AMERICAN ACADEMY OF PEDIATRICS
CENTERS FOR DISEASE CONTROL AND PREVENTION

Strategies for States - Improving Pediatric Preparedness

The American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) convened an inaugural Pediatric and Public Health Tabletop Exercise in January 2016. The list below was extrapolated from the detailed Meeting Proceedings and Executive Summary, available on the AAP Pediatric and Public Health Tabletop Exercise Web page (www.aap.org/disasters/tabletop). The list offers strategies for states to consider when aiming to a) improve pediatric preparedness for disasters and public health emergencies, b) initiate drills and exercises, and c) integrate pediatric injects or topics into existing exercises. The following ideas or strategies were suggested during the exercise.

GENERAL SUGGESTIONS TO ENHANCE PEDIATRIC PREPAREDNESS

1. Review emergency preparedness and response initiatives; increase the focus on children.
2. Identify specific processes, outcomes and actions that the public health and clinical communities should jointly take to improve pediatric preparedness.
3. Review materials within the CDC Children's Preparedness Unit home page www.cdc.gov/childrenindisasters/.
4. Begin building linkages to better understand the roles, responsibilities, strengths, and limitations of constituents (i.e., pediatrician leaders, public health officials).
5. Explore how to implement pediatric tabletop exercises in all states.
6. Identify gaps in pediatric preparedness specific to known threats in geographical areas.
7. Design a virtual exercise for public health and clinical pediatric representatives so that other states can participate remotely.
8. In planning for or messaging about parental presence when children were potentially exposed to an infectious disease, consider up front how to reinforce that parents are an integral part of the care team for children affected by any infectious agent.
9. Offer education on children's needs and preparedness strategies to personnel who work in places where children congregate (eg, Head Start/child care programs, schools, camps).
10. Put memoranda of agreement or understanding (MOA/MOU) in place to support cross-state preparedness efforts.
11. Engage the AAP to ensure pediatric clinicians in each state play a prominent role in future tabletop exercises with scenarios that include threats that impact children.
12. Share that the National Hospital Available Beds for Emergencies and Disaster System is available to all states to rapidly identify the number of staffed negative pressure rooms that are available at regional, state and local levels in real time.
13. Apply the experiences/lessons learned in managing housing and caring for unaccompanied minors who cross the U.S.-Mexico border to pediatric preparedness initiatives.
14. Encourage AAP chapters in states affected by disasters to apply for AAP Friends of Children Disaster Relief Funds.
15. Form a state pediatric preparedness task force. Encourage outreach out to the relevant AAP chapter to obtain support for children's preparedness activities in the state and localities.
16. Target education on children's disaster preparedness to medical residents and trainees.
17. Address the limited supply of pediatric medical materials in state stockpiles.

18. Develop clear guidance to improve state plans for distributing and dispensing MCMs to children.
19. Find social workers and other representatives from the state's psychological support services to help children cope with death and other trauma after a disaster.
20. Act on every opportunity to ensure children's issues are fully represented in disaster drills and other exercises routinely conducted by health departments in individual states.
21. Suggest to health departments that children's preparedness serve as the primary focus of upcoming exercises.
22. Engage Emergency Management Services in children's preparedness efforts at the outset to resolve transport issues.
23. Utilize all opportunities to collaborate with preparedness efforts focused on adults.
24. Establish formal MOAs/MOUs in advance to enable pediatric providers to prescribe MCMs across state lines.
25. Convene pre-planning/preparedness meetings to clearly define the roles and responsibilities of specific groups during an event or disaster situation that will impact children.
26. Certain sub-sets of children are at increased risk in a PHE. Conduct an assessment to determine their specific needs.
27. Engage hospital or local Emergency Operation Centers or Incident Command Systems in pediatric preparedness activities.

GUIDANCE FOR TABLETOP EXERCISES

28. Planning Teams should establish/articulate ground rules that are exercise-specific.
29. Exercises should reflect and attempt to build on the different and unique experiences of the public health and clinical pediatric participants.
30. For exercises with a focus on a specific natural disaster or infectious disease threat, ask an expert to provide a brief overview of that threat (eg, smallpox) and the population at risk (eg, children) to ensure exercise participants have the same orientation to the scenario.
31. For infectious disease threat scenarios, the expert overview should provide: empiric surveillance information, epidemiologic data, case identification strategies, isolation options, and details on contact tracing and vaccination of contacts.
32. Scenarios should identify and address several specific pediatric-focused questions.
33. Scenarios that focus on children should always consider how to handle/incorporate the issue of school closures.
34. Obtain guidance from pediatric preparedness experts before making a decision to close or delay the opening of a school.
35. Identify funds to convene a one- or two-day tabletop exercise that would specifically focus on addressing gaps in public health/pediatric medicine planning and readiness.
36. Connect with the state Hospital Preparedness Program and health care coalitions to establish or enhance linkages between private health care providers and public health.
37. Invite the representatives who attended the 2016 Tabletop Exercise (state teams and subject matter experts) to attend a future/expanded tabletop exercise.
38. Use the Tabletop Exercise as a model or approach to help states to develop children's preparedness plans for non-infectious disease threats,
39. Ask pediatricians or other child health advocates to contact their county or state health department to propose ideas of children's preparedness exercises so that public health and pediatricians could jointly conduct these exercises in the future.

40. Include Federal Emergency Management Agency (FEMA) representatives in future children's preparedness exercises.
41. Urge constituents to complete educational offerings. The FEMA Emergency Management Institute offers online trainings/exercises, including several virtual tabletop exercises.

Implement strategies to optimize plans for distributing and dispensing MCMs that are suitable for pediatric care and relevant to the tabletop scenario:

42. Put in place MOAs/MOUs with pharmacies.
43. Compile a list of pre-screening guidelines to assist in properly dispensing MCMs and preparing adult formulations for children.
44. Implement a rapid notification process.
45. Engage law enforcement, attorneys, and social services to address legal and other specialized issues related to administering MCMs to children.
46. Develop a protocol in advance to allow EMS providers to administer vaccines in an emergency.

COLLABORATIONS WITH OTHERS

Tabletop exercises and preparedness initiatives should address:

How to Partner with or Engage:

47. AAP Chapter leaders
48. Behavioral health experts
49. Emergency Medical Services
50. Family-to-Family Health Network Centers
51. Hospital leaders, including the Chief Information Officer
52. Media spokespersons
53. Public health epidemiologists
54. School districts and/or school superintendents
55. State health officials
56. State hospital associations
57. State medical associations
58. Statewide nursing line
59. Medical transportation services

Leveraging Expertise Outside of the State, such as Connecting with:

60. Emergency Support Function 8 Network
61. Joint Information Center
62. Regional Advisory Councils or designated regional coordinators
63. National medical associations
64. Pediatric societies

Partnering to Leverage Existing State Funding Opportunities:

65. Emergency Medical Services for Children (EMSC)
66. Hospital Preparedness Program (HPP)
67. Public Health Emergency Preparedness (PHEP)

Roles and Responsibilities:

68. Define and articulate the roles and responsibilities for participants.
69. Clarify the role of the health care facility in the exercise/planning process (hospital, clinic, others).

Utilizing the AAP to Connect with Other Associations:

70. American Academy of Family Physicians
71. American College of Obstetrics and Gynecologists
72. American College of Physicians
73. American Nurses Association
74. Association of State and Territorial Health Officials
75. Emergency Nurses Association
76. National Association of County and City Health Officials
77. National Association of Pediatric Nurse Practitioners
78. National Association of School Nurses

The AAP (or another association) can provide value in a disaster/emergency through:

79. Identifying subject matter experts and forming a leadership or response team.
80. Aiding in the delivery of consistent messages and the dissemination of accurate information.
81. Standardizing talking points; preparing FAQs for members and families.
82. Consolidating and clarifying messages to address confusion.
83. Utilizing its Web site to compile guidance/details relevant to members.
84. Assisting with translations.
85. Sharing updates in a video from the CEO.
86. Convening daily conference calls or teleconferences with CDC leadership.
87. Obtaining answers to questions from the CDC INFO or Emergency Operations Center staff.
88. Reaching out to its existing pool of respected pediatric communicators and bloggers to develop and disseminate videos and press releases to pediatricians in the field.

COMMUNICATION STRATEGIES

89. Planners should agree on general principals of communication.
90. Scripts and other communication materials should be developed prior to an event.
91. Develop a plan to address any mass hysteria and confusion.
92. Use a toll-free hotline to centralize information sharing and offer an easy way for everyone to receive consistent messages.
93. If a state Emergency Operations Center is activated, consider how all other planners/responders will receive details/updates.
94. Consider how best to include tribal partners. Are there tribal leaders who already serve as the spokesperson(s) for individual Tribal Nations?
95. Monitor and have a plan to address any gaps in information sharing.
96. Discuss ways to connect with large health care facilities, small private practices, and individual physicians' offices.
97. Monitor social media postings of hospital staff, and take steps to address the delivery of inaccurate information.

98. Use existing telephone banks or texting methods within school systems to disseminate accurate and factual information.
99. Leverage the AAP, CDC, and other professional associations as sources of high-level and credible information to respond appropriately.
100. Support local leaders and respected community members to combat the social media rumors with indisputable facts.
101. Know who identified spokespersons are; select others as appropriate. Provide talking points to identified spokespersons.
102. Utilize informal networks to facilitate communication.
103. Disseminate information in various ways. Identify and use the existing mechanisms to deliver messaging.
104. Forward Health Alert Network (HAN) notices to physicians and hospitals.
105. Expand the reach of the HANs to include medical trainees.
106. The AAP leadership should determine whether the national or state HANs have sufficient capacity to handle children's preparedness communications to its entire membership of ~64,000 pediatric health care providers across the country.
107. Messaging should describe or emphasize the risk of exposure.
108. Find out if your state (or a nearby state) has a "shelf kits" for smallpox and other threats that are available in American Sign Language (ASL) and can be shared with other states.
109. Implement a daily (brief) update for health care professionals.
110. Plan ahead to translate messages and materials into various languages. Identify interpreters and translators up front to address specialized issues related to cultural competency, language barriers, and tribal medicine.
111. Engage public information officers in the development and dissemination of messaging to health care providers.
112. Designate a Web page to focus on preparedness issues specific to children.
113. Adapt the communication schools use to notify parents of key issues in an emergency for broader use (eg, reverse 911 system).

STEPS TO IDENTIFY, OUTREACH TO, AND VACCINATE APPROPRIATE CONTACTS

114. If an exercise or plan attempts to address a threat where there is an immunization, determine what steps the state team should take to develop a vaccine distribution and administration plan.
115. Consider how to ensure that the hospital and health department staff receive appropriate training and education.
116. Replicate the "influenza model", where vaccination is required or strongly recommended; those who get immunized receive an incentive or wear a sticker, while those who abstain have a consequence (must wear a mask or watch a 4-hour training video on why immunization is critical).
117. Plan to develop and distribute Frequently Asked Questions and responses.
118. Clarify a plan to monitor those who were vaccinated for adverse events.
119. Convene an epidemiologic team to conduct contact tracing.
120. Integrate community paramedicine resources into the vaccination strategy, such as Emergency Medical Services providers.
121. Replicate the mass vaccination campaign in school systems (eg, in pre-planning activities for infectious disease threats).

122. Identify pediatricians with skills and experience in overcoming vaccine hesitancy and barriers to administer vaccine to infants and young children.
123. Address upfront ways to address the special health care needs of children with disabilities during a PHE. Many parents likely would not consent to administering of vaccines.
124. Leverage existing collaborative efforts in children's preparedness, such as those with school-based influenza vaccination campaigns.
125. Consider and articulate in advance whether adverse events from vaccines (particularly those not licensed for use in the United States), would be covered by the National Vaccine Injury Compensation Program.

Steps to ensure that a limited supply of vaccine is appropriately dispensed among children:

126. Prepare a targeted vaccination administration strategy.
127. Develop and use an existing pre-screening vaccination form.
128. Ensure that all individuals in line for vaccination have been screened for priority criteria.
129. When there is a need to prioritize a certain vaccine over others for groups such as children, conduct a more in-depth screening of the patient; consider asking the patient's physician to perform a physical examination; or request written confirmation of the condition (eg, asthma, atopic dermatitis) from the physician referenced on the patient's medical records.

DIAGNOSE AND TREAT POTENTIAL PATIENTS

130. Determine whether there is an existing process to communicate information from state public health to the frontline health care professionals who will screen and treat potential patients.
131. Identify centralized sites for persons to present for appropriate testing and treatment.
132. Seek clarification from the CDC regarding the polymerase chain reaction (PCR) testing options, the turnaround time for receiving results, and whether to initiate or delay treatment.

CONTROL THE SPREAD OF INFECTION

133. In certain situations, guidance should be offered to hospitals about the need to close urgent care clinics or sections within hospitals to control the spread of infection.
134. Outline the characteristics of patients who need to be quarantined, and summarize the overall quarantine process.
135. Consult with human resources, legal personnel, and others to address issues such as review of state sanitary codes, voluntary versus mandated quarantine process, staff benefits, and quarantine monitoring options.
136. Consider in advance how to identify and leverage resources to support the quarantine process.
137. A process to actively monitor anyone in voluntary or required quarantine is needed.
138. Obtain information on the infection control practices where exposure(s) happened.

Reach out to the AAP for assistance; see www.aap.org/disasters or e-mail DisasterReady@aap.org.