

EXPANDING THE PUBLIC'S ROLE IN HEALTH EMERGENCY POLICY

THE INCOMING FEDERAL LEADERSHIP can enhance the country's resilience to catastrophic health events by enabling individuals, families, and community groups to engage in a broad range of civic contributions, including individual self-protection, collective volunteer action, and communitywide deliberation of health emergency management policy.

National policy has traditionally defined the role of citizens in public health preparedness as assembling an emergency stockpile and listening to the radio or television for official instructions. But in practice, U.S. residents and civic groups have played a far greater role in disasters and epidemics. In an emergency, family, friends, coworkers, neighbors, and bystanders often conduct search and rescue and provide medical aid before police, fire, and other officials arrive on the scene. During major outbreaks of smallpox, polio, and HIV/AIDS, volunteers have helped run mass vaccination clinics and nurse homebound patients; they have supported the sick and their families with basics like grocery shopping and childcare; and they have participated in policy decisions about disease prevention, care delivery, and drug development.

Recommendations

► The Administration should work with Congress to fund public preparedness and community resilience at levels commensurate with their official status as core features of public health security.

Both the executive and legislative branches of the U.S. government have said that members of the community have key responsibilities in public health preparedness, yet federal funding does not reflect this position. The 2007 Homeland Security Presidential Directive 21, National Strategy for Public Health and Medical Preparedness (HSPD-21), named "community resilience" as one of the "four most critical components of public health and medical preparedness" along with biosurveillance, countermeasure distribution, and mass casualty care. The bipartisan-supported Pandemic and All-Hazards Preparedness Act of 2006 (PAHPA, P.L. 109-417) identified "public preparedness" as an "essential public health security capabilit[y]."

But public health preparedness dollars do not support the public's active role in health emergencies in any substantial way.

To engage the U.S. public more fully in public health preparedness, the Administration should seek to have Congress:

- Restore the Public Health Emergency Preparedness (PHEP) grant funding to its original levels. Community members require strong health departments with which to partner, and federal monies have been essential in building the core preparedness and response capacities of state and local health departments.
- Augment baseline PHEP funds with additional monies that would enable state and local health agencies to increase their public involvement activity, most notably in building partnerships with grassroots groups and local businesses and in engaging the public in health emergency policy decisions. Health agencies require dedicated staff and administrative capacity to carry out these additional labor- and time-intensive activities, and community- and faith-based organizations with limited resources need incentives to join the health emergency planning table.

► CDC should help augment state and local health departments' capacity to build partnerships with community- and faith-based organizations and local businesses.

Initial PHEP investments in risk communication have largely fostered one-way flows of mass-mediated information to the public; the next step is to build two-way channels with grassroots leaders. Working alongside health authorities, community- and faith-based organizations and local businesses can reach out to vulnerable populations, disseminate meaningful emergency health messages, and help plan the mass distribution of drugs and vaccines.

Preparedness grants to state and local health departments identify "risk communication and health information dissemination" as one of 7 priority areas. Many health agencies have used this funding stream to train designated spokespersons and hire public information officers. Simi-

larly, CDC should designate “community resilience partnerships” as one of the funded PHEP activities and provide incentives to health departments to hire the necessary personnel to interact with grassroots leaders over time. Partnerships will be unable to flourish without dedicated staff to nurture relationships.

► **CDC should enable community- and faith-based organizations, especially those who represent vulnerable populations, to collaborate more easily with health and disaster agencies.**

Neighborhood associations, faith-based communities, trade groups, fraternal organizations, ethnic centers, social service nonprofits, and other civic-minded organizations can mobilize their networks for public health preparedness aims. These diverse groups can develop their own continuity plans, represent their constituents in official health emergency planning, tap into pre-event public education and crisis communication campaigns, provide mutual aid in an emergency, and offer logistical support to professional responders.

Just as health departments must enhance their capacity to interact with grassroots leaders, so too must community- and faith-based organizations be enabled to work more closely with public health and disaster agencies. Health departments must receive sufficient funds, grant-making flexibility, and direction to allocate a meaningful portion of the PHEP dollars to grassroots organizations. Nonprofits may be unable to join the health emergency planning table if it means diverting their limited resources to an additional mission. Priority recipients of PHEP support should be nonprofit groups rooted in and representative of minority communities where social networks, cultural practices, and special needs are not well understood by mainstream organizations.

► **The Administration should urge Congress to authorize legal protections for nonprofit and business entities that act in good faith during a public health emergency.**

Nonprofit and business entities have expressed reluctance to volunteer their resources in emergency response and recovery efforts if the organization can be held liable for its good faith actions. Some state legislatures have passed legislation that provides Good Samaritan liability protection to entities, but entity protection is still less common than protections for individual volunteers. Congress should legislate a uniform federal approach to this issue and more quickly achieve a national state of legal preparedness.

Another inhibition to nonprofits and businesses participating in community public health preparedness efforts is concern over the lack of “workers’ compensation” or similar injury/illness benefits for the individual volunteers de-

ployed. This is especially a concern in the case of communicable diseases. Legal protections, thus, should address both liability and workers’ compensation concerns.

► **CDC should equip more state and local health agencies with the skills to engage the public in health emergency management policy decisions.**

Efforts to incorporate citizen input into public health preparedness policy decisions—that is, “community engagement”—have occurred but only on an ad hoc, experimental basis; these efforts have not yet been institutionalized at the state and local levels. For example, in 2005 federal health authorities piloted public deliberations among citizens-at-large and national stakeholders about the best early use of limited vaccine in an influenza pandemic and, in 2006, about potential communitywide control measures to slow the spread of flu. In September 2008, CDC awarded grants to 6 state and local health agencies for demonstration projects that engage residents in the decision-making process for pandemic flu preparedness.

To encourage more state and local health agencies to replicate these innovations, CDC should identify community engagement as a priority objective in PHEP guidance. In addition, CDC should provide technical guidance and promote peer-to-peer mentoring between health departments that are more novice and those that are expert in public involvement techniques. The benefits of community engagement include fostering greater trust between the public and officials, incorporating local knowledge that ultimately improves plans, having policy decisions reflect public views and preferences, and building up a political constituency that ensures follow-through on policy decisions.

► **The Administration should increase volunteer opportunities for Americans to protect the health, safety, and security of their hometowns.**

In the wake of the September 11 attacks and the resulting groundswell of volunteerism, the federal government established the Citizen Corps (CC). But despite the initial fanfare, support for this initiative has remained modest. The Medical Reserve Corps (MRC) program in HHS and the Community Emergency Response Teams (CERT) program under DHS/FEMA are 2 of the CC partner programs that have strongly been engaged in hometown security. MRC units are made up of volunteer physicians, nurses, epidemiologists, veterinarians, and other health professionals, as well as non-medically trained personnel. They augment an area’s response to a health emergency and promote improvement of the public’s health on a routine basis through activities such as health fairs, immunization campaigns, and disease screenings. CERT members learn about

disaster preparedness; train in basic skills such as fire safety, first aid, and search and rescue; and stand ready to act in their locality.

To create more opportunities for U.S. residents to protect the health, safety, and security of their hometowns, the Administration should urge Congress to pass authorizing legislation for the Citizen Corps and to appropriate sufficient funds to enable more states and localities to set up and maintain fully functional Citizen Corps Councils (CCCs), MRC units, and CERT teams. Mature CCCs depend on dedicated coordinators to help engage the public in disaster management policy and to coordinate disaster-related volunteer programs.

If public preparedness for a health emergency is ever to become something more than a motto, then the icon of

the stockpiled basement needs to be demoted. In its place can be the town hall meeting or the neighborhood association blog where top health emergency questions are debated, such as who will care for large numbers of sick people when hospitals are overburdened. Another image is a council of nonprofit and business leaders who work alongside local authorities to plan the mass distribution of antibiotics or emergency health information. Federal leadership and financial support can help realize these and other meaningful visions of public preparedness throughout the U.S.

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