The Role of Public-Private Partnerships in Mass Prophylaxis Campaigns

By Tom Russo, MA, CEM, Director, Emergency Preparedness, South Carolina Department of Health and Environmental Control Region 6

The hallmark of the 2009 H1N1 Pandemic was the dependence on the private sector to assist public health with both the logistics of vaccine distribution and access to priority groups for its vaccination campaign. The irony was that federal planning guidance, during the formative years of public health preparedness, directed state and local departments of health (DOH) to focus on public health operated mass vaccination clinics and assume responsibility for vaccine distribution.

Much of this guidance dated back to the 20th century, so it caught public health planners by surprise when a "blended" model was rolled out by the Centers for Disease Control and Prevention (CDC). The blended model was defined as a mix of DOH-operated mass vaccination clinics supplemented with physician practices that could reach at-risk priority groups and protect them against the H1N1 novel virus.

The most prominent role the private sector assumed was that of logistics. In the days following the World Health Organization's announcement in April 2009 that H1N1 had reached pandemic proportions, the CDC learned from its conferences with state DOH that the logistics function of vaccine storage and distribution in most states had been disassembled as a result of budget cuts in the 1990s. Thus, CDC had to find a way to get the vaccine from manufacturer to medical providers without the benefit of a state-driven logistics infrastructure. Given a declared public health emergency, HHS/CDC had to act and construct an alternative distribution and administration infrastructure to replace a system that had eroded over two decades.

Creation of Centralized Distribution Depots

This led CDC to reach into its toolkit and look to its partnership with McKesson Medical Specialties, whose core competency was centralized distribution. McKesson was already known to CDC, since it had managed vaccine distribution for the CDC's Vaccines for Children (VFC) program – but on a much smaller scale. McKesson responded by proposing that centralized distribution depots be set up to receive vaccine from manufacturers, package, and ship vaccine from those locations to medical providers.

Consequently, the Department of Health and Human Services (HHS) contracted with McKesson to distribute vaccine to 90,000 registered providers. In six weeks, McKesson had four depots set up and running. H1N1 vaccine was ordered from five different manufacturers, four of which were offshore, and shipped to one of the four McKesson depots strategically located around the country. From each depot, vaccine orders were filled, packaged, and shipped to both private and public providers.

The ability of McKesson to scale up and accommodate vaccine distribution was impressive, considering that initially orders for vaccine were estimated at 220 million doses. Thus, the logistics function of vaccine distribution was contracted out to McKesson, a private sector entity, redefining the public private relationship for public health emergencies.

The private sector was also engaged for vaccine administration by not only medical providers, but also chain pharmacies and big box in-store clinics, to reach priority groups as mentioned previously. Priority groups included pregnant women and children 18 years of age and younger. Public health's role was to "qualify" each provider. Providers agreed to serve CDC priority groups as a condition of receiving H1N1 vaccine. Thousands of memorandums of agreements were processed to network private sector providers into a mass vaccination public-private infrastructure with the local and state DOH, CDC and McKesson.

Challenge to all Jurisdictions to Meet HHS Goal

Roll forward to 2011, when HHS/CDC challenged all jurisdictions to expand mass prophylaxis plans to meet the HHS goal. These plans must be capable of dispensing operations that can reach 100 percent of the jurisdiction's population in 48 hours in the event of a declared public health emergency that requires dispensing medications.

Originally, the Cities Readiness Initiative (CRI), a biosecurity project for major metropolitan cities, had to develop these plans to meet the HHS goal as a grant deliverable. But project scope was expanded to incorporate all CDC grantees. Public health's non-CRI projects were now expected to meet the goal.

As a result, jurisdictions found themselves exploring alternative options in terms of staffing and facilities to meet the HHS goal. The success of the 2009 H1N1 Pandemic and its partnership with the private sector provides a base of experience and points to recruitment of local private sector entities in dispensing operations.

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Lessons Learned the Hard Way – and Why Is That?

By Frank J. Kriz, MS, CEM, CPM, PEM, Consultant, Lighthouse Readiness Group, Indianapolis, Ind.

What an appropriate question. As I sat and reflected on this topic, I was able to come up with many examples of incidents and/or exercises where an almost identical issue came up over and over again.

- How many after action reports and improvement plans do we have to do, before we as individual organizations, states or nations, realize that many communications problems identified hundreds of times still exist and have never been corrected?
- How many people must suffer needlessly, when an incident occurs that is almost a carbon copy of an exercise that we recently held – but had yet to implement actions to mitigate identified shortfalls?
- How many times do we plan for the worst case scenario, only to realize that we dramatically underestimated nature and/or man's capabilities to far exceed our abilities to envision a worst case scenario?

Suffice it to say that more than likely everyone who reads this article can probably add to this list many times over.

Wasting a Valuable Opportunity

So when I looked at the topic for this issue of the *IAEM Bulletin*, I have to ask myself why we have to have "Lessons Learned the Hard Way" in the first place. To me, learning the hard way means that the issue has been previously identified at least somewhere. Yet we had not addressed and/or resolved it before it landed in our lap. If we merely read the articles here or from other sources, and then do not apply them to our particular setting, then we as authors and you as readers have wasted a valuable opportunity.

I don't want you to misunderstand. There will be issues that arise that could not be foreseen or planned for – and from those, we hopefully learn a lesson. Where the rub comes in, is when we are already aware of a potential problem or issue and fail to act with due diligence.

Reasons Given About Why Things Can't Be Corrected

I also understand that there can be a myriad of reasons why things can't be corrected. I am sure that we have all heard hundreds of reasons, often starting with statements such as:

- That couldn't happen here.
- The cost to correct it is far more than the benefit of not correcting it.
- We don't have the funds.
- Risk management (basically betting against the house).

The list can go on and on, but the bottom line is that – for whatever reason – we (personally) or others (collectively) have not acted on a pre-identified issue that has now become a full-blown problem.

How Do We Avoid Lessons Learned the Hard Way?

1. The first and probably the most important way is to be sure that we as professionals stay abreast of what is going on in the world. Some examples are:

- For those of us who have to deal with nuclear power plants in earthquake zones, let's be sure that we see what went wrong in Japan.
- For those of us who have not yet developed a community-wide evacuation plan, because we just can't envision an event that could cause the need for such evacuation, just do it.
- For those of us in many metropolitan areas, let's come to the realization that, although we may never have experienced a tornado in our downtown area, that doesn't mean it can't happen.

2. For others, it's taking the time to sit down and review the after action reports and/or improvement plans from exercises and events within your community. Identify the shortfalls, and confirm that not only have they been fixed, but also that they have been retested either through exercising or actual events.

3. It might be assembling a list of identified issues and working with the community to address them, even in these tough economic times. If items receive pushback, look at how you might solicit community support and collaboration to let your elected officials know that there is solid support and interest in addressing the items.

I realize that there will always be "Lessons Learned the Hard Way" somewhere. Let's just try our best to make sure they are not in our community on our watch.

Role of Public-Private Partnerships

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A survey of retail executives revealed a willingness by those executives to support public health emergencies. Public health represents 3,036 local and tribal departments of health. In contrast, Walgreens reports 7,100 pharmacies, and CVS boasts another 3,000 pharmacies, most of which give flu shots. This illustrates the scalability and power of the private sector to assist with a public health emergency. With diminishing resources, public health must continue to explore and nurture these public-private partnerships to support emergencies where mass prophylaxis is the mitigation strategy.