for ill family members, and as dissemination points for education.

Given the great concerns regarding the potential loss of income during a pandemic, employees may bring children to work or go to work when ill. Businesses could play a key role in disease prevention by allowing employees to work from home, preserving work benefits for those unable to work, supporting childcare options, and designing alternative work practices. Businesses should also serve as educators to employees and customers. Public health officials should offer guidance so that these needs are addressed and that continuity of operation plans are in effect to minimize business consequences of a pandemic.

16. Coordinate planning with other governmental entities, utilities, safety forces, and social service providers to assure they are prepared for increased demand.

Essential services such as gas, water, and electric may be jeopardized if those who provide the service are unable to work. Additionally, residents whose incomes are compromised during a pandemic may experience a temporary inability to meet payment obligations. Safety forces and governmental entities such as food stamp or medical care providers may also experience a reduction in available workers at a time when need may be increased. Public health officials can assist these groups to prepare for the changing needs in advance of the peak outbreak.

17. Train and engage volunteers in response efforts.

Enlisting volunteers is a way to address increased demands and compensate for reductions in workforces among service providers. Advanced screening and training for volunteers are needed.

18. Rely on stakeholder groups to disseminate information, share resources, and reinforce public health messages among populations they reach.

Stakeholders readily identified actions that they could take to assist public health officials. Among the actions named were: disseminating education and information within the agencies they represent and to their external constituents and clients, linking public health to other potential partners, sharing volunteers, communicating with other service providers, filling identified gaps in response, and - as employers themselves - modeling the alternate work practices they would like other community businesses to adopt.

EXAMPLES OF PARTICIPANT COMMENTS:

- Economic – really difficult for parents/grandparents to stay home Caregivers can't work so impacts all levels of family income – if no pay can't make rent

- What if I lose my job?
- May cause other businesses to close if parents stay home
- Should burden shift to businesses to accommodate?
- Mask and gloves to be worn when at work
- Co-workers may bring sick kids to work (or attend work when they are sick themselves); lots of missed work
- Public health officials should encourage businesses to be lenient with staff
- Reimburse for unused tickets/venues
- Flu kit instructions at stores
- Could be run on grocery store, pharmacies, gas, supplies, banks, we must protect
- Medical care on wheels
- Public health work with Action for Children and Child and Family Services to address this issue and problem, be inclusive in ALL discussions
- Electric, gas, utilities, water – how will these continue?
- Train volunteers to be called upon within the community during pandemic
- Need protocols today – think through volunteer recruitment bank and roles they will play

RECOMMENDATIONS – CUYAHOGA COUNTY

Guidelines for Social Distancing during a Pandemic

1. Create guidelines not mandates.

The participants want public health officials to create guidelines for social distancing strategies. They do not want state mandates requiring closures or particular modifications to worship services, lifecycle/special events, and/or provision of social services. For a variety of reasons – spiritual, financial, sustaining of important social services, and personal liberties – a complete suspension of religious services and events will not be tolerated and is not practical.

2. Sustain separation of church and state.

Many participants blanched at even the thought of state mandated suspensions of faith-based services and events. Public health officials need to be aware of the strong public commitment to the separation of church and state and act in a manner that will be perceived as consistent with it.

3. Work with the faith-based community to develop the guidelines.

Public health officials should further engage religious leaders to develop specific guidelines related to faith-based activities and reducing transmission of influenza during a pandemic. Religious leaders' knowledge of their congregations and religious practices should be incorporated into the guidelines. In addition, a

community that knows its leaders helped develop the guidelines will be more likely adhere to them.

4. Include advice on closures and modifications within the guidelines.

Participants identified possible modifications to religious practices, but also understood that a severe pandemic could lead to the need for closures. They want clear advice regarding the conditions under which both closures and modifications should be considered and adopted.

5. Ensure implementation remains within the purview of the religious leadership.

Participants wanted their religious leaders to have decision-making authority for when and how public health guidelines affecting faith-based activities should be implemented. They said that congregants, employees, and recipients of faith-based services would be more like to accept such decisions when made by their own religious leaders.

EXAMPLES OF PARTICIPANT COMMENTS:

- The government has guidelines but church should still decide
- Church should be separate from government
- Some people won't follow guidelines anyway
- Guiding principles ONLY – Alienate people unnecessarily
- The church should decide this. Separation of church and state. Do not want to give up religious freedoms
- Public health to provide recommendations
- Can't mandate them to cancel but can tell them how to be safe
- Faith needs to work with public health to develop guidelines on what should be suspended
- Need clear guidelines from public health on what can occur
- How the message is delivered is important
- Who delivers is critical
- Understand church vs. state.
- Mistrust of government may impact public decisions
- Should recommend, not mandate that services be suspended
- Engage church leaders, explain to them the reality of the situation, help them implement the "policy"
- Doors of church will be open although public health may recommend suspending services. Give parishioners the choice

Maintenance of Essential Services of Faith-Based Communities

6. Recognize and support continued delivery of faith-based social services that meet people's daily needs, for example, meals, food pantries, counseling, and shelter.

The faith-based community provides for daily needs to the poor, elderly, homeless, and infirm. In a severe pandemic, a loss of these services will have grave consequences for those reliant on them.

7. Provide specific guidance for reducing risk of infection.

The faith-based community wants specific advice and guidance on how to protect volunteers, employees, and clients from illness even as they continue to provide essential services. For example, the guidelines may suggest alternative methods for service provision and the use of particular types of personal protective equipment.

8. Inform faith-based community leaders about alternatives for social services should their organizations become unable to provide them.

In the event of a severe pandemic, volunteers may be unable to serve the community as they are taken ill or caring for their own family members. Given that in many instances they are providing life-sustaining care, their absence could result in tragic results. Public health should work with the faith-based community to create backup plans for the provision of necessities such as food, counseling, delivery of medicines, and shelter.

EXAMPLES OF PARTICIPANT COMMENTS:

- Deliver meals. Leave at door. Don't go in
- Food issue – How to prepare can be modified and dispersing as well
- Modify delivery of social services, train people providing service on personal protections
- Counseling via phone
- Smaller childcare groups
- Integrate faith based organization into existing system to distribute goods and services
- Essential services open as long as possible
- Based on severity, you would have to limit social interactions and practices
- Limit number of people accessing these services at the same time
- How do you sustain needed services to at-risk populations during a closure?
- Keep involving shut-ins: Essential social services, activate networks.
- Food related services are necessary for survival and wouldn't be suspended. Consider developing multiple times for the availability of social services, as to limit interactions/allow for better spacing (i.e. hot meals, food pantries)

- Consider ways to deliver food to homes.
- How does the community maintain its functionality?

Modifications for Worship Services and Life-Cycle/Special Events

9. Work with the faith-based community to identify risks inherent in worship services and special events.

The faith-based communities know their practices. Public health officials understand the risks for exposure and transmission pathways. By working together, they can develop modifications that respect religious rituals while also protecting the community.

10. Develop tiered guidelines for modifications based on the severity of the pandemic.

The public understands that pandemics can occur at varying levels of severity and that things can change quickly. They asked for guidelines that present a range of social distancing strategies for various levels of risk.

11. Acknowledge and be sensitive to unique practices of different faiths.

Adherents of at least twelve different religions participated in the public engagement meetings. Participants learned of traditions and practices different from their own. They said that public health officials should work with the faith-based community to ensure that guidelines respect the variety of religious practices. Local public health officials should be in active dialogue with the faith-based leaders to gain an understanding of the different services and events that are associated with different faith groups, with a goal of generating consensus and support for public health guidelines.

12. Provide faith-based leadership with clear information to assist them in their decisions regarding modifications.

Faith-based leaders will need clear information to determine what decisions and actions are necessary at any given time. They will need a mechanism for obtaining accurate information directly from public health officials. This information also will enable them to explain the rationale for particular decisions to their communities.

EXAMPLES OF PARTICIPANT COMMENTS:

- Lifetime milestone events that take place through a faith-based organization still need to take place. Modifications to these events are OK and should be based on severity of illness
- Contingency plans should be based on level of severity of situation in both government and faith-based organizations
- Keep Sabbath, cancel mid-week services

- Private prayer allowed within sanctuary
- Lifetime events to continue but be modified
- Distancing during services? 6 ft., how do we do this?
- Provide masks to those entering service
- Virtual, TV, computer web vs. close personal contact.
- Local stations to broadcast religious services
- Online sermons and classes
- Counsel over phone
- We do call off church services for weather so it is not unreasonable to cancel due to pandemic flu
- Maintain lifecycle events
- What's important: saving lives vs. events?
- Weddings - limit size of attendance
- May need to bury for health but delay ceremony
- May have less people attend funeral services

Cooperation and Coordination Between Public Health and the Faith-Based Community

13. Invite leaders of the faith-based community to assist in the development of the guidelines.

Public health officials need to partner with faith-based organizations. Many of the participants were deeply moved by the invitation from public health officials to participate in discussions on an issue of great concern. They expressed the hope that public health departments would continue to include them in the dialogue and build on the relationships formed at the public engagement meetings.

14. Provide religious leaders with accurate, timely information for distribution through their congregations and networks.

Effective methods of communication between local public health departments and the faith-based community need to be developed and strengthened. Public health officials need to gain a better understanding of the value of the faith-based community and seek ways to integrate them as response partners.

15. Provide education on pandemic influenza including strategies for preventing illness and flu care for oneself, family, and community members.

Participants asked that information about caring for the ill during a pandemic be provided by public health officials via paper and email, as well as through training. It was suggested that training be provided for parish nurses and other medical professionals within the faith community. Public health officials should visit houses of worship to provide information to congregants face-to-face.

16. Rely on religious leaders for information regarding the impact of public health policies and guidelines within the community.

As the H1N1 situation unfolds this fall, religious leaders can help public health officials understand what is happening out in the community. As state policies and guidelines are implemented in a rapidly changing environment, public health officials may benefit from speaking with religious leaders about how policies and guidelines are affecting their communities.

17. Consider the faith-based community as a resource for public health activities, for example, through the use of parish nurses and as sites for vaccination clinics.

The faith-based community is a resource that can serve its own and the wider community. At the public engagement meeting, individuals shared ideas for distributing information, holding education days, using their houses of worship for vaccination clinics, and dispatching parish nurses to the community.

18. Train individuals to serve as volunteers to assist within the community during a severe pandemic.

Many people expressed interest in helping their communities during a crisis if they are able to do so. Local health departments should provide community members with information about how they can be trained to provide assistance during a severe pandemic.

EXAMPLES OF PARTICIPANT COMMENTS:

- Communications to all denominations, all shapes and sizes. Tough!
- Have public health set up ways to communicate and disseminate accurate information to the leaders of faith-based organizations
- Effective two way communication
- Education critical – faith groups need to think about this from spreading disease standpoint. Educate church leaders
- Offer classes on universal precautions. Educator for classes should be leadership or medical professional in church
- Would welcome local health officials coming to faith community
- Each church has different rules. Faith-based organization leadership will need to come together with public health to develop common ground on public health interventions to lower transmission
- Basic, factual information about pandemic influenza
- Guidance on preventing the spread of infection
- We need public health to provide: education/training, communication, leadership, resources, guidelines
- Public health collaboration for education and understanding
- Correct information - how do you disseminate this?

- How should houses of worship handle cases within their congregation?
- Need for training: parish nurses/nurse guilds
- Let leaders carry message to members (leaders have credibility)
- Share "pulse" of congregation with public health. What are the concerns?
- Truth vs. rumor

PUBLIC ENGAGEMENT PROCESS

Background

The Ohio Public Engagement Demonstration Project targeted two urban areas: Franklin County in central Ohio and Cuyahoga County in northeast Ohio, each with a population of over a million residents. Both have unique characteristics that impact their public health approaches, policies, and programs.

Franklin County has a minority population that is greater than 25% of its total residents. Foreign-born residents constitute over 8% of the population. Nearly 15% of the population is considered disabled. The City of Columbus has the second highest Somali population in the country. Columbus is also home to the nation's largest public university, which supports a student resident population of over 50,000. In Cuyahoga County, 34% of the population belongs to a minority group, 7% are foreign-born, and nearly 18% are disabled. Over 11% of families in both counties are at or below the poverty line.

Multiple local health jurisdictions in each of these counties worked collaboratively to accomplish the project objectives. The participating health departments in Franklin County were Columbus Public Health and Franklin County Board of Health. In Cuyahoga County the participating health departments were Cuyahoga County District Board of Health, City of Cleveland Department of Public Health, and Shaker Heights Health Department.

For its public engagement meetings, Franklin County sought input on pending decisions related to the closure of schools, childcare facilities, and businesses such as malls and movie theaters, as well as cancellation or postponement of events such as graduations, weddings and funerals. Cuyahoga County sought to gain input related to how social distancing actions would impact faith-based communities.

Structure & Roles

The Center for Public Health Practice of The Ohio State University College of Public Health (CPHP) provided overall project coordination and served as the primary interface with CDC, Susan Podziba & Associates (SP&A), Ohio Department of Health (ODH), and the contributing local health departments. CPHP worked to convene planning meetings, design the public engagement meetings, perform reporting functions, and deliver facilitator training. It also created a facilitation process guide, co-facilitated the public engagement meetings, and provided staff support during the engagement days.

The local health jurisdictions:

- Provided one point of contact for CPHP interface;

- Identified and convened appropriate jurisdictional work groups and steering committee participants;
- Contributed to overall project planning;
- Identified appropriate facilities/meeting sites;
- Determined meeting dates/times to support optimal participation by target groups;
- Identified and communicated with stakeholders and the community-at-large, assured inclusion of diverse, at-risk, and special populations;
- Designed, developed, and disseminated information and messaging appropriate for stakeholder and community groups that included diverse, at-risk, special populations;
- Identified at least four individuals from each area to participate in facilitation training and serve as facilitators for community-at-large and stakeholder meetings;
- Assured involvement of appropriate decision makers and dissemination of project findings; and
- Contributed to interim and final reports by providing unique local descriptions, experiences, outcomes, and lessons learned.

Susan Podziba & Associates, a firm specializing in public policy mediation and consensus building, provided services in conjunction with CPHP, including support for the Steering Committee and Jurisdictional Work Groups; facilitation training for the small group facilitators; process and meeting design support; facilitation for the Steering Committee, community-at-large, and stakeholder meetings; compilation of the newsprint notes from the public engagement meetings; assisting with development of the draft recommendations; and drafting the final report. In addition, the SP&A Team included a scientist skilled in preparing communications for people at various literacy levels.

Evaluation for the project was provided by the University of Nebraska Public Policy Center. It developed and administered pre- and post-surveys, performed the associated data analysis, and provided overall evaluation of the six demonstration projects collectively. (See Appendix I for Evaluation Surveys and Responses.)

Planning

The planning process for the public engagement meetings began in October 2008. It included: (1) establishing a steering committee and two jurisdictional work groupwork groups to assist with designing the public engagement meetings; (2) recruiting participants; and (3) facilitation training. The project process map at Appendix B provides a graphic illustration of the parts and flow of the project.

Steering Committee: The Steering Committee included individuals who supported the project objectives and had responsibilities for or expertise in preparedness planning at the state or local levels, and/or knowledge of the individual

communities. Its charge was to offer general guidance to the project. Members represented the Ohio Department of Health's Office of Health Preparedness and legal counsel, Centers for Disease Control and Prevention, Center for Public Health Practice, Susan Podziba & Associates, the contributing counties' health jurisdictions, and the University of Nebraska Public Policy Center.

The Steering Committee met face-to-face to kickoff the project planning and identify additional members. Additionally, it held three conference call meetings.

Jurisdictional Work Groups (JWG): A Jurisdictional Work Group was established in each county to provide detailed planning for project implementation. Prior to the public engagement meetings, each JWG developed the County's Non-Pharmaceutical Interventions focus, background information materials to present and distribute, a pandemic-outbreak scenario, questions to be posed, meeting agendas, and recruiting strategies that ensured diverse participation from the community and appropriate representation of various stakeholders. In addition to the public health jurisdiction planners, the Cuyahoga County JWG included representatives from faith-based communities, and the Franklin County JWG included representatives from schools and child care centers.

The County JWGs each met face-to-face twice, held numerous conference calls, and communicated continually via phone and e-mail. The local health agency members completed significant tasks between meetings.

(See Appendix A for a list of Steering Committee and Jurisdictional Work Group Members.)

Recruiting Participants: The JWG members recruited participants through their networks, such as faith-based and community leaders. Recruitment tools included a cover letter and a flyer with information about the purpose of the meetings.

In Franklin County, recruitment was accomplished primarily through flyers, e-mail, and listservs. Interested citizens were screened when they called to register in order to exclude those in health care professions and to assure that all demographics and census tracks were represented. Once capacity for a desired demographic was reached, a wait list was developed. Registrants received reminder phone calls the day before the event.

In Cuyahoga County, participants were recruited through local media outlets such as radio and cable television. Cover letters and flyers were distributed in-person and by mail or email to identified target organizations. In addition, flyers were placed at community venues such as libraries and recreation centers. Participants were screened to assure that a range of faith communities were represented.

At all meetings, breakfast and lunch were provided. For the Franklin County community-at-large meetings, participants were given fifty-dollar gift cards as an incentive to participate.

Facilitation Training: With partial support from independent funding sources, CPHP and SP&A provided full-day facilitation trainings in each county for public health employees, who facilitated and recorded the small group sessions at the public engagement meetings. In addition, 30-minute facilitator briefings were held just before the community-at-large and stakeholder meetings to review expectations and materials, distribute supplies, and to note any last minute changes. Following each engagement event, facilitators (and scribes, where applicable) were asked to complete a feedback form to identify what worked, what could have been improved, what was helpful, what challenges they encountered, and whether the training was helpful in preparing them to facilitate the engagement meetings.

In Franklin County, seventeen people participated in the June 3, 2009 facilitation training, and fourteen people participated in the June 4, 2009 training in Cuyahoga County. (See Appendix C for the Facilitator Overview and Training Agenda.)

Implementation

Two sets of audiences were targeted for public engagement: the community-at-large and stakeholders. Stakeholders, as opposed to the community-at-large, were defined as individuals or participants from organizations that would be directly involved in or affected by the implementation of NPI. In Franklin County, stakeholders included representatives from public schools, governmental and children's service providers, and a state legislator's office, and in Cuyahoga County, stakeholders included representatives of ministry associations, and nine different religious communities.

The community-at-large engagement meetings were held at Corporate College East in Warrensville Heights, Ohio on June 6, 2009 and at The Arts Impact Middle School in Columbus, Ohio on June 20, 2009. The stakeholder meetings were held at Cuyahoga County District Board of Health in Parma, Ohio on July 21, 2009 and at Columbus Public Health in Columbus, Ohio on July 23, 2009. A total of approximately 116 residents and 49 stakeholders participated in the community engagement meetings – 73 residents and 31 stakeholders in Franklin County and 43 residents and 18 stakeholders in Cuyahoga County.³ The participants reflected a wide range of educational and income levels as well as racial, ethnic, age, and linguistic backgrounds. (See Appendix I for additional demographic information.)

The meetings included:

³ Attendance at the public engagement meetings may have been affected by the respective ability of Franklin County and inability of Cuyahoga County to provide financial incentives.

- Presentation of factual information about pandemic influenza and a fictitious pandemic scenario to provide context;
- Small group (seven to ten participants) discussions of five questions about containment measures and response preferences;
- Gallery Viewing to review small group results;
- Large group overview discussions;
- Electronic polling questions;
- Focus group discussion of volunteer participants (six to eight individuals) to provide feedback on the meeting; and
- Presentation of the community responses (stakeholder meetings only).

(See Appendix D for the public engagement meeting agendas.)

The pandemic influenza presentation provided participants with basic information and facts essential to informed participation in the meetings. Since the meetings were held as the pandemic struck, the public had numerous questions about H1N1 and time was allotted to answer those questions. In addition, health experts were present throughout the meetings and were available to answer substantive questions that arose during small group discussions. (See Appendix E for the Pan Flu 101 Presentation Slides.)

The small group discussions were initiated with a pandemic influenza scenario. In small groups assisted by a trained facilitator, participants discussed questions concerning impacts of social distancing strategies for reducing infection rates during a pandemic influenza. (See Appendix F for the Scenario and Questions.)

Participants' comments were recorded on newsprint by the facilitators. (See Appendix G for the compiled newsprint data.) The newsprint sheets with answers to the question, "If you were to talk to public health decision makers about today's discussion, what five points would you want to make?" were posted on walls around the room. Participants were asked to move around the room for a "gallery viewing" of the answers developed in each small group.

After the gallery viewing, participants reconvened for a final plenary session during which they identified themes common across all the groups, similarities and differences among the groups' recommendations, and surprising responses.

Electronic polling focused on questions that were similar to those discussed in the small group dialogues in Cuyahoga County to ascertain quantitative collective standing on the issues. In Franklin County, questions focused on preferred and trusted sources of information and level of concern related to the pandemic. Facilitated large group discussions related to the responses followed the polling. (See Appendix H for the electronic polling questions and results.)

The meeting concluded with an explanation of the next steps for developing the recommendations, information about the follow up meetings, and how public health policymakers will use the participants' input in their pandemic influenza planning.

A small group of individuals participated in a focus group after the meeting adjourned to discuss their experiences as participants in the public engagement meeting.

The stakeholder meetings used a similar format. In addition, they included a summary presentation on the community-at-large meeting results and additional questions concerning short- and mid-term actions the stakeholders and public health official might undertake.

Final Report

This report is meant to summarize the project activities and provide recommendations for the development of community containment plans, specifically related to non-pharmaceutical interventions that would be employed during an influenza pandemic. This report will be made available to the public engagement meeting participants, public health officials in Ohio, and CDC. CDC will make the report available to state and local public health officials nationally.

CONCLUSIONS AND LESSONS LEARNED

The yearlong effort of the Ohio Pandemic Influenza Public Engagement Demonstration Project resulted in thirty-six recommendations from the public regarding Non-Pharmaceutical Interventions for reducing infection rates during a pandemic influenza – eighteen related to faith-based communities, and eighteen concerning school and daycare closures. It is expected that these recommendations will be considered and integrated into community containment plans by the Ohio Department of Health, the participating local health jurisdictions, and perhaps, through dissemination by CDC, by public health officials across the country.

In addition to the recommendations, the project also provides some lessons learned for planning and implementing public engagement processes.

First and foremost, the project affirmed that a well-planned, well-designed, and well-executed process on a topic of interest to the public, for which public officials sincerely need and seek input, will result in effective public engagement and useful advice. The meeting format, which included providing factual information and opportunities for dialogue in small groups, contributed significantly to enabling participants to share their thoughts and opinions freely.

High-level state and local public health officials attended, welcomed, and were visible throughout the meetings. This visible presence of public health leadership

demonstrated a commitment to the community. As a result, participants were assured that their recommendations would be genuinely heard and considered by key decision-makers.

The intensive involvement of local public health officials assured that the meetings were tailored to local needs and issues, even as they were focused on developing statewide recommendations. Each county chose issues important to its community containment planning and for which public engagement was essential. As a result, the local project partners displayed a high level of passion, interest, and commitment throughout the project planning, and even more importantly, during the public engagement meetings.

To ensure the desired diversity within each small group, it is best to assign individuals to small groups prior to their arrival. This proved more effective than assigning people randomly as they arrived.

Finally, the facilitation training created and left an increased capacity within state and local jurisdictions for managing future community meetings. A total of thirty-one public health employees were trained during two facilitation trainings. Virtually all reported a sense of ease in the role of facilitator and scribe, and demonstrated competence in fulfilling those roles during the public engagement meetings. Already, the newly trained facilitators have been tapped to run additional public health meetings.

The facilitation training also served as a test run of the meeting format. During the training, each participant had the opportunity to facilitate discussions of at least one public engagement meeting question. As a result, some of the questions as well as times allotted were revised after the trainings.

A great number of people contributed their time, energy, and expertise to the success of the Ohio Pandemic Influenza Public Engagement Demonstration Project with the hopes of helping public health departments respond effectively to reduce infection rates through Non-Pharmaceutical Interventions during a pandemic influenza. It is now up to public health officials to translate the public's recommendations into policy decisions. If they do so, the public will have contributed to protecting people from illness, flu complications, and death.