

EMS and Clinics H1N1 Preparedness Surveys

A. **Purpose:** To determine the levels of preparedness of Oregon's medical clinics and EMS transport agencies for a H1N1 pandemic

B. **Background:** During the height of the H1N1 2nd wave response in October 2009, the Public Health Division's Agency Operations Center (AOC) Healthcare Planning Unit requested that a survey be developed to determine both the planning/preparedness levels of the clinics and EMS agencies and a SitStat survey to determine the impact of the pandemic on these organizations. Surveys were developed based on input from clinic and EMS administrators. Support was provided by the Oregon Medical Association (OMA) and Oregon Medical Group Management Administrator (OMGMA) for the clinic surveys and by the Oregon Fire Medical Administrators' Association (OFMAA) and Oregon State Ambulance Association (OSAA) for the EMS surveys¹. Each of these organizations signed a letter to their respective members (along with Dr. Melvin Kohn, Public Health Division Director) asking that the surveys be completed. Surveys were posted in November on Survey Monkey, concurrent with letters to clinics and EMS agencies. These letters and electronic copies of the surveys were forwarded to membership of the respective agencies via those agencies' list serves, a total of 671 medical clinics and 57 EMS agencies. By early December, approximately five EMS surveys and eight clinic surveys (exact figures not available) had been completed. Given the poor response, the preparedness survey was resubmitted to the same agencies in January 2010. This resulted in an improved, although still low, response from 46 clinics and 32 EMS agencies.

C. Clinic Preparedness Survey:

1. The survey was sent to 671 clinics on the Oregon Medical Association list serve. This compares to 1,200 Oregon primary care clinics alone sent another survey approximately 2 years ago by Department of Human Services.
2. Responses were received from 46 clinics, or a response rate of 6.9%.
3. The survey consists of 25 *yes/no* questions that can be divided into three categories: (a) staff (b) patient and (3) operations-related questions.
4. Summary analysis:
 - a. Staff-related questions: Responding clinics (90% or more) stated that they had considered:
 1. Short and long term implications of reduced staffing,
 2. Human Resource-issued policy relating to reduced staffing,
 3. Guidance to staff if they became sick or are exposed to H1N1.

¹ All surveys are confidential

b. Patient-related questions:

- 95% of respondents provide staff with talking points if a patient calls in with Influenza-Like Illness (ILI) symptoms.
- Only 67% of respondents provide their front office staff with talking points if a person calls in who is asymptomatic but has household exposure to influenza.
- 94% of respondents provide masks, hand sanitizers or gloves to their patients.
- Only 68% of respondents have a recall policy for vulnerable or target groups as vaccine becomes available.

c. Operations-related questions:

- 75% provide at least some employees with remote access to patient and staff information.
- 87% have considered how to deliver flu shots to their patients other than through routine appointments.
- 87% have also thought about how to modify intake procedures to limit contact with potential H1N1 patients.
- 85% of respondents have established working relationships with their local health departments.
- 41% of respondents have not developed an emergency administrative packet.
- While 93% of respondents reported they were aware of changes in visitation policies at local hospitals, 37% had not informed their patients of these visitation policy changes.

D. EMS & Transport Preparedness Survey:

1. The survey was sent to 57 EMS agencies (40 in the Oregon Fire Medical Administrators' Association and 17 in the Oregon State Ambulance Association). The response rate (32 of 57) was 56%.
2. The survey consisted of 11 primary questions, of which 9 were *yes/no* and 2 had several subsections with additional *yes/no* responses. Questions can be divided into the following: (a) plans/planning (b) Vaccination (c) PPE and (d) operations.
3. Summary analysis:
 - a. Plans-related questions:
 - 28% (9 of the 32) of respondents do not have an emergency response plan.
 - Of those 9 stating they have no emergency response plan, 4 (44%) state it was because of funding, 6 (67%) stated they did not have the

personnel to write the plan and 5 (56%) stated they lacked the expertise to write a plan.

- b. Vaccination: 96% of respondents (31) state they encourage seasonal and H1N1 vaccination for their staff.
- c. PPE:
 - 72% stated they are building up PPE inventory.
 - 78% have thought about increasing PPE inventory (though it is unclear how many of this group is included in the “yes” column that is building up inventory).
- d. Operations:
 - 55% (17) responding agencies do not have an agreement in place to alter dispatch/PSAP protocols in the event of a pandemic.
 - 31% (10) responding agencies do not have the ability to implement an internal policy for prioritizing unrelated calls from multiple patients /patient scenes.

E. Survey limitations:

4. **General**: Survey responses were anonymous. Therefore, we are unable to generalize results based on any characteristics of respondents.

5. Clinic Survey

- a. There was no method of defining clinic type, whether primary care or specialty.
- b. Survey went only to members of Oregon Medical Association (671 clinics).

6. EMS Survey

- a. Member organizations of the OFMAA are a mix of transport and non-transport organizations. Several of the questions would have applied only to transporters. We do not know the mix of transport and non-transport that responded, thus possibly skewing the results.
- b. Responses were received from 32 agencies, or 56% of the 57. This should be taken in the context of the fact that there are a total of 148 licensed transport agencies. If 148 were the denominator, the response rate would be about 22%.

F. Conclusions & Recommendations: While there are substantial limitations to the survey results, including a low response rate, these data do provide some valuable insights that lead to recommendations for the future:

1. Clinic Preparedness:

a. Conclusions:

- 1) Responding clinics have, in general (1) planned for staffing issues relating to H1N1 (2) been proactive in providing patients with information on ILI symptoms (3) provided patients with PPE (gloves, masks, hand sanitizers) when in the office.
- 2) Clinics have been less successful (1) in providing asymptomatic patient callers with information on household exposure (2) in notifying vulnerable or target groups of vaccine availability and (3) on operational issues, pursuing development of emergency administrative packets and notifying patients and/or their families of hospital H1N1 visitation policies in the community.

b. Recommendations:

- 1) That the OMGMA and OMA share results of the survey with their members so that results can be reviewed and gaps addressed in the individual clinic planning process in anticipation of the next potential wave of pandemic H1N1.
- 2) That all clinics, and especially Primary Care Clinics, also consider using, or adapting elements of, the attached *Abbreviated Pandemic Influenza Plan Template for Primary Care Provider Offices* developed for the CDC. Those clinics just starting the planning process should find the document useful.

2. EMS Preparedness

a. Conclusions:

- 1) A significant planning gap exists with 28% of EMS transport agencies lacking emergency response plans. This gap is attributed to lack of funding, personnel or training.
- 2) Important operational issues exist when (a) 55% of respondents state that they do not have an agreement in place to alter dispatch/PSAP protocols in the event of a pandemic and that (b) 31% do not have the ability to implement an internal policy for prioritizing unrelated calls from multiple patients/scenes.

b. Recommendations:

- 1) That the OFMAA, OSAA and State EMS and Trauma Systems share results of the survey with state EMS agencies so that results can be

reviewed and gaps addressed in the individual agency planning process in anticipation of the next potential wave of H1N1.

- 2) As an *interim measure*, that those transport agencies without a plan consider using the framework provided by one of several plans developed by other states. One such plan is by Minnesota and is attached. Additional guidance may also be found at :
http://www.cdc.gov/h1n1flu/guidance_ems.htm#e (Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients with Confirmed or Suspected Swine-Origin Influenza A (H1N1) Infection.
- 3) As a *long term solution* that the State EMS and Trauma Systems office, working in partnership with the OFMAA and OSAA, develop an EMS Emergency Planning Template available to all transport agencies throughout the state.

Submitted by

A handwritten signature in black ink, appearing to read "Allan Visnick". The signature is stylized and includes a large, sweeping flourish at the end.

Allan Visnick, MBA, COL (USAR-Ret)
Public Health Emergency Preparedness
Department of Human Services
State of Oregon
800 NE Oregon St., Suite 465B
Portland, OR 97232
Direct & Cell: 503-572-7658
allan.d.visnick@state.or.us
FAX: 971-673-1307/1309