

NATIONAL HEALTHCARE PREPAREDNESS EVALUATION PRESENTATION SUMMARY

Dr. Richard Niska, MD

Measuring Performance From the Ground Up

Wednesday, July 22, 2009

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**About The Speaker-** Dr. Niska is a medical officer with the Centers for Disease Control (CDC). Dr. Niska is currently assigned to CDC at the National Center for Health Statistics.

A) Discussion Topics/Presentation Points:

- Have office -based physicians been trained? Preparedness for bio, chemical and radiological terrorism became a priority after the anthrax scare in 01.
- The National Ambulatory Medical Care Survey's objective was to study the associations between terrorism preparedness training and physician demographic and practice characteristics.
- The survey methods included:
  1. A multistage random sampling design.
  2. Almost 4,000 non-Federal office-based physicians.
  3. Face-to face interaction between physician and an interviewer
  4. Data were weighted by inverse selection probability.
- Results/Key Findings/ Conclusions of survey:
  1. Anthrax and smallpox were the areas that physicians had the most training/knowledge of.
  2. Most office-based physicians were not trained for weaponizable biological, chemical or radiological exposures.
  3. Some improvements for family physicians were made since 2001.
  4. Primary care and medical specialists are more likely than surgeons to be trained for terrorism-related exposures.
  5. Middle-aged physicians are less likely to be trained than young physicians.
  6. Physicians involved in managed care are more likely to be trained than those not involved.
  7. This study was the first to address physician training comprehensively since September 11, 2001.
  8. Terrorism response training is transferable to management of epidemics, chemical mishaps, and radiological emergencies.
  9. Limitation of the survey is that the data are self- reported, so there is some room for error.
  10. The survey does not include an assessment of training quality.

B) Question and Answer Session: Open to all participants

1. Q: If you are seeing a break in the doctors aged 50-60 years old who are not trained in these areas about how to recognize these events, how can we count on these same doctors on the frontlines to recognize these diseases and problems? What does that mean for us and what does that tell us? R (Niska): I think it is about the doctor's motivation. We have to get the message out that doctors need to get this emergency preparedness training and use it in their daily practice. There is also a low perceived risk about these things. For example we saw that many docs did not get their smallpox vaccine because they didn't think they were going to see it or be deployed.
2. Q: Did the surveyors ask if the respondents had any training or current training? It was training since 2001, could you link the training to competencies for providing services? Were ER doctors excluded from the survey and do you know the level of training for ER docs? R: This was for practice -based doctors only so we didn't look at ER docs.
3. We are trying to be more precise and procedural in the training we provide to hospital staff that may need to be prepared for something like this. How do we standardize training

and education materials? R: There is a lot of terrorism training response information out there now, so I would look at that and then decide what to distribute.

4. I had a question about the data collection from the CDC side. Do you compare those doctors side- by- side to see what is being asked on the CDC side and the public health side? Has anybody done any time studies on how long it takes to do those reports from the hospital level all the way up to the Federal level? R (Thomas): At the CDC we look at the other grants that are out there so that there is consistency; there is clearly a public health role and a hospital role. When possible we try to coordinate across the different levels. When we pilot the measures we do look at how long they take to complete and we take into consideration the times the reportees will have to report to us. It is now done on an annual basis to reduce the burden on the stakeholder.