– OB/GYN Providers H1N1 Influenza Vaccine Survey –

Directions: Please complete these questions to the best of your knowledge. Mark only one answer for each question unless directed otherwise.

1. At this point in time, how concerned are your **pregnant patients** about contracting H1N1 influenza?
   - ☐ Very concerned – nearly all of my pregnant patients express concern about H1N1
   - ☐ Concerned – most of my pregnant patients express concern about H1N1
   - ☐ Moderately concerned – about half of my pregnant patients express concern about H1N1
   - ☐ Slightly concerned – a few of my pregnant patients express concern about H1N1
   - ☐ Unconcerned – nearly none of my pregnant patients express concern about H1N1

2. At this point in time, approximately how many of your pregnant patients have inquired about the **availability** of H1N1 vaccine?
   ☐ Nearly all ☐ Most ☐ Some ☐ A few ☐ Nearly none

3. At this point in time, approximately how many of your pregnant patients have inquired about the **safety** of H1N1 vaccine?
   ☐ Nearly all ☐ Most ☐ Some ☐ A few ☐ Nearly none

4. At this point in time, are you encouraging your pregnant patients to receive the injectable H1N1 vaccine?
   ☐ Yes ☐ No

   If no, why not? _____

5. Do you feel adequately **protected from liability** under your state's laws or regulations if one of your pregnant patients experiences an adverse event from the H1N1 influenza vaccine?
   ☐ Yes ☐ No ☐ Not sure

   Comment: _____

6. Do you feel confident that the H1N1 influenza vaccine safety data on pregnant women is adequate?
   ☐ Yes ☐ No ☐ Not sure

7. Do you have concerns about vaccinating pregnant women with the injectable H1N1 vaccine?
   ☐ Yes ☐ No

   If yes, please comment: _____

8. Would you offer an injectable H1N1 vaccine to your pregnant patients if it was released by the FDA under an Emergency Use Authorization (EUA), without FDA licensure?
   ☐ Yes ☐ No ☐ Not sure

9. At this point in time, how concerned are **you** about your pregnant patients contracting H1N1 influenza?
   ☐ Very concerned ☐ Concerned ☐ Moderately concerned ☐ Slightly concerned ☐ Unconcerned

10. a. Is your practice **receiving and administering** H1N1 vaccine this fall?
    ☐ Yes ☐ No ☐ Not sure

    b. If yes to 10a, are you already administering injectible H1N1 vaccine to pregnant women?
    ☐ Yes ☐ No

c. If no to 10a, how will you inform your patients about where they can receive H1N1 vaccine? (Mark all that apply.)

- ☐ Notice posted in practice
- ☐ Notice mailed to all patients
- ☐ Refer *all* patients to alternate vaccination locations
- ☐ Refer *all patients in priority groups* to alternate vaccination locations
- ☐ No communication will be provided on H1N1, unless patient asks
- ☐ Other, specify: _____

11. Are you encouraging your **clinic staff** to receive the H1N1 vaccination?

☐ Yes, it is required of staff ☐ Yes, they are encouraged to receive it ☐ No

If no, why not? _____

12. Which of the following do you believe is a priority group for H1N1 vaccination? (Mark all that apply.)

- ☐ Pregnant women
- ☐ Household contacts and caregivers of children younger than 6 months of age
- ☐ Children from 6 months through 18 years of age
- ☐ Young adults 19 - 24 years of age
- ☐ Persons aged 25 - 64 years who have health conditions associated with higher risk of medical complications from influenza
- ☐ Persons aged 65 and older

13. Is your practice planning to vaccinate any patient in a priority group, regardless of their capacity to pay?

- ☐ Yes, we are planning to vaccinate any patient who is within a priority group
- ☐ No, but we will refer patients who cannot pay to alternate vaccination locations
- ☐ N/A – our practice is not administering H1N1 vaccine
- ☐ Other, specify: _____

14. If your practice administers H1N1 vaccine this fall, does your practice plan to implement additional follow-up measures to track adverse events more thoroughly?

- ☐ Yes
- ☐ No
- ☐ Decision has not yet been made
- ☐ N/A – our practice is not administering H1N1 vaccine

If yes, please describe: _____

15. Is your practice submitting or planning to submit H1N1 immunization data to your state's immunization information system (IIS)/vaccine registry?

☐ Yes ☐ No ☐ N/A---our practice is not administering H1N1 vaccine

16. Does your practice plan to extend hours (e.g., evenings, weekends) to vaccinate patients against H1N1 and/or seasonal influenza this year?

☐ Yes ☐ No ☐ Not sure

Comment: _____

17. a. Have **you** gotten vaccinated with the H1N1 vaccine?

☐ Yes ☐ No

b. If no to 17a, do you plan to get the H1N1 vaccine?

☐ Yes ☐ No

If no to 17b, why not? _____

18. Which of the following entities do you **trust most** to obtain timely, accurate information regarding updated guidance on H1N1 influenza vaccine administration? (Check only one.)
    - ☐ Federal government agencies (e.g., CDC)
    - ☐ State health department
    - ☐ Local health department
    - ☐ National Vaccine Information Center (CONAVA, Birmex)
    - ☐ News media (e.g., TV, internet news sites, newspaper)
    - ☐ Other health-care providers' advice
    - ☐ Pharmaceutical/Vaccine Companies
    - ☐ Professional societies (e.g. ACOG)
    - ☐ Other, specify: _____

    Comment: _____

19. What is your preferred method of receiving updated guidance on H1N1 influenza vaccine administration? (Check only one.)
    - ☐ Email
    - ☐ Fax
    - ☐ In person visits to provider offices
    - ☐ Newsletters
    - ☐ Notifications by postal mail
    - ☐ Notifications through the Health Alert Network (HAN)
    - ☐ Phone calls
    - ☐ Posting information on general health department website
    - ☐ Sponsored conference call(s)
    - ☐ Text message alerts
    - ☐ Twitter feeds
    - ☐ Other, specify: _____

    Comment: _____

20. Do you have any concerns regarding vaccine administration for the 2009-2010 influenza season?
    ☐ Yes ☐ No

    If yes, please describe: _____
    _____
    _____

21. What recommendations do you have for **state and local public health officials** to help you plan and manage the current seasonal influenza/H1N1 vaccination campaigns as effectively as possible?
    _____
    _____
    _____

22. Do you currently offer **seasonal influenza vaccinations** to your pregnant patients?
    ☐ Yes ☐ No

23. Do you typically encourage your pregnant patients to receive the **seasonal influenza** vaccine?
    ☐ Yes ☐ No

24. In a given year, what percentage of your pregnant patients **receives** the seasonal influenza vaccine?
☐ 0 – 19% ☐ 20 – 39% ☐ 40 – 59% ☐ 60 – 79% ☐ 80 – 100%

25. In a given year, what is the **typical demand** by your pregnant patients for the seasonal influenza vaccination?
☐ Very high – nearly all of my pregnant patients request the vaccine
☐ High – most of my pregnant patients request the vaccine
☐ Moderate – about half of my pregnant patients request the vaccine
☐ Low – a few of my pregnant patients request the vaccine
☐ Very low – nearly none of my pregnant patients request the vaccine

26. How many times in the last five years have **you** received the seasonal influenza vaccine?
☐ None ☐ Once ☐ Twice ☐ Three times ☐ Four times ☐ Five times

27. If a need is indicated, which of the following vaccines does your practice offer to pregnant women? (Mark all that apply.)
☐ Hepatitis A
☐ Hepatitis B
☐ Meningococcal (MCV4)
☐ Pneumococcal
☐ Polio (IPV)
☐ Seasonal Influenza (inactivated)
☐ Tetanus, Diphtheria (Td)
☐ Tetanus, Diphtheria, Pertussis (Tdap)
☐ None of the above

28. Do you have concerns about administering certain vaccines to pregnant patients due to worries about the **safety of the fetus**? ☐ Yes ☐ No

If yes, please indicate which vaccines: _____
_____
_____

29. If your practice does **not** provide vaccines to pregnant women, what are the top **two** reasons why not? (Mark only two.)
☐ Not applicable (our clinic provides vaccines to pregnant women)
☐ Cost (lack of insurance reimbursement)
☐ Lack of availability of vaccines
☐ Lack of time required to appropriately inform patients of risks and benefits of vaccines
☐ Lack of trained staff
☐ Liability associated with administering vaccines to pregnant women
☐ Patients are unwilling to accept vaccines
☐ Uncertain of current vaccination recommendations
☐ Uncomfortable with administering vaccines
☐ Other, specify: _____

30. Of your pregnant patients, what percentage inquires about **recommended childhood vaccines?**
☐ None ☐ 1 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

31. Do you believe educating pregnant women about **recommended childhood vaccines** is part of your role as an obstetrician?
☐ Yes ☐ No ☐ Not sure

32. Does your practice provide information to your pregnant patients regarding recommended childhood vaccines as part of its standard pre-natal care (i.e., without the patient asking)?

☐ Yes ☐ No

33. How much influence do you think you have over your pregnant patients' decisions to do any of the following?

	Very Little	A Little	Neutral	Some	A Lot		Don't Know
Receive the seasonal influenza vaccine	☐	☐	☐	☐	☐		☐
Receive the H1N1 influenza vaccine	☐	☐	☐	☐	☐		☐
Get their child vaccinated with recommended childhood vaccines	☐	☐	☐	☐	☐		☐

34. How likely do you think an **<u>un-immunized</u>** child in the U.S. is to get the following diseases during the next ten years?

	Very Unlikely	Unlikely	Neutral	Likely	Very Likely		Don't know
Haemophilus influenza type b (Hib)	☐	☐	☐	☐	☐		☐
Hepatitis B	☐	☐	☐	☐	☐		☐
Diphtheria	☐	☐	☐	☐	☐		☐
Measles	☐	☐	☐	☐	☐		☐
Mumps	☐	☐	☐	☐	☐		☐
Pertussis/whooping cough	☐	☐	☐	☐	☐		☐
Pneumonia	☐	☐	☐	☐	☐		☐
Polio	☐	☐	☐	☐	☐		☐
Rotavirus	☐	☐	☐	☐	☐		☐
Rubella/German measles	☐	☐	☐	☐	☐		☐
Tetanus	☐	☐	☐	☐	☐		☐
Varicella/chicken pox	☐	☐	☐	☐	☐		☐

35. How well do you think most childhood vaccines **<u>prevent</u>** disease (assuming the child completes the full recommended series)?

☐ Very well ☐ Well ☐ Neutral ☐ Not well ☐ Not well at all ☐ Don't know

36. How **<u>safe</u>** do you think most childhood vaccines are?

☐ Very safe ☐ Safe ☐ Neutral ☐ Unsafe ☐ Very unsafe ☐ Don't know

37. Please indicate your level of agreement or disagreement with the following statement:

Vaccine preventable diseases can cause severe illness in children less than 5 years of age if they contract the disease.

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐ Don't know

38. Please describe the type of clinical practice in which you work. (Mark all that apply.)

☐ Health department/community health center
☐ Multispecialty group
☐ Non-Governmental hospital/clinic
☐ Nonprofit community health clinic
☐ Physician network – not HMO
☐ Physician network – HMO
☐ Private/Independent practice
☐ Staff model HMO
☐ Other, specify: _____

39. Approximately how many pregnant women do you see in a week?

__,__ __ __

40. Please estimate what proportion of your pregnant patients pay for services from the following sources (please ensure that your responses add up to 100%):

Public Insurance/Medicaid	__ __ __ %
Private Insurance/HMO	__ __ __ %
Self Pay	__ __ __ %
Other	__ __ __ %

41. What best describes the community primarily served by your practice? (Mark all that apply.)

☐ Urban (inner city) ☐ Suburban ☐ Rural

42. What is the zip code of your practice? _____

43. In which decade were you awarded your primary clinical degree?

☐ Before 1980 ☐ 1980 – 1990 ☐ 1991 – 2000 ☐ 2001 – Present

44. In which country did you obtain this degree?

☐ United States ☐ Other, specify: _____

45. Are you:

☐ Female ☐ Male ☐ Other, specify: _____

Thank you for completing our survey. As compensation for your participation, we will donate **$15** to one of the five charities you select below. Please choose one:

☐ March of Dimes ☐ Ovarian Cancer Research Fund ☐ Ronald McDonald House
☐ American Red Cross ☐ United Way

Optional:
Should we have any questions about your survey, we would like to be able to contact you. The information you provide below will not be shared with anyone beyond the research team.

Name: _____
Email address: _____
Phone number: _____

Please provide us with any additional comments or feedback you would like us to know:

_____
_____
_____
_____

This is the end of the survey. Thank you for your participation.