

Wisconsin Hospital Association H1N1 Debriefing Session

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Background	
<p>Wisconsin hospitals and care providers have been immersed in activities related to H1N1 treatment and prevention. Hospitals have worked closely with the state and their local public health departments to ensure a coordinated statewide response. The purpose of the debriefing meeting was to determine what worked well and what lessons can be learned that can improve future responses to the threat of pandemic disease.</p>	
Strengths	Weaknesses
Communication	Communication
<ul style="list-style-type: none">• Communication from DHS/WI Public Health was consistent statewide.	<ul style="list-style-type: none">• There were gaps in communication between hospitals and local public health departments, especially as it related to the distribution of vaccine and whether the local public health department was adhering to the CDC recommendations re: target populations for vaccination.• Related to the above, but also in other instances, hospitals received different messages and interpretations on recommended protocols from their local public health departments. Local health department messages represented one county but many hospitals and especially healthcare systems cross many counties and thus providers were receiving multiple messages.• It is difficult for healthcare systems to do planning since there are so many different local health department jurisdictions involved, e.g. some health care systems may serve 20 or more counties.• Communication was complex by its very nature, but the state public messaging should have augmented local public health communications to ensure there was a consistent message statewide to the public.

- Better coordination and communication needed among various levels of government, especially between State Public Health and Local Public Health Departments.
- Hospitals reported that local health departments did not have public health messages to help hospitals deal with surge. It is not clear who is responsible for communicating with the public regarding H1N1 issues related to healthcare, e.g. advice on how best to use the healthcare system so as not to surge hospitals and physician offices.
- Some hospitals reported that local health departments were unresponsive to their request to get messages out to the media to help control surge at hospitals and clinics. Should hospitals and clinics have their own public messaging campaign in the future? Tools to help direct patients with flu-like illness toward more appropriate healthcare utilization were mounted on pandemic.wisconsin.gov, but may not sufficiently have been brought to hospital/health system/local public health attention.
- DPH needs to strengthen communications and operations with border state health departments. Providers serve patients in border states and have clinics in border states. There were often conflicting messages and practices coming to providers who serve multiple states.
- Surveillance from the state appeared to be “looking through the rear view mirror” rather than looking forward. Healthcare stakeholders may have benefited from more detailed and real-time access to surveillance information like that Aurora derived from BioSense.
- State Daily (and later Weekly) Situation Reports provided information that was very generic and not very useful. Web casts were excellent.
- State stated that it did not consider it practical to absolutely enforce all guidance down to the local level based on recognized variation in local capacity and vaccine supply.

	<p>Some providers stated all state messages are considered as “hard” guidance by providers, while others said that some guidance was disregarded (for cause) by healthcare providers. DPH should define consequences to health departments and providers of not following state guidance.</p> <ul style="list-style-type: none"> • Communication liaison is needed between WHA and DHS. Early on, Lisa Pentony worked between the two organizations effectively, but when she was transferred to another position, the communications were lost. This loss became particularly difficult as it relates to two issues: <ul style="list-style-type: none"> ○ Web site. DHS pandemic flu Web site must be able to serve both providers and the public. If it doesn’t, both of these audiences move to different resources that provide information even if it does not align with Wisconsin’s response or approach. If hospitals do not see DHS Web site as the primary education/communication resource, they build their own and divert attention away from DHS. Clinically, if they do not receive the information they need from DHS, they turn to other sources, including professional organizations, which deepens confusion. ○ Benefit for the uninsured. Better communication was necessary between DHS and WHA on this as hospitals were unsure when the benefit would be available, if they were on the list, and how patients would know if they qualified for it.
<p>Organization/Preparedness/Infrastructure</p>	<p>Organization/Preparedness/Infrastructure</p>
<ul style="list-style-type: none"> • State took the lead, was accountable and local health departments could leverage the work of the State Health Department in their local communities • WHA regional meetings early in the process helped organize local and state response and provided a forum for delivering consistent, accurate messages. Region meeting sent a strong message to providers that WHA and DHS were working 	<ul style="list-style-type: none"> • Relationships between some local and state public health departments are not well established. It varies from county to county, with providers often caught in the middle because their service territories include multiple municipalities and counties. [I would say that State-Local Health Dept. relationships are strong and clear, but that Local Health – Provider relationships are not. This can result in the two

<p>together to ensure they had the resources they needed to respond. Gave them multiple points of contact at WHA and within the State Health Department.</p> <ul style="list-style-type: none"> • Wisconsin clearly had a strong foundation due to collaboration among all providers, state, local public health departments. Playing field was level, all prepared for the pandemic using the same plan and developed an infrastructure that helped reduce anxiety. • The Hospital Preparedness Program reached out to hospitals and did not wait for hospitals to contact the program; Director of HPP offered assistance, was accessible and was a direct link back to DHS/State Health Department for hospitals on multiple issues. • The infrastructure that was developed through the work of the State Expert Panels brought strength to the DHS-hospital relationship. • Incident command structure really works at both state health department and in hospitals. • The hospitals have a strong response infrastructure that has been built but the response infrastructure in many ambulatory clinics is weak. • Hospital PPE Stockpile was able to meet all requests for PPE from not only hospitals but also other healthcare facilities. 	<p>sectors diverging in individual communities.</p> <ul style="list-style-type: none"> • State Health Department found it difficult to communicate with clinics and physicians. Medical Society was not as centrally engaged or as able to reach physicians as WHA was with hospitals. Better communication between State public health and physicians is needed.
<p>Response</p> <ul style="list-style-type: none"> • Services like telenurse and 2-1-1 helped field calls and kept resources free for other needs. • People were available within their organizations and were responsive. Masks, anti-virals were available through the stockpile. Hospitals shared limited resources and rapidly responded to one another's calls for assistance. • Hospitals had surge plans in place and were able to handle patients. The real surge was at the clinics and they were not prepared to handle the influx of patients and calls. 	<p>Response</p> <ul style="list-style-type: none"> • Clinics saw a surge in activity but did not have well-developed plans in place to handle it. There is a gap in their preparedness efforts with the focus being hospitals, but clinics present a challenge that should be addressed. There is no funding for clinics, which are the front-lines in most infectious disease outbreaks. • Long term care facilities do not have strong emergency response plans. They were sending suspected h1N1 patients to hospitals. EMS, similar situation. Gaps exist in their responses.

	<ul style="list-style-type: none"> • The variation in response (especially vaccine administration) between and among counties confused the public. • Outpatient emergency response plan is not as strong as hospital preparedness effort. • Isolation guidance, protective equipment guidelines and visitor restrictions varied among WIS and its border states. For health systems that straddle or work across borders, this proved challenging.
<p>Vaccine/Immunization Clinics</p>	<p>Vaccine/Immunization Clinics</p>
<p>Private providers were consistent in how they handled the limited supply of vaccine. They cooperated with State Health Department to move vaccine where it was needed most. (It was stated by the few organizations in the room, but we cannot know that this reflects all hospitals and other providers.</p>	<ul style="list-style-type: none"> • Public immunization clinics were scheduled and some were carried out before those on target list received vaccine, but these soon ran afoul of unplanned vaccine supply shortages. Some school immunization clinics started (then were stopped) before health care workers were vaccinated. • Public health vaccinating high risk patients---Aren't hospitals and clinics in a better position to immunize these patients, but did not have vaccine? Counter-position was stated that unless providers mount high-throughput vaccination clinics it would take a long time to vaccinate patients by appointment. Question remains on appropriate role for hospitals and clinics regarding who is in best position to provide mass vaccinations. • Early on, health systems that received vaccine at a single site for providers in many counties failed to be recognized by DHS as requiring higher volume of vaccine (i.e., they were considered in a single county's allocation.] WHA provided DHS with a list of health care systems, but systems were not provided any more vaccine than single hospitals. Systems are hubs for vaccine distribution to not just their hospitals but to clinics as well, and across multiple counties. DHS should be aware how systems distribute vaccine. • More transparency is needed in the vaccine distribution, how much is there and where is it going? Some counties met their

	<p>priorities much faster than others. It is important that once the vaccine priorities are set, all counties and all providers adhere to those priorities.</p> <ul style="list-style-type: none"> • Concern was expressed that significant funding was made available to health departments (PHER) but no dollars were made available to providers.
Tracking	Tracking
<ul style="list-style-type: none"> • WITRAC was very helpful as 100 percent of the hospitals used it. Aurora also reported their cases on BioSense, which Dr. Foldy said is useful in comparing what is happening in WIS with other parts of the country. DHS received automated real-time information from Wisconsin Health Info Exchange in Milwaukee area. The hope is to have more information from hospitals and clinics without manual reporting in the. 	
Next Steps	
<p>All group participants review the strengths/weaknesses and provide comments . WHEPP is hosting “after action” conferences in May in Wausau and Madison. Grants will be available for hospitals to write up and share their after action assessments.</p>	
Participants in WHA Debriefing Session	
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