

**AMERICAN ACADEMY OF PEDIATRICS  
CENTERS FOR DISEASE CONTROL AND PREVENTION**



American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN®



**AAP/CDC Pediatric and Public Health Tabletop Exercise  
January 26, 2016  
Atlanta, Georgia**

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**Record of the Proceedings**

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## AMERICAN ACADEMY OF PEDIATRICS CENTERS FOR DISEASE CONTROL AND PREVENTION

### AAP/CDC PEDIATRIC AND PUBLIC HEALTH TABLETOP EXERCISE January 26, 2016 Atlanta, Georgia

#### Summary Report

The American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) convened the “Pediatric and Public Health Tabletop Exercise” on January 26, 2016. The exercise was held at the CDC Tom Harkin Global Communications Center, Auditorium B3, in Atlanta, Georgia.

The AAP/CDC Exercise Planning Team organized the Tabletop Exercise with five state teams to address a threat of smallpox that would impact children and require the use of supplies from the Strategic National Stockpile (SNS). The state teams included public health representatives who were CDC Public Health Emergency Preparedness (PHEP) grantees and pediatricians from AAP chapters in five Region VI states: Arkansas, Louisiana, Oklahoma, New Mexico and Texas.

The AAP/CDC Exercise Planning Team charged the state teams with establishing and maintaining capabilities in three core areas over the course of the Tabletop Exercise.

- *Planning:* The state teams would conduct a systematic process in the development of executable, strategic, operational and/or community-based approaches to meet defined objectives. The state teams would engage the entire community in this effort as appropriate.
- *Operational Coordination:* The state teams would establish and maintain a unified and coordinated operational structure and process to appropriately integrate all critical stakeholders and support the execution of core capabilities.
- *Operational Communications:* The state teams would ensure the capacity for timely communications in support of security, situational awareness and operations by any and

all means available in the impact area and all response groups. The state teams would facilitate communications among and between all affected communities.

## Opening Session

### **Eric Dziuban, MD, DTM, FAAP**

Lead, Children's Preparedness Unit  
Division of Human Development and Disability  
National Center on Birth Defects and Developmental Disabilities  
Centers for Disease Control and Prevention

Dr. Dziuban moderated the opening session and welcomed the participants to the Tabletop Exercise. He introduced the panel of AAP and CDC speakers who would provide welcoming remarks.

### **RADM Stephen Redd, MD**

Director, Office of Public Health Preparedness and Response  
Centers for Disease Control and Prevention

Dr. Redd thanked the participants for taking time from their busy schedules to travel to Atlanta to conduct the Tabletop Exercise. He explained that Dr. Thomas Frieden, Director of CDC, established public health/clinical medicine collaboration as one of CDC's top three priorities for the nation to achieve better overall health.

Dr. Redd emphasized that the Tabletop Exercise would serve as an excellent model to support this priority, because CDC's responses to three public health emergencies (PHEs) at this time all focus on the clinical care of children to some degree. The CDC has the longest history and most experience with polio response efforts. All polio surveillance and interventions are focused on children <5 years of age.

Ebola does not have the same impact on children as polio, but the disease still has numerous implications for children in West Africa, such as high fatality rates of their parents and poorly functioning medical care systems that do not provide adequate care and treatment. Moreover, some school-aged children in the United States with family members who returned from Africa faced stigma during the early phase of the 2015 Ebola outbreak.

The ongoing Zika virus outbreak in South America is a maternal-pediatric problem that principally affects children as well. CDC has not officially activated a response to the lead poisoning crisis in the Flint, Michigan water supply at this time, but this PHE also will have a significant impact on children.

Dr. Redd acknowledged that CDC and all of its federal partners need to increase the focus on children in their emergency preparedness and response activities. Most notably, the Trust for America's Health published a report in October 2007 that identified critical gaps related to children in the U.S. government's pandemic influenza preparedness efforts. The report noted that children and adolescents from 0-19 years of age accounted for nearly 46% of all deaths from H5N1 influenza, but no pediatric formulations of antiviral drugs had been developed.

Dr. Redd concluded his opening remarks by asking the state team members to identify specific processes, outcomes and actions that the public health and clinical communities should jointly take to improve pediatric preparedness. He hoped the Tabletop Exercise would serve as a starting point in initiating significant changes in this area over the next year.

**Coleen A. Boyle, PhD, MSHyg**

Director, National Center on Birth Defects and Developmental Disabilities  
Centers for Disease Control and Prevention

Dr. Boyle joined her colleagues in thanking the state public health representatives and AAP members for their participation in the critically important Tabletop Exercise. She pointed out that CDC's priority to strengthen public health/clinical medicine collaboration in the United States is particularly timely. For example, the CDC recently reached out to AAP leadership for assistance in developing "Interim Guidelines for the Evaluation and Testing of Infants with Possible Congenital Zika Virus Infection-United States, 2016." The AAP member expertise on the best clinical approaches to evaluate children with suspected Zika virus exposure was instrumental in helping the CDC experts to refine and finalize the recommendations. The clinical guidelines will be featured as an early release in the January 26, 2016, edition of the *Morbidity and Mortality Weekly Report*.

Dr. Boyle confirmed that CDC recognizes the importance of placing a special focus on children and their safety. Most notably, Dr. Redd provided leadership in facilitating collaboration across multiple National Centers and leveraging funds from various internal budgets to support CDC's children's preparedness initiative. She also was pleased that AAP is serving as a strong partner to CDC in addressing the ongoing Zika virus outbreak.

**Georgina Peacock, MD, MPH, FAAP**

Director, Division of Human Development and Disability  
National Center on Birth Defects and Developmental Disabilities  
Centers for Disease Control and Prevention

Dr. Peacock announced that the longstanding AAP/CDC partnership in children's preparedness was initiated with the H1N1 influenza response. The key outcomes of the response were to ensure children were immunized, help administer antiviral drugs to children early in the influenza season, and clearly define the role and responsibilities of pediatricians in the public health response. Since that time, the Office of Public Health Preparedness and Response (OPHPR) and

the National Center on Birth Defects and Developmental Disabilities (NCBDDD) have partnered to establish a formal children's preparedness initiative at CDC. This activity still covers influenza readiness, but has been expanded over time to include the development of anthrax clinical guidelines for children as well as a focus on children's health issues during the 2015 Ebola outbreak and the ongoing Zika virus outbreak.

After Dr. Frieden established public health/clinical medicine collaboration as one of CDC's top three priorities, an agency-wide leadership management team was formed to strengthen relationships between the public health and pediatric communities. CDC leadership agreed that a tabletop exercise with integrated public health/pediatric teams would be the best mechanism for both groups to begin building linkages to better understand the roles, responsibilities, strengths and limitations of the other group. These newly-established relationships could then be leveraged to enhance children's preparedness and response efforts at state, local and regional levels.

Dr. Peacock concluded her opening remarks by thanking and formally recognizing several groups that have played a key role in CDC's children's preparedness initiative.

- CDC staff involved with the children's preparedness initiative over the past four years
- Members of the CDC leadership management team
- AAP staff, CDC staff and other subject-matter experts (SMEs) on the Tabletop Exercise Planning Team

**Steven E. Krug, MD, FAAP**

Head, Division of Emergency Medicine  
Ann & Robert H. Lurie Children's Hospital of Chicago

Dr. Krug also thanked AAP/CDC leadership and the state team members for their attendance at and ongoing support of the Tabletop Exercise. He reiterated remarks by the previous speakers in terms of the strong, productive and longstanding AAP/CDC partnership that has successfully addressed numerous children's preparedness issues in the past. He pointed out that the Tabletop Exercise demonstrates CDC's priority to strengthen public health/clinical medicine collaboration.

At the national level, Dr. Krug noted that the Planning Team reflects excellent representation by AAP/CDC leadership, SMEs and other professionals with extensive expertise in preparing the country to provide better care to children. At state and local levels, he explained that public health and AAP chapters must take joint leadership in conducting children's preparedness and response activities. He emphasized that CDC can award funding and offer guidance in this regard, but no federal agency has authority over frontline providers in the field.

Dr. Krug added that the AAP/CDC Planning Team anticipates the Tabletop Exercise will serve as a mechanism to establish and sustain solid public health/clinical medicine relationships prior to a PHE to improve state and local responses to any type of event. Based on its outcomes and

overall success, AAP chapters intend to present the Tabletop Exercise beyond the five Region VI states for replication in the future.

Dr. Krug concluded his opening remarks by thanking and formally recognizing AAP staff and members who serve on the Disaster Preparedness Advisory Council and the Exercise Planning Team. He announced that the Tabletop Exercise would include a review session or “hotwash” and designated time for the state team members to complete an evaluation form. The AAP/CDC Exercise Planning Team would use this feedback to inform additional children’s preparedness exercises in the future.

Dr. Dziuban concluded the opening session with additional acknowledgments.

- Senior leaders from the OPHPR, NCBDDD and other National Centers were thanked for their participation and ongoing support, particularly in light of CDC’s competing priority to respond to the Zika virus outbreak.
- CDC’s federal partners were thanked for their attendance and ongoing support: Ms. Dara Spector (U.S. Department of Health and Human Services (HHS), Region IV, Office of the Assistant Secretary for Preparedness and Response) and Mr. James Davis, Jr. (Federal Emergency Management Agency (FEMA), Region IV).
- The AAP/CDC Exercise Planning Team members were applauded (Ms. Laura Aird, Mr. Michael Bartenfeld, Mr. Sean Diederich and Ms. Wendy Ruben) for their dedicated efforts over the past seven months in making travel arrangements and addressing all other logistical issues for the participants to attend the Tabletop Exercise.
- The floor was opened for introductions of the state team members in the five Region VI states (*Attachment 1: Participants’ Directory*).

## Overview of the Pediatric and Public Health Tabletop Exercise

### **Eric Dziuban, MD, DTM, FAAP**

Lead, Children’s Preparedness Unit  
Division of Human Development and Disability  
National Center on Birth Defects and Developmental Disabilities  
Centers for Disease Control and Prevention

Dr. Dziuban presented an overview of the Tabletop Exercise. The overarching mission of the CDC Children’s Preparedness Unit is to champion the needs of children in emergency preparedness and response by integrating children into public health planning at federal, state and local levels. CDC fulfills its mission by conducting four core activities, which are to:

- Build an evidence base of best practices, tools and other resources to guide planning.

- Increase awareness of the importance of incorporating children into preparedness planning.
- Offer technical assistance and serve as SMEs to federal, state and local public health.
- Develop partnerships with preparedness planning leaders.

The CDC Children's Preparedness Unit established three key goals to guide its activities. First, linkages among public health, pediatricians, children's hospitals and other stakeholders will be fostered and sustained to improve children's preparedness efforts domestically. Second, the need for timely, accurate and comprehensive data and recommendations on the care, treatment and involvement of children in PHEs will continue to be emphasized. Third, pre-planning for upcoming events will include reviewing lessons learned, developing strategic communications, and filling gaps in preparedness for known threats.

Dr. Dziuban explained that this exercise arose from results/discussions related to a CDC Leadership Management Initiative. Further, he reported that after the AAP and CDC agreed on the need to convene the Tabletop Exercise and formed the Exercise Planning Team, the first step was to clearly define the purpose of this effort. Connectedness between public health preparedness professionals and pediatricians would be improved. The knowledge of pediatricians about PHE preparedness and response would be strengthened. Understanding among public health professionals regarding the needs of children in disasters and the role of pediatricians would be enhanced. Lessons learned would be identified and steps that can be taken to help states improve pediatric preparedness would be proposed.

The Planning Team's next step was to determine objectives and evaluation measures to guide the Tabletop Exercise.

1. Identify at least 10 collaborative strategies that AAP chapters, pediatric clinicians and public health leaders could implement to advance pediatric preparedness at state and local levels.
2. Determine at least 5 steps that states could take to improve communications, specific to children's issues, between public health and pediatric leaders during a response to a PHE to sufficiently address the needs of children.
3. Discuss and evaluate strategies to optimize plans for the distribution and dispensing of medical countermeasures (MCMs) that would be suitable for pediatric care and relevant to the infectious disease threat outlined in the Tabletop Exercise scenario.

To achieve these goals, the Exercise Planning Team invited two public health and two clinical pediatric representatives to serve on each of the five state teams. The Planning Team envisioned that this structure would provide both groups (public health planners and pediatric leaders) with more access to the other group and improve their capacity to effectively collaborate during an emergency. Based on the outcomes and overall success of the Tabletop Exercise, the Exercise

Planning Team hopes to design a virtual exercise for public health and clinical pediatric representatives so that other states can participate remotely.

Dr. Dziuban concluded his overview by clarifying that although the Exercise Planning Team selected smallpox as the infectious disease threat to children, the Tabletop Exercise would not be specific to this disease. Instead, the state teams would have a much broader charge of recommending partnership approaches and communication strategies and processes to improve children's preparedness in a natural disaster or any other type of PHE.

## Overview of the Pediatric and Public Health Tabletop Exercise Process

### **David Schonfeld, MD, FAAP**

Professor of the Practice in the School of Social Work and Pediatrics  
University of Southern California and Children's Hospital Los Angeles  
Director, National Center for School Crisis and Bereavement

### **Margaret C. Fisher, MD, FAAP**

Medical Director  
The Unterberg Children's Hospital at Monmouth Medical Center

Drs. Schonfeld and Fisher served as the moderators of the five modules the state teams would conduct over the course of the Tabletop Exercise. Dr. Schonfeld began the overview by reviewing the ground rules for the state team members.

- Cell phones and other electronic devices should be silenced during the Tabletop Exercise and used during breaks only.
- The attention of the state team members should be directed toward their specific tasks and roles while the modules are being conducted. Discussions should be limited to the event and details within the scenario.
- Instructions by the facilitators to advance to the next question should be immediately followed because the scenario will be presented in "real time."
- Reasonable assumptions should be made as needed.
- Questions should be asked only if clarification is important or critical to continue with the scenario.
- Ambiguity or lack of detailed information may occur in the scenario as it does during a real event and should be managed by the participants when instructed by the facilitators.
- Any event described by the facilitators should be considered as an actual occurrence for the purpose of the Tabletop Exercise.
- Debriefing should occur after rather than during the Tabletop Exercise.
- Discussions should immediately cease when the facilitators interject with critical updates or additional information as the scenario evolves over the course of the five modules.

- Issues that were overlooked or any other gaps should be addressed if any state team completes a module ahead of schedule.

Dr. Fisher provided additional details on the rationale for the Exercise Planning Team's selection of smallpox for the scenario. The possibility of using pandemic influenza as the infectious disease threat to children was initially proposed, but the Planning Team noted that this emergency has been the subject of numerous tabletop exercises in the past. As a result, the Exercise Planning Team agreed that the Smallpox Tabletop Exercise would be a different and unique experience for both the public health and clinical pediatric representatives. Moreover, the states likely would have no smallpox SMEs on their teams.

Dr. Fisher further noted that significant knowledge gaps exist related to smallpox. Despite the common belief of smallpox being eradicated worldwide, the scenario would demonstrate that the disease could be a potential threat through an accidental exposure. However, the Tabletop Exercise was not intended to strengthen the expertise, knowledge or understanding of the state team members in smallpox. Instead, the key outcome would be to enhance communications, collaboration and coordination within and across states to improve children's preparedness and response to any type of PHE.

Dr. Fisher concluded the overview by introducing the five facilitators who would provide technical assistance while the state teams conducted the modules: Ms. Laura Aird, Dr. Sarita Chung, Mr. Sean Diederich, Dr. Eric Dziuban and Dr. Scott Needle.

## MODULE 1: THREAT OF SMALLPOX

The session for Module 1 included an overview of smallpox, an introduction of Module 1 (the threat of smallpox on days 1-21 of the scenario), and state team reports of their findings in response to the Module 1 questions.

### Overview of Smallpox

#### **Brett Petersen, MD, MPH**

Commander, U.S. Public Health Service  
Medical Officer, Poxvirus and Rabies Branch  
National Center for Emerging and Zoonotic Infectious Diseases  
Centers for Disease Control and Prevention

Dr. Petersen presented an overview of smallpox and described CDC's strategic response to a potential smallpox emergency. Smallpox is a clinically evident disease with no sub-clinical illness. The incubation period lasts 10-12 days on average, but can range from 7-17 days. Although persons are not infectious and do not show signs of illness during the incubation period, all infected persons show symptoms as the disease progresses over time.

The prodrome period lasts 2-3 days and is characterized by severe influenza-like illness, including fever and prostration. A rash that develops lasts for 2-3 weeks on average and progresses from macules and papules to vesicles and pustules. Smallpox is transmitted person-to-person through close contact with respiratory droplets. Transmission is greatest in the first week after the onset of the rash.

Epidemiologic data show that household contacts primarily become infected from cases. Modeling data of the current population estimate that 2-4 persons will become infected from a case. Untreated persons have a 30% case fatality rate on average, but vaccination with the vaccinia virus provides protection from disease. However, smallpox vaccination has not been routinely given since 1972. Moreover, vaccination typically provides immunity from smallpox for no longer than 20 years.

The CDC maintains vaccine in the SNS as the primary MCM for smallpox. The SNS currently stores sufficient vaccine to vaccinate all persons in the United States. The two replication-competent vaccines in the SNS require one dose and have a high efficacy rate of  $\geq 95\%$ . ACAM2000™ is a clonal vaccine that is derived from the same virus as Dryvax. The Aventis Pasteur Smallpox Vaccine is a historic vaccine.

The attenuated, replication-deficient vaccine in the SNS, IMVAMUNE® (MVA), requires two doses and was developed for use in persons who are at high risk for adverse events (AEs). The SNS also stores antiviral drugs, including tecovirostat, for the treatment of active disease and cidofovir in an intravenous formulation to treat nephrotoxicity. CDC maintains diagnostic capacity for smallpox cases through Laboratory Response Network (LRN) sites and its onsite reference center for case confirmation.

CDC's vaccination strategy is guided by several key principles. The core goal of stopping disease transmission will be achieved by vaccinating persons with a live, replication-competent smallpox vaccine. Data show that pre-exposure smallpox vaccination is most effective. Because the efficacy rate of post-exposure smallpox vaccination greatly ranges from 23%-91%, the best strategy is to revaccinate persons <7 days post-exposure. The use of attenuated vaccine will reduce AEs as well.

The goal of implementing a tiered response to control the spread of disease will be achieved through empiric surveillance information, epidemiologic data, case identification, isolation of cases, contact tracing and vaccination of contacts. Data show that the epidemic curve of smallpox is episodic and slow with a range of 7-17 days between generations. However, the CDC

recognizes the potential need to modify its tiered response based on the scope and size of the outbreak and changes in surveillance data.

CDC gathered strong evidence from the smallpox eradication era in 1968-1969 to support its ring vaccination approach of identifying cases and vaccinating contacts. Historical data showed that smallpox cases persisted even with a high rate of vaccination coverage in the population. However, the implementation of an active surveillance and containment response, including contact tracing and vaccination, resulted in a dramatic decrease in the number of smallpox cases and successfully eradicated disease.

Overall, smallpox disease is spread through close household contact rather than through casual social contact, such as contact on mass transportation. The identification and isolation of cases and vaccination of contacts will aid in stopping disease transmission; strategically focusing efforts; and targeting both vaccine and human resources to contacts who are most likely to become infected. The use of smallpox vaccine should be limited to persons at highest risk because vaccines used during the eradication era resulted in death and other severe AEs. This strategy will minimize AEs in non-close contacts and other populations with a low likelihood of infection.

Dr. Petersen provided additional details on smallpox in response to specific questions posed by the participants.

- The primary mode of smallpox transmission is person-to-person through close contact with respiratory droplets. The progression of disease includes rashes or lesions in the oropharyngeal area, the release of virus through respiratory droplets, and infection of mucous membranes in the respiratory system. Smallpox typically is not transmitted by fomites, but individuals could have contaminated clothing or bedding because the lesions excrete an infectious virus. Moreover, the infectious virus is still present even after the lesions heal and develop a crust. Overall, the transmission of smallpox infection through fomites or skin-to-skin contact with lesions is possible, but these routes are extremely rare.
- Patients should be considered to be infectious from the onset of fever until all lesions have healed, crusted, scabbed and disappeared to reveal healthy skin underneath. Based on the timeline between the onset of fever and complete healing of the rash, the infectious period lasts 3-4 weeks on average.
- A minimum age has not been established for smallpox vaccination or antiviral treatment. Because exposure to smallpox places an individual at great risk for a highly fatal disease, no absolute contraindications have been identified for vaccination. However, AEs in special populations must be considered. For example, smallpox vaccine can be given to pregnant women, but the development of fetal vaccinia is a potential risk to the pregnant woman and fetus.
- Several logistical issues must be addressed in smallpox vaccination. Most notably, the vaccine is administered by bifurcated needle. The vaccine is a lyophilized or freeze-dried formulation that must be administered within 24 hours after reconstitution. The CDC can rapidly deploy vaccine from the SNS to states within 24-48 hours.

## Introduction of Module 1

Dr. Schonfeld introduced Module 1 by describing the threat of smallpox on days 1-21 of the scenario.

### *Day 1*

- Amelia Xang is attending a summer science program at a medical school in Wichita, Kansas that allows high school students to shadow scientists in laboratory settings. Amelia is cleaning a biohazard freezer where smallpox samples are unknowingly stored with no security measures. She drops a vial in the hallway that breaks open. She uses the bathroom to wash up after noticing that the broken glass has caused a small cut to her hand. Brian Yoder also is a student and helps Amelia with the cleanup and disposal of the vial in the regular trash. Neither student reports the incident to staff.

### *Days 13-20*

- Amelia becomes febrile on the last day of the program. Although her temperature is 102°F, she still attends the graduation ceremony and returns home by bus with her mother. She and her mother present to a medical clinic on the following day and Amelia is diagnosed with a “viral illness.” After her health continues to deteriorate, she and her mother travel by bus to a community hospital emergency department (ED). Amelia is diagnosed with a “presumptive enterovirus infection.” She and her mother return to the hospital ED by bus the following day, and Amelia is admitted. After a macular rash is noticed on her face and becomes papular, exposure to smallpox is recognized. She is transported to a facility within the Emory Healthcare System that has been designated to care for patients with potential smallpox. Amelia’s mother updates her Facebook page with a new posting: “Going to Emory for my daughter’s smallpox.” The message goes “viral”, and the national media contact the hospital for comment.

### *Day 21*

- A “health expert” from a television news station in Lincoln, Nebraska recommends vaccination of all residents in the state. The health expert further speculates that vaccine is not being provided to all persons because the smallpox case is a poor minority youth. All newspaper and television outlets in the five “TALON” states (Texas, Arkansas, Louisiana, Oklahoma and New Mexico) extensively cover the story and broadcast messages on the same day. The local hospital contacts public health. The five TALON states are asked to implement ring vaccination and identify all potential contacts who might have been exposed to smallpox.

Dr. Schonfeld gave the state teams 30 minutes to address the Module 1 questions.

## State Team Reports: Module 1 Questions

Dr. Schonfeld moderated a session for the state teams to report their findings in response to the Module 1 questions.

1. *What is your state team's follow-up questions about smallpox, its effect on children, or children-specific vaccine recommendations for the experts?*
  - Louisiana advised the experts to address several pediatric-specific questions related to smallpox: diagnostic testing of smallpox and its reliability in children; the earliest time smallpox can be diagnosed in children; and differences between smallpox isolation procedures for children and adults.
  - Louisiana noted that the smallpox scenario occurred during the summer, but advised the experts to develop a process to consider whether or not there should be school closures in response to events occurring during the school year.
  
2. *Based on the current composition of your state team and expertise of the members, what other groups in the state would be engaged in the discussion?*
  - Louisiana would immediately engage its public health epidemiologists and other state officials (e.g., Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP), Emergency Operations Center (EOC), and Rapid Response and Strike Teams) that have a role in emergency preparedness. These groups are responsible for communicating and coordinating with CDC to activate the SNS and conducting contact tracing in the state. The Louisiana Hospital Association, AAP chapter and behavioral health experts in the state also would be extensively engaged due to their broad networks and influence in communities. However, Louisiana would leverage expertise outside of the state as needed because the infrastructure of its public health system has been severely weakened over the past few years.
  - Texas would implement a multi-level approach to engage local, state, regional and national groups. The city, county and state public health officials would be engaged to provide epidemiologic expertise to the community hospital that diagnosed presumptive enterovirus infection. Regional Advisory Councils would be engaged to apply their experience in disaster mitigation and response and also to provide technical assistance and resources to small, under-funded hospitals. The Texas Medical Association, Texas Pediatric Society, AAP chapter and other professional associations would be engaged as well. Various federal agencies and national groups would be engaged to coordinate and vet communications at the local level. Public policymakers would be engaged at the outset. Although Texas recognizes the importance of a multi-level approach, strong efforts would be made to clearly define and articulate the roles and responsibilities of each specific group.

- Arkansas would engage national and/or state hospital associations, hospital leadership and media spokespersons to clarify the role of health care facilities. Most notably, hospitals would be expected to offer infection control expertise and guidance, provide appropriate isolation rooms, ensure the availability of an adequate number of beds, and designate a full team of physicians, nurses and other healthcare providers (HCPs) to care for smallpox patients.
  - New Mexico would engage the Chief Information Officer in its state health department to develop a plan to address any mass hysteria and confusion caused by inaccurate social media postings.
3. *What steps would your state team take to identify, outreach to and vaccinate appropriate contacts if the smallpox situation occurred in your state?*
- Arkansas has a robust communicable disease section in its state health department that conducts contact tracing for several diseases. Smallpox would be included in the state's existing infrastructure after health department staff received appropriate training and education. Arkansas also would begin to build strong relationships with other state health departments because the scenario calls for smallpox exposure to eventually spread to other states.
4. *Would your state team make any efforts to identify contacts on mass transportation?*
- Louisiana's position was that smallpox would still be infectious on mass transportation after day 15 of the scenario. As a result, efforts would be made to identify contacts based on the specific bus route, date and time. A toll-free hotline would be publicized through the media for persons with potential exposure to contact local public health. However, messaging from the Louisiana EOC would be coordinated and thoroughly vetted by the governor's office and state department of public health.

## **MODULE 2: STRATEGIC COMMUNICATIONS AND EFFECTIVE MESSAGING**

The session for Module 2 included an introduction of Module 2 (strategic communications and effective messaging on days 1-21 of the scenario) and state team reports of their findings in response to the Module 2 questions.

## Introduction of Module 2

Dr. Schonfeld introduced Module 2 by describing the general principals of communicating during a crisis. Communications about a crisis should not serve as a source of further crisis. The two basic reasons for public communications in a crisis setting are to reassure the public and provide information for individuals to take appropriate actions to decrease their risk. Examples of reassuring and actionable messages are outlined below, but the “low-risk” language does not apply to smallpox.

### *Reassuring Messages*

- “The risk of infection is low.”
- “The risk of serious illness when infection occurs is low.”
- “Serious outcomes are rare if the disease is identified early after exposure.”
- “Symptoms are easily recognized.”

### *Actionable Messages*

- “Take these simple steps to prevent exposure.”
- “Seek evaluation at [name of place] if you are concerned you might be exposed.”
- “These are the signs of infection you might observe in your children that suggest the need for further evaluation.”

Other principles that should guide crisis communication efforts are highlighted as follows. Messaging should include language that is direct, simple and easy to understand. Accurate and timely information should be provided, but speculation should be avoided. A sufficient amount of information should be provided for persons to understand the crisis and have knowledge of appropriate actions to take, but the level of information should not be overwhelming or cause confusion. All information communicated to the general public should be regularly monitored, particularly to identify and correct inaccurate information.

Scripts and other communication materials should be developed prior to an event because information often is not properly given or received during a stressful crisis situation. Information disseminated by multiple sources will convey conflicting messages. Inaccurate information often is more interesting and compelling and typically will travel faster than accurate information. Persons who are poorly informed often will formulate explanations that are convincing to other poorly informed individuals. Persons generally base trust on interpersonal factors (e.g., empathy, connectedness and genuineness) and primarily use trusted sources in making decisions on information that is “accurate.” “Common sense” typically is uncommon during a crisis.

Dr. Schonfeld gave the state teams 30 minutes to address the Module 2 questions.

## State Team Reports: Module 2 Questions

Dr. Schonfeld moderated a session for the state teams to report their findings in response to the Module 2 questions.

5. *What steps would your state team take to collaborate with potential hospital ED contacts (i.e., other patients in the ED at the time)?*
  - Oklahoma would revise its existing process to communicate information from state public health to frontline HCPs who will screen and treat smallpox patients. Pediatric infectious disease physicians traditionally have been contacted first during a crisis, but other groups would now be engaged at the outset as well. The hospital's public information officer (PIO) would be contacted to facilitate ongoing communications with the media. The section medical director would be contacted to develop a screening protocol, ensure that smallpox patients have no contact with other patients in the ED, triage smallpox patients without establishing a secondary triage area or waiting room, and isolate smallpox patients in negative flow rooms. Based on its Ebola experience, Oklahoma would implement this process by closing the urgent care section.
  
6. *What type of information would your state team provide to contacts, other medical staff and the general public?*
  - Oklahoma would include tribal partners in the dissemination of information during the statewide response.
  - Oklahoma would activate its Health Alert Network (HAN) to widely and rapidly distribute information to all hospitals and primary care physicians in the state. However, Oklahoma acknowledges that several gaps need to be addressed at the state level to improve the distribution of HAN messages. Most notably, HAN alerts, advisories and updates are disseminated during an emergency, but the information often is limited to "top-level" officials and other leadership. Information to individual physicians in the hospitals generally is distributed on a "need-to-know" basis. For example, the HAN currently is being used to distribute daily notices regarding the ongoing Zika virus outbreak, but several physicians in Oklahoma hospitals and private practices are not included in these communications. Oklahoma's next steps in improving the HAN will be to ensure that pediatric ED physicians, medical staff and other frontline HCPs are continuously given up-to-date information as an event rapidly evolves. Oklahoma recognizes that information dissemination and communications during an emergency are effective from federal to state levels, but need to be enhanced from state to local hospital and private practice levels. Oklahoma also intends to address gaps in communications that are specific to large health care facilities, small private practices and individual physicians' offices.

- New Mexico would monitor social media postings of hospital staff and take other steps to prevent the delivery of inaccurate information. For example, hospital personnel who updated their Facebook pages with information on an emergency have been terminated in the past.
- New Mexico would select appropriate spokespersons for message delivery, information dissemination and communications. For example, the New Mexico Secretary of Indian Affairs serves on the Homeland Security Advisory Council and would be asked to help identify tribal leaders who could serve as spokespersons to the 25 different Tribal Nations in the state.
- Louisiana would utilize informal networks to correct inaccurate information that is posted on social media during an emergency. For example, a case of suspected meningitis caused panic in a local community due to premature, inaccurate information that was posted on Facebook about the undiagnosed case. Pediatricians conducted active surveillance of the social media postings by obtaining anecdotal reports from patients of HCPs in the local community and students who attended school with their children.
- Texas would disseminate different types of information depending on the target audience, such as the general public, physicians/other HCPs and first responders. Texas would deliver messaging to explain the transmission of and exposure to smallpox, describe the signs and symptoms of smallpox, identify centralized sites for persons to present for appropriate testing and treatment if needed, outline the characteristics of patients who need to be quarantined, and summarize the overall quarantine process.

7. *What actions would your state team take at the facility where the exposure occurred (e.g., the medical school, clinic, hospital or other locations)?*

- Louisiana would use its existing pool of resources to disseminate HAN notices to physicians, talking points to spokespersons, updates to hospitals, and accurate information to communities during the event. These resources would include the Joint Information Center, Emergency Support Function 8 Network, and Designated Regional Coordinators (DRCs). The DRCs would closely collaborate with infection control staff and facilitate ongoing communications during the event with patients in the ED, the local medical school where the smallpox exposure occurred, and clinics/hospitals that treated Amelia. Louisiana would engage in extensive discussions with the CDC to obtain more information on the infection control practices of the medical school laboratory, such as its storage of additional vials of smallpox samples and routine use of universal precautions. Louisiana would launch a communications campaign to reach clinic/hospital laboratory staff that handled Amelia's specimens and persons who rode on the same bus as Amelia during her infectious period. Because Amelia is not a household contact, however, Louisiana's messaging would emphasize the low risk of exposure. Louisiana would use its shelf kits to rapidly distribute pre-scripted messages to first responders, vulnerable populations and other potentially affected groups. Louisiana would open a toll-free hotline to disseminate smallpox information to community leaders and other members of the public. Louisiana would reach out to its Bureau of Media and Communications to ensure

that GOHSEP officers, regional medical directors, regional officers and other state officials post accurate and consistent information on Facebook, Twitter and other social media outlets. Louisiana's shelf kits for smallpox and other events are available in American Sign Language (ASL) and can be shared with other states.

8. *Would your state team include any component of quarantine for exposed persons or isolation for ill patients? If so, what steps would your state team take to implement this process?*

- Texas would determine whether public health and local law enforcement officials should be involved in the quarantine process. However, Texas acknowledges that resources would need to be identified and leveraged to support the quarantine process. Most notably, Texas would consult with human resources personnel at the outset to address issues related to exposed HCPs who self-quarantine in their homes, such as paid leave time.
- Louisiana would replicate its Ebola experience for the smallpox scenario by implementing a voluntary quarantine process. Strike Teams would actively monitor individuals who self-quarantine in their homes based on their signs and symptoms. Louisiana would consult with its legal department in all aspects of the quarantine process, including a review of the state's existing sanitary codes, to avoid future litigation.
- Arkansas would need to obtain expertise from the CDC on whether parents can remain in an isolation room with their children who are an index smallpox case. Dr. Fisher explained that guidance on this issue will differ depending on the infectious agent (e.g., smallpox, Ebola or influenza). Hospital infection control staff should consult with CDC to address the complexities related to a specific agent. Dr. Petersen's position was that parents should be allowed to remain in the isolation room with their children. Parents who are vaccinated prior to exposure will be provided with some level of protection from smallpox. However, smallpox vaccine can still be given to parents who were exposed prior to their child's hospitalization. Based on this feedback, the state teams asked the AAP and CDC to develop and issue quarantine and isolation guidelines for pediatric cases of smallpox, Ebola and other infectious agents. The state teams pointed out that the new AAP/CDC guidelines should emphasize the following message: "Parents are an integral part of the care team for children affected by [infectious agent]." The state teams recognized that the new quarantine and isolation guidelines would be much easier to implement at a pediatric rather than a non-pediatric hospital.

### **MODULE 3: SMALLPOX VACCINATION**

The session for Module 3 included an introduction of Module 3 (smallpox vaccination on days 1-21 of the scenario), state team reports of their findings in response to the Module 3 questions, and an overview of the role of the national AAP office/leaders in the smallpox scenario.

## Introduction of Module 3

Dr. Schonfeld introduced Module 3 by announcing that a decision has been made to vaccinate all members of the medical staff in the clinic, ED and hospital. Vaccination also is now being offered to members of the public health department who were involved in secondary case finding.

Dr. Schonfeld gave the state teams 25 minutes to address the Module 3 questions. For all three questions, he instructed the state teams to describe both the content of messages and their methods of distribution.

## State Team Reports: Module 3 Questions

Dr. Schonfeld moderated a session for the state teams to report their findings in response to the Module 3 questions.

9a. *What is your state team's strategy for delivering messaging to HCPs at sites where smallpox vaccination is offered?*

- New Mexico would deliver consistent messaging to HCPs from a single source (ideally the state health department). The messaging would thank HCPs for providing excellent care to their patients; acknowledge concerns about the safety of patients due to the smallpox case that presented to the hospital; describe the risks of smallpox (e.g., the 30% case fatality rate among untreated persons); and highlight the benefits of smallpox vaccination (e.g., the high efficacy rate of  $\geq 95\%$ ). New Mexico would strongly encourage and advocate for smallpox vaccination of HCPs to ensure the safety of their patients and family members. Because New Mexico is uncertain of its legislative authority to implement mandatory smallpox vaccination of HCPs, the influenza model would be replicated. HCPs who receive flu shots have a recognizable sticker on their hospital badges, while HCPs who do not receive flu shots are required to wear a mask for the duration of the influenza season.
- Texas would launch a campaign to offer smallpox vaccination to the family members of HCPs who potentially were exposed and might pose a risk for transmission of infection.
- Oklahoma would first identify the best site for smallpox vaccine delivery to HCPs, such as hospitals, the state health department or state Medical Reserve Corps. After selecting the vaccine delivery site, Oklahoma would convene hospital town hall meetings to disseminate messaging to HCPs at multiple levels; develop and distribute a list of frequently asked questions; and provide physicians with rigorous scientific data from the CDC: "No absolute contraindications have been identified for smallpox vaccination." "The two replication-competent smallpox vaccines in the SNS have a high efficacy rate of  $\geq 95\%$ ." Oklahoma's

messaging also would provide HCPs with truthful and straightforward information regarding the AEs associated with smallpox vaccination, the administration route, and necessary monitoring post-vaccination to document uptake.

- Arkansas would present a brief synopsis to HCPs at sites where smallpox vaccination is offered. The overview would cover smallpox signs and symptoms, AEs, appropriate storage and proper administration of the vaccine, and contact information for smallpox SMEs in the state. The HCPs would be given sufficient training to ensure that the integrity of smallpox vaccine that the CDC deployed from the SNS is not compromised. However, Arkansas would need to modify its existing legislative authority to implement mandatory smallpox vaccination of HCPs.
- Louisiana would consult with the CDC to obtain expertise on logistical issues related to smallpox vaccine administration. Louisiana does not have sufficient capacity, trained staff or other resources at this time to implement mass vaccination to HCPs, first responders and their exposed family members during the smallpox scenario. Dr. Dziuban clarified that in the smallpox scenario, states could utilize the existing Epi-Aids process to request SMEs or other types of technical assistance from the CDC during an emergency.

9b. *What is your state team's strategy for delivering messaging to HCPs at sites in the city or state where smallpox vaccination is not offered?*

- New Mexico's messages to this group of HCPs would be similar to those for HCPs at sites where smallpox vaccination is offered. However, the messaging would emphasize that the state health department only recommends vaccination of HCPs who were directly involved with the smallpox case. Any HCPs with questions or concerns regarding their potential exposure would be advised to contact the statewide nursing line for referral to an epidemiologist at the state health department.
- Texas would use its existing pool of resources to deliver messaging to diverse groups of HCPs, including communication channels of local health care facilities to reach individual HCPs; the HAN to reach a broader audience of HCPs; and Regional Advisory Councils to reach hospital preparedness HCPs, emergency medical services staff and staff in 650 hospitals.

9c. *What is your state team's strategy for delivering messaging to staff at the medical center where the exposure occurred (i.e., the healthcare facility where Amelia received treatment)?*

- Texas would offer smallpox vaccination to this group of HCPs first due to their direct role in administering the vaccine to Amelia and handling her specimens.

## Overview of AAP's Role in the Smallpox Scenario

### **Benard P. Dreyer, MD, FAAP**

President  
American Academy of Pediatrics

### **Karen Remley, MD, MBA, MPH, FAAP**

Executive Director & CEO  
American Academy of Pediatrics

Drs. Dreyer and Remley joined the Tabletop Exercise by teleconference to describe the role of AAP leadership in disseminating information to its entire membership of pediatric providers during the smallpox scenario.

Dr. Remley explained that AAP's first step would be to gather accurate information on all aspects of the smallpox exposure from credible sources, such as the CDC and the Kansas Department of Health and Environment. The AAP would then begin developing the communications and messaging strategy by forming a leadership team with representation by its Executive Committee, head of public affairs, and the chairperson of the AAP Committee on Infectious Diseases. Dr. Pam Shaw, Vice Chairperson for the AAP district that includes Kansas, also would be engaged with the leadership team at the outset.

The AAP would target the communications strategy to both its membership and the general public. During the dissemination of information to the public, it would be particularly important to address confusion regarding exposure to a disease that is commonly believed to have been eradicated. Most notably, the AAP offers a comprehensive Web site for parents or uses HealthyChildren.org. This Web site has 86,000 registered subscribers and receives ~2 million views per month. A duplicate site is provided in Spanish. The AAP would use HealthyChildren.org to inform the public of up-to-date pediatric health news during the smallpox scenario and provide links to important information from the CDC. Depending on the questions from the "worried well" population, the AAP also would post a video on its Web site to describe the events that caused Amelia's exposure to smallpox and the risk of exposure to other persons.

The AAP leadership would be a key participant in daily teleconferences with the CDC leadership over the course of the smallpox scenario. Most notably, the AAP and CDC would designate skilled, trusted and experienced liaisons to ensure that the communications strategy was organized, systematic, coordinated and collaborative. The AAP and CDC liaisons would have oversight of ongoing message delivery to frontline clinical pediatric providers and public health officials in the field.

Dr. Dreyer added that AAP would use a variety of mechanisms to facilitate ongoing and rapid communications with its membership. The AAP Web sites would be continuously updated with messages as the smallpox scenario evolves, particularly protocols for pediatricians to take action. The *AAP SmartBrief* publication would be used to inform pediatricians of emerging developments in the smallpox scenario on a daily basis. A set of standardized talking points would be widely distributed to ensure that AAP chapters in Kansas and other states deliver consistent and accurate messages to local media outlets. Specific state and local information would be directly disseminated to leadership and members of the AAP Kansas chapter if needed.

Drs. Dreyer and Remley provided additional details on the AAP communications and messaging strategy during the smallpox scenario in response to specific questions posed by the state team members.

- The AAP would provide pediatricians in the field with several resources to aid in the delivery of consistent messages and the dissemination of accurate information to families during the smallpox scenario. For example, the AAP Web sites would be updated with links to talking points for pediatricians, information for pediatricians from credible sources, and a list of key points for pediatricians to communicate to the parents of their patients. Pediatricians would be able to download and print all of these resources to be displayed in their offices or distributed to families. The AAP would provide pediatricians with guidance on effective and rapid communications with families via email blasts, and Facebook, Twitter or other social media outlets. The AAP would reach out to its existing pool of respected pediatric communicators and bloggers to develop and disseminate videos and press releases to pediatricians in the field. Based on feedback from the state teams, however, the AAP leaders acknowledged the need to collaborate with the CDC to develop a package of smallpox materials for pediatricians to display in their offices.
- The AAP would implement the communications campaign during the smallpox scenario in close collaboration with its large pool of national partners that also advocate for and have a strong interest in children's health.
  - The American College of Physicians would be engaged for outreach to its membership of internists and other medical sub-specialties.
  - The American Congress of Obstetrics and Gynecologists would be engaged for outreach to its membership of clinicians who serve women of childbearing age, pregnant women and the fetus.
  - The American Academy of Family Physicians would be engaged for outreach to its membership of family physicians, residents and medical students.
  - The American Nurses Association, National Association of Pediatric Nurse Practitioners, National Association of School Nurses, and the Association of Public Health Nurses would be engaged for outreach to their memberships of pediatric nurse practitioners.
  - The Association of State and Territorial Health Officials and the National Association of County and City Health Officials would be engaged for outreach to their memberships of public health officials at state, territorial, city and county levels.

## MODULE 4: STRATEGIC NATIONAL STOCKPILE

The session for Module 4 included an overview of the SNS, an introduction of Module 4 (deployment of the SNS on days 22-23 of the scenario), and state team reports of their findings in response to the Module 4 questions.

### Overview of the Strategic National Stockpile

#### **Susan Gorman, PharmD, MS, DABAT, FAACT**

Associate Director for Science, Division of Strategic National Stockpile  
Office of Public Health Preparedness and Response  
Centers for Disease Control and Prevention

Dr. Gorman presented an overview of the SNS that the CDC established in 1999. The SNS is a \$6.5 billion repository that currently maintains 900 different line items (e.g., antibiotics, chemical antidotes, antitoxins, vaccines, antiviral drugs and other lifesaving medical material) to supplement and re-supply state and local public health agencies in the event of an emergency. SNS medical material is held in a network of locations near U.S. transportation hubs and is positioned to optimize timely and clinically relevant deployment.

The SNS material utilization plans are integrated with state and local planning and also with a broader U.S. government preparedness and response framework. All states and territories have developed their individual plans to receive and distribute SNS medicine and medical supplies to local communities as quickly as possible. Tribes are incorporated into state and local plans, but might request direct support from the SNS. CDC uses FedEx, UPS and other commercial partners to deliver materials through their existing capabilities that are used daily throughout the United States and internationally.

The CDC can deploy SNS support teams to assist state and local officials in receiving stockpile assets during a PHE. The role and responsibilities of the SNS support teams include helping to establish federal medical stations and serving as liaisons between EOCs in affected areas and the SNS. However, vaccinators do not serve on the SNS support teams.

The CDC rationale for stockpiling material is three-fold. First, some required products, such as smallpox vaccine, are not commercially viable or available. Second, because the U.S. pharmaceutical supply chain operates on a just-in-time model, commercial products might not be available in the projected quantities required or might be unable to reach affected populations in adequate timeframes or quantities. Third, the commercial supply chain is not optimized to dispense products to affected populations at the required time, volume or level.

The CDC has prioritized biological, chemical, radiological/nuclear and pandemic influenza formularies in the SNS. Agents treated by these formularies include smallpox, anthrax, botulism, viral hemorrhagic fevers, plague, tularemia and nerve agents. The process for requesting SNS assets begins with the recognition that drugs and medical supplies have exceeded state and local resources. Governors, their designees or other state officials request federal assistance. After key officials from HHS, the U.S. Department of Homeland Security, the CDC and the requesting state discuss the request, federal officials deploy SNS assets to augment federal, state or local medical material resources.

The CDC has developed several product configurations to meet the needs of a particular SNS deployment. Forward-placed caches of chemical nerve agent antidotes (i.e., CHEMPACKS) must be rapidly administered to be clinically effective. The 12-hour push package includes about 50 tons of various medical materials that are deployed within 12 hours of federal approval. The CDC deploys this product configuration when the threat is unknown. The SNS-managed inventory represents the bulk of the repository, including vaccines, antiviral drugs, antibiotics, smallpox MCMs and specialized response kits. The vendor-managed inventory stockpiles MCMs that have a commercial use. The CDC also has the ability to directly order products that are not stockpiled in the SNS at the time of an event.

Smallpox MCMs that are stockpiled in the SNS at this time are highlighted as follows. The three smallpox vaccines include ACAM2000™, WetVax and MVA. A package insert and medication guide CD-ROM are deployed with ACAM2000™ because this product is the only smallpox vaccine approved for use by the U.S. Food and Drug Administration (FDA). Ancillary supplies needed to administer smallpox vaccine include diluent, transfer needles, bifurcated needles and vial stabilizers. Other MCMs include vaccinia immune globulin, cidofovir, probenecid and tecovirimat.

The CDC deployment of vaccine from the SNS will depend on the scale of an event. To administer smallpox vaccine to all persons in the United States, for example, the CDC developed a plan in the early 2000s to deliver the first 75 million doses within 24 hours of a large-scale event. Pre-configured doses would be deployed to each city with a population of >10,000 persons. Smallpox vaccine for a smaller, more contained event would be shipped to a receiving/storage/staging area that has been pre-designated in each state or the state/local health department. Unlike influenza vaccine, the CDC does not ship smallpox vaccine from the SNS directly to individual physicians' offices.

The CDC has addressed all issues related to shipping smallpox vaccine from the SNS. All of the vaccines have a cold-chain requirement of being stored frozen at -20°F, but the products can be shipped refrigerated at 2-8°F. This is because the FDA has not approved the use of MVA at this time, however, the manufacturer's preference is for the product to be shipped frozen at -20°F. Depending on the type of shipping container that the CDC uses, the temperature of frozen or refrigerated smallpox vaccine can be maintained from 6-128 hours. Ancillary supplies are shipped separately from, but at the same time as smallpox vaccine at room temperature. Each shipment

also includes a gauge to verify the temperature of the vaccine and instructions on the time restrictions of its storage and use.

## Introduction of Module 4

Dr. Schonfeld introduced Module 4 by describing plans to deploy the SNS.

### *Day 22*

- The decision is reached to vaccinate all students who attended the same program as Amelia in the event of their potential exposure.
- The following information becomes known. Brian Yoder, the student who helped Amelia with the cleanup and disposal of the smallpox vial, traveled to Houston, Texas by Greyhound bus on day 19 to attend a large family reunion. Brian's ~75 relatives from the five TALON states, Alaska, Idaho, Montana, North Carolina and Oregon already were in attendance before he arrived. Although Brian felt ill on day 19 and was febrile on day 20, he still attended the family reunion. Brian went to bed later in the day, but several relatives hugged him prior to their departure. Brian's health continued to deteriorate and he was taken to a local ED on day 21. He was admitted, but the hospital had no access to his medical records. His condition was diagnosed as likely enterovirus infection.
- The hospital is informed that Brian possibly was exposed to smallpox.

### *Day 23*

- The decision is made to broaden vaccination beyond Kansas.

Dr. Schonfeld gave the state teams 30 minutes to address the Module 4 questions.

## State Team Reports: Module 4 Questions

Dr. Schonfeld moderated a session for the state teams to report their findings in response to the Module 4 questions.

*10. What other groups would your state team now include in plans for smallpox vaccination?*

- Louisiana's vaccination strategy would include all travelers who rode on the same Greyhound bus as Brian, all of his relatives who attended the family reunion, and all local ED staff directly involved in his treatment. Louisiana would convene an epidemiologic team to conduct contact tracing. Louisiana would consult with the CDC and maintain ongoing communications with the other nine states where Brian's potentially exposed relatives reside.

- Oklahoma would convene teleconferences with the CDC and representatives from the other four TALON states to develop an ongoing, effective and coordinated communications protocol over the course of the multi-state vaccination strategy. Oklahoma would solicit technical assistance and expertise from the CDC to form a team of trace workers and epidemiologists. Oklahoma would extensively integrate community paramedicine resources into the vaccination strategy, such as EMS providers who have a special scope of practice to vaccinate individuals. Oklahoma would vaccinate all of Brian's relatives who attended the family reunion and follow up with their family members who were not in attendance. Oklahoma would use CDC's existing guidelines to follow-up with travelers who rode on the same Greyhound bus as Brian.
- Texas would not include travelers who rode on the same Greyhound bus as Brian in its vaccination strategy. Because persons are not infectious during the 7- to 17-day incubation period, Brian likely posed no risk when he rode on the Greyhound bus and became febrile on days 19-20 post-exposure. Moreover, the hospital learned of Brian's potential exposure on day 22, but a smallpox diagnosis was never made. Based on these factors, Texas would limit its vaccination strategy to Brian's family members. Travelers on the Greyhound bus would be identified for quarantine, isolation and observation to rule out smallpox. However, Texas would need clarification from the CDC regarding the turnaround time for polymerase chain reaction (PCR) test results before implementing its proposed strategy. Dr. Petersen explained that the CDC uses swabs of the patient's lesions to conduct diagnostic PCR testing of smallpox and can obtain results within 24 hours after receiving the specimens. To eliminate delays due to shipping specimens to the CDC, various LRN sites across the country can be used to conduct variola testing as well.
- New Mexico would include all symptomatic persons in its vaccination strategy because atopic dermatitis is the only relative contraindication.

11. *What recommendations would your state team make to address Brian's relatives who were exposed at the family reunion in Houston and already have returned to their home states? (Note: With the exception of two cousins who have upper respiratory infection symptoms and a low-grade fever, none of Brian's other relatives are ill).*

- Louisiana would recommend isolation, vaccination and quarantine of all persons with identified exposure until the end of the infectious period.
- Oklahoma would deploy Strike Teams to address Brian's relatives who attended the family reunion and already have returned to their home states. This approach would be taken to minimize fear and emphasize that the smallpox exposure is confined to a small group of individuals.

12. *The SNS contains a sufficient supply of smallpox vaccine to immunize all persons in the country, but the CDC recommendation is that ACAM2000<sup>TM</sup> is contraindicated for individuals with atopic dermatitis unless clear exposure is evident. MVA is a safer alternative for persons with atopic dermatitis, but the SNS has a limited supply of this product. What steps would*

*your state team take to ensure that this limited supply is appropriately dispensed among children?*

- Louisiana would implement a targeted vaccination strategy to ensure that the limited MVA supply in the SNS is adequate to meet the needs of children and other populations in the state. Louisiana would revise its existing pre-screening vaccination form by including an additional question: “Do you or your child have atopic dermatitis?” The use of the revised pre-screening form by the epidemiologic team would strengthen Louisiana’s capacity to properly allocate limited resources throughout the state.
- New Mexico would take a proactive approach to requesting SNS assets by asking CDC to deploy 8,000 doses of WetVax and 4,000 doses of MVA. New Mexico’s position was that these doses would be sufficient to vaccinate ~10,000 persons in the state. New Mexico has developed a rigorous protocol for distributing and dispensing MCMs, antiviral drugs and smallpox vaccine from the SNS throughout the state. New Mexico would notify its primary transport resources and maintain ongoing communications with the emergency management services (EMS) community.
- Arkansas would conduct surveillance to ensure the judicious use of smallpox vaccine. Patients with possible smallpox exposure would be screened to identify a history of atopic dermatitis and inform decision-making on vaccination with MVA versus ACAM2000™. Arkansas would develop a pre-screening vaccination form to support this effort.
- Texas is aware that some individuals might falsify their pre-screening vaccination forms to receive a safer smallpox vaccine with fewer complications. Texas would verify cases of atopic dermatitis before administering MVA by conducting more in-depth screening of the patient, asking the patient’s physician to perform a physical examination, or requesting written confirmation of atopic dermatitis from the physician based on the patient’s medical records.

## **MODULE 5: SOCIAL MEDIA**

The session for Module 5 included an introduction of Module 5 (social media postings on day 25 of the scenario) and state team reports of their findings in response to the Module 5 questions.

### **Introduction of Module 5**

Dr. Schonfeld introduced Module 5 by describing changes in the smallpox scenario in response to social media postings. The following messages have appeared on social media outlets as plans are being implemented for vaccination.

- “The smallpox vaccine causes and prevents smallpox at the same level.”

- “The smallpox vaccine causes heart attacks.”
- “The smallpox vaccine is associated with autism.”
- “The government is going to run out of the vaccine within 24-48 hours.”

A high-ranking official in Louisiana is interested in limiting “scary” messaging about a possible case in a second state (e.g., Texas). A high-ranking official in New Mexico recently launched an election campaign and is in a period of critical fundraising. She has insisted on vaccination for all New Mexico citizens to show her effectiveness as a leader.

#### *Day 25*

- Several county hospitals in New Mexico have started diverting all pediatric patients with fever or any other symptoms that suggest a possible infectious disease to a children’s hospital in Arizona. However, Arizona has no known smallpox cases and none of Brian’s relatives from the family reunion are residents of the state. The children’s hospital in Arizona has no smallpox treatment unit and has become overwhelmed by the surge in patient referrals. Most of these patients do not appear to require evaluation or treatment at a specialized children’s hospital.
- Schools are scheduled to resume in your state. Some school and government authorities in your state have questioned whether school openings should be postponed.

Dr. Schonfeld gave the state teams 30 minutes to address the Module 5 questions. Unlike the other modules, however, he explained that the state teams would partner with their colleagues in neighboring states to conduct Module 5.

### **State Team Reports: Module 5 Questions**

Dr. Schonfeld moderated a session for the state teams to report their findings in response to the Module 5 questions.

13. *What advice would your state teams provide to the school systems regarding closures or delayed openings?*

- Arkansas would encourage schools to remain open and disregard the panic and hysteria caused by social media rumors.
- Oklahoma would provide local school superintendents with accurate and up-to-date information and expertise on children’s preparedness at the outset to inform their decisions on whether to close or delay openings of schools. Oklahoma would implement this strategy based on valuable lessons learned during the 2015 Ebola outbreak. Several Oklahomans were on one of the cruise ships that returned from Africa, but ~6 school districts in the state closed their schools for no apparent reason. Due to losses in revenue, work productivity and staff resources, school superintendents now recognize the critical

importance of obtaining guidance from pediatric preparedness experts before making a decision to close or delay the opening of a school.

- Louisiana would replicate its mass influenza vaccination campaign in school systems in pre-planning activities for smallpox. This effort has resulted in a successful collaboration among public health, school systems and individual academicians. For example, school superintendents and school nurses have direct contact information to local public health officials and pediatricians to rapidly obtain expertise and guidance on closing or delaying the opening of a school in response to an infectious disease threat or other health crises. Moreover, local public health officials routinely are on school meeting agendas, serve on a workgroup with the Department of Education, and regularly engage school nurses in pre-planning activities. Close collaboration, coordination and communications are particularly important in Louisiana because public, private/parochial and charter schools in the 64 parishes across the state greatly vary in terms of their leadership, organizational structures and operations.

14. *What strategies would your state teams implement to respond to each of the social media rumors?*

- Oklahoma and New Mexico would use existing telephone banks within in their school systems to disseminate accurate and factual information via mass text messaging and by responding to questions posed by parents, teachers and the general public.
- At the national level, Arkansas would use the CDC, AAP and other professional associations as sources of high-level and credible information to respond to social media rumors. At the community level, Arkansas would reach out to local leaders and respected community members to combat the social media rumors with indisputable facts.
- New Mexico would engage its PIO to monitor social media messages and directly respond to rumors with accurate information on Facebook, Twitter or other platforms. Both New Mexico and Oklahoma would post the following message on their health department Facebook pages: "For correct information, please go to [link]."

15. *What approaches would your state teams use to brief HCPs?*

- This was believed to have been sufficiently addressed in previous discussions. None of the state teams responded to question 15.

16. *What steps would your state teams take to create plans for handling up to 25 cases of smallpox in your state and for monitoring, isolating and quarantining up to 250 children? (The state teams were instructed to consider sharing resources across state lines.)*

- Arkansas, Louisiana, Oklahoma and Texas have a long history of planning and collaboration, such as launching regional planning exercises for Ebola, conducting a recent tabletop exercise, establishing formal memoranda of agreement or understanding (MOAs/ MOUs) to support cross-state preparedness efforts, and maintaining strong

partnerships and workgroups. The four TALON states would use their existing cross-state infrastructure to handle the smallpox cases and monitor, isolate and quarantine additional children. However, the four TALON states acknowledged that two key gaps need to be addressed to increase opportunities for regional planning and preparedness activities. First, the public health community should make stronger efforts to engage AAP to ensure pediatric clinicians in each state play a prominent role in future tabletop exercises of threats that impact children. Second, a strategy should be developed to manage the disconnect and inconsistency between federal regions and AAP districts. For example, all five TALON states are within HHS Region VI, while Mississippi and four TALON states (Texas, Arkansas, Louisiana and Oklahoma) are within the same AAP district. (It was recommended that AAP consider “re-districting” to be consistent with federal regions.)

- New Mexico would replicate the existing system that Oklahoma has established for persons who self-quarantine, such as designating individuals to provide food, assistance and other necessary resources.
- Texas would use its state Hospital Preparedness Program and health care coalitions to establish linkages between private HCPs and public health to collectively handle the smallpox cases and monitor, isolate and quarantine additional children. However, the composition and organizational structure of health care coalitions vary across states. For example, oversight of health care coalitions is by Regional Advisory Councils in Texas and by the Missouri Hospital Association in Missouri.
- Texas has a high level of capacity and resources, including several children’s hospitals, to handle 25 smallpox cases. Moreover, 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. Texas would share these resources with neighboring states to ensure that all 25 smallpox cases are appropriately handled across state lines. To monitor, isolate and quarantine 250 children, Texas would apply its experiences and lessons learned in housing and caring for unaccompanied minors who cross the U.S.-Mexico border.

#### **CONCLUSION OF THE SMALLPOX SCENARIO**

*17. The PHE is now over and your state team is convening a task force to develop future preparedness plans for children. Your state team is asked to identify potential task force members and offer ideas for specific planning. What would be your state team’s potential recommendations? Why would your state team provide this guidance? What steps can your state team take to improve plans for distributing and dispensing MCMs to children?*

#### *Recommendations by the New State Task Forces*

- Oklahoma was impressed by the children’s preparedness activities conducted by the CDC and state health departments overall, but gaps in linking these public health efforts to emergency medicine and general pediatrics stakeholders were noted. Oklahoma advised the AAP/CDC consider identifying funds to convene a one- or two-day tabletop exercise that would specifically focus on filling gaps in public health/pediatric medicine planning and readiness. Oklahoma also emphasized the need to invite SMEs and the TALON states to

the tabletop exercise. Oklahoma's position was that a future drill and ongoing AAP/CDC support would be extremely valuable in helping the TALON states to organize their task forces. Dr. Fisher announced that the AAP offers a mechanism for states to enhance disaster preparedness/response efforts through its Friends of Children Fund for disaster relief. Although the fund is specifically targeted to recovery efforts, she raised the possibility of using these resources to support public health/pediatric medicine disaster planning exercises for children.

- Oklahoma advised the TALON states to reach out to their AAP chapters to obtain support for children's preparedness activities in their individual states and localities. Several AAP chapters leverage discretionary funding from private foundations that can be used for various purposes.
- Texas recommended using the Tabletop Exercise as a model for the TALON states to develop children's preparedness plans for non-infectious disease threats, such as preparedness for natural disasters or storm readiness.
- Texas recommended targeting education on children's disaster preparedness to medical residents. This approach would increase the available pool of skilled and trained SMEs during a PHE. A representative from Texas currently is developing a disaster preparedness educational program for medical residents and would welcome the opportunity to share this resource with others after its completion.
- New Mexico recommended providing parents and other caregivers with clear guidance in two key areas to improve plans for distributing and dispensing MCMs to children: (1) use of purified or distilled water rather than tap water as a diluent to reconstitute amoxicillin and (2) instructions for crushing doxycycline tablets. New Mexico emphasized that the current doxycycline tablet crushing instructions include erroneous information. Dr. Fisher reminded the state teams that MVA is not a licensed smallpox vaccine in the United States, but the product can be used under the Emergency Use Authorization mechanism. As a result, guidelines also would need to be disseminated on the limitations, restrictions and special considerations regarding the use of MVA in children. For example, MVA might be excluded from the National Vaccine Injury Compensation Program (NVICP) because NVICP only covers AEs from vaccines that are recommended for universal use. However, CDC will confirm whether NVICP covers AEs from MVA.
- New Mexico, Louisiana and Texas recommended the following groups to serve on their state task forces.
  - Law enforcement
  - Attorneys to address legal issues related to isolation and quarantine
  - Emergency management to ensure core competencies in the FEMA *Comprehensive Preparedness Guide* and other capabilities
  - Social workers and representatives from psychological support services to help children cope with death and other trauma
  - Interpreters, translators and tribal leaders to address specialized issues related to cultural competency, language barriers and tribal medicine
  - Pediatricians with skills and experience in overcoming vaccine hesitancy and barriers to administering vaccine to infants and young children

### *Recommendations on Children's Preparedness Resources*

- Texas noted that the HHS Hospital Preparedness Program (HPP) and the CDC PHEP cooperative agreements both require exercises to be conducted from the tabletop level up to a full-scale event. Texas recommended that the HHS and CDC consult with AAP leadership to ensure that language on children's preparedness exercises is included when these funding opportunity announcements are developed. Texas also advised pediatric clinicians to contact their local, state or regional health department to propose ideas of children's preparedness exercises so that public health and pediatricians could jointly conduct in the future. Dr. Fisher added that AAP members should act on every opportunity to ensure children's issues are fully represented in disaster drills and other preparedness exercises routinely conducted by health departments in their individual states. She also urged AAP members to make suggestions to health departments in which children's preparedness would serve as the primary focus of upcoming exercises. Dr. Krug wholeheartedly agreed with the recommendations by Texas and Dr. Fisher for the state teams to strongly advocate for children's preparedness at state and local levels. He pointed out that recent data show that current hospital readiness exercises typically exclude children or include no more than two children.
- New Mexico conveyed that the Health Resources and Services Administration funds the Emergency Medical Services for Children (EMSC) Program in each state. The state EMSC programs have made tremendous progress over time in improving the pediatric components of emergency medical care in their states, particularly in the area of mass casualty readiness. The state teams should extensively engage EMSC representatives in their children's preparedness efforts, but funding streams greatly vary across states. For example, New Mexico allocates all of its EMSC funds to support the program coordinator. Colorado allocates all of its EMSC funds to programmatic activities, development and outreach because other resources are leveraged to support personnel.
- The FEMA representative informed the state teams that the Emergency Management Institute (EMI) has added 4-5 virtual tabletop opportunities over the past two years to be conducted in collaboration with local emergency management. These exercises include infectious diseases, but pediatric issues generally are excluded. However, the EMI has expressed a willingness to allocate its FEMA resources to design tabletop exercises in response to proposals that are submitted.

### **Hotwash Session**

#### **Aaron Gardner, MD, MPH, FAAP**

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Eastern Idaho Regional Medical Center

Dr. Gardner moderated the hotwash session for the state team members to reflect on the objectives of and their individual experiences with the Tabletop Exercise; review key points raised

during the discussions; highlight effective strategies and lessons learned; propose suggestions to improve children's preparedness efforts in the future; and describe practical changes that will be made in states as a result of the Tabletop Exercise.

#### *Effective Strategies*

- The AAP/CDC Exercise Planning Team organized an extremely productive Tabletop Exercise by convening the five TALON states that already have a history of cross-state collaboration. The structure of state teams addressing various issues over the course of the smallpox scenario was effective as well. This format enabled the public health and pediatric clinical communities to establish new partnerships and identify opportunities for collaborative efforts in the future. Generally, the pediatric and public health representatives on the state teams had not met each other before, and most were not aware of preparedness efforts occurring in other disciplines. Some state teams already were proposing future agreements for communication and had identified specific follow-up actions.
- The AAP/CDC Exercise Planning Team should continue to invite FEMA representatives to future children's preparedness exercises.
- The outstanding facilitators of the Tabletop Exercise were extremely knowledgeable.

#### *Lessons Learned*

- Children's hospitals in the TALON states that provide care to critically ill children should establish MOAs/MOUs in advance to ensure ongoing support across state lines and minimize the burden on a particular state or region during a PHE. For example, Arkansas previously conducted a survey to all EDs in the state to determine their pediatric mass casualty plans for any emergency. All EDs that responded to the survey planned to transport their pediatric cases to the Arkansas Children's Hospital in Little Rock during an event. Based on the survey results, Arkansas would have no capacity to handle 25 smallpox cases or monitor, isolate and quarantine 250 children. The establishment of MOAs/MOUs also would be critical to other rural states that have only one children's hospital.
- EMS should be engaged in children's preparedness efforts at the outset to resolve transport issues well in advance of a PHE. If a smallpox event occurred during influenza season, for example, hospitals in one state already would be at full capacity and would need to transport their pediatric cases to facilities in other states.
- Opportunities to collaborate with adult preparedness efforts should be identified. These groups are well-established and have an existing pool of resources that could be leveraged to include children's preparedness efforts.
- The HPP and PHEP grantees have made strong efforts over time to collaborate in aligning their adult preparedness activities. The CDC Division of State and Local Readiness should provide national leadership in identifying opportunities for HPP and PHEP grantees to coordinate their activities with pediatric preparedness efforts at state and local levels.

#### *Areas of Improvement*

- The AAP/CDC Exercise Planning Team should improve the following areas before the Tabletop Exercise is replicated for use by states, localities and regions.
  - A stronger focus should be placed on addressing national pediatric surge capacity. To enhance efforts in this area, states should leverage their collective assets to create a broader base of resources to meet the needs of 25 smallpox cases outlined in the scenario.
  - More modules and questions that are specific to the SNS (to tap into the specific expertise of the state public health SNS representatives) should be included.
  - Most real-life PHEs impact multiple states and require collaboration across state boundaries. More cross-state collaboration should be included in the exercise for state teams to identify common gaps, overlapping activities and potential opportunities to share resources. The Tabletop Exercise allowed state teams to partner across states in conducting only one of the five modules.
  - Module 2 (strategic communications and effective messaging) should be revised to include an exercise on overcoming historical cultural issues. For example, African American and Native American parents might be particularly distrustful of their children being vaccinated, especially with a non-licensed product.
  - Module 3 (smallpox vaccination) should be revised with an exercise on engaging PIOs in the development and dissemination of messaging to HCPs.
  - An existing module should be revised or a new module should be added with an exercise on addressing the special health care needs of children with disabilities during a PHE. For example, many parents likely would not consent to administering smallpox vaccine to their autistic, blind, deaf or wheelchair-bound children.
  - Local groups that will be extensively involved in the response in the field should make brief presentations to introduce each module, such as an emergency preparedness overview by a state police officer or a school superintendent.
  - More emphasis should be placed on addressing the limited supply of pediatric medical materials in state stockpiles. For example, the supply of adult medical materials in the Oklahoma stockpile at this time could not be used to care for pediatric patients.
  - Frontline HCPs that play a significant role in PHEs in the field should be invited to future exercises, including local public health, EMS, transport providers and hospital representatives. Because the state teams would be larger, more resources should be devoted to convening future exercises for more than one day.
- The communication strategy that AAP leadership would develop and implement during a PHE should include the following message for its membership of pediatricians: “Contact your local jurisdiction for specific guidance.” During the 2015 Ebola outbreak, for example, local and regional public health staff in several states noticed that different guidance was distributed at the local level (compared to national guidance). The fact that there will be differences between national and state/local guidance, should be recognized and addressed. Consistent guidance that is specific to the local level where the response will occur should be disseminated.

### *Upcoming Changes in States*

- New Mexico will build and maintain a strong relationship between its state health department and the EMSC coordinator.
- Louisiana will invite the pediatricians on the state team to serve on its Senior Advisory Group at the state health department. Louisiana will use its HAN to disseminate children's preparedness messaging and update its shelf kits with information on pediatric readiness issues. The Louisiana Volunteers in Action Registry will be used to determine smallpox vaccination coverage among medical and non-medical volunteers who provide assistance during emergencies. Louisiana will conduct an inventory of supplies in its cold storage stockpile at this time. The Louisiana AAP chapter will use a portion of its foundation funds to convene a half- or full-day session on pediatric/public health issues during its August 2016 AAP chapter meeting. The public health officials on the state team will be invited to the AAP chapter meeting along with communication experts, nurses and pediatric hospital representatives. The state team will initiate plans to replicate and conduct the Tabletop Exercise in public health regions within Louisiana.
- Several states will launch vaccination campaigns for children and their families that plan to attend the Summer Olympics in Rio de Janeiro, Brazil in August 2016. Many of these travelers might return to their home states with the Zika virus.

Dr. Schonfeld reminded the state team members to complete the worksheet in their meeting notebooks requesting them to identify actions and strategies. The AAP/CDC Exercise Planning Team would use the written responses from these worksheets and the feedback provided during the hotwash session to evaluate the overall success of the Tabletop Exercise, share effective strategies with other groups that also have an interest in pediatric preparedness exercises, and identify areas of improvement based on specific outcome measures.

#### **WRITTEN RESPONSES TO THE EVALUATION QUESTIONS**

*What collaborative strategies could AAP chapters, pediatric clinicians and public health leaders implement to advance pediatric preparedness at state and local levels?*

- The CDC should extensively engage public policymakers and hospital affiliations in its pediatric planning efforts.
- States should increase the use of their HANs to improve smallpox knowledge and subject-matter expertise. The AAP chapters should encourage their memberships of pediatric providers to register to receive HAN alerts and text messages in their states.
- The CDC should provide contact information for its EOC staff to enable public health and pediatric providers at state and local levels to obtain guidance in response to their smallpox questions.
- States should implement a process to determine current smallpox vaccination coverage among first responders and emergency volunteers in their states and localities.
- States should facilitate opportunities for public health preparedness staff and EMSC coordinators to build and sustain strong collaborative relationships over time.

- States should ensure that pediatric providers are routinely included in their cross-state public health preparedness drills and other exercises. (It was noted that an AAP chapter contact for disaster preparedness is already available in every state.)
- States and localities should conduct joint public health/pediatric exercises and training events that are similar to the Smallpox Tabletop Exercise to strengthen collaboration in children's preparedness.
- States should designate a children's preparedness page on their Web sites that would allow pediatric providers to download information on the current event in real-time, toolkits and other resources. States could use the medical licenses of pediatric providers to control access to and ensure the security of their Web sites.
- States and localities should widely publicize the following message during an emergency involving children: "If you believe you were exposed, call [toll-free hotline] or seek care at [name of alternate care facility]. This approach would decrease the surge at EDs and the offices of pediatric providers.
- States should establish formal MOAs/MOUs in advance to enable pediatric providers to prescribe MCMs across state lines during an emergency involving children.
- Schools and public health should leverage their existing collaborative efforts in children's preparedness, such as school-based influenza vaccination campaigns, to improve pediatric planning and readiness efforts at state and local levels.
- States should convene pre-planning and preparedness meetings to clearly define the roles and responsibilities of specific groups during a pediatric event: health departments, AAP chapters, epidemiologic staff, hospital associations, infection control staff, PIOs, tribal partners, behavioral health experts and the HAN.
- States and localities should establish a toll-free hotline and develop a list of frequently asked questions in advance that would be available to the public during a pediatric event.
- Localities should direct persons with potential exposure or those showing symptoms to an alternate care site to protect ED patients from exposure.
- States and localities should extensively engage pediatric providers with emergency preparedness experience outside of children's hospitals and other health care facilities.
- States should reach out to the Texas AAP chapter to obtain guidance in developing a pediatric screening form for all Category A agents.
- States should use their health care coalitions to establish and maintain linkages to pediatric preparedness efforts.
- The HHS/HPP and CDC/PHEP grantees should engage pediatric providers in their federally-funded preparedness efforts.
- States should conduct an assessment to determine needs, identify other specific issues, and evaluate the current level of capacity in children's preparedness at state, local and regional levels.

*What steps could states take to improve communications that are specific to children's preparedness?*

- States should designate a page on their Web sites with standardized scripts, key talking points and other resources that would be available to pediatric providers to facilitate children's preparedness communications.
- State public health representatives should collaborate with their AAP chapters to increase the number of pediatric providers who subscribe to and regularly use the HAN. States also can expand their HANs to include medical trainees and other health partners in children's preparedness communications. However, states should first take steps to update, improve and fill gaps in the messaging capabilities of their HANs. Most notably, pediatric providers should be educated on the ability of state HANs to deliver unified messaging. States should closely collaborate with the CDC to ensure that information and messaging from its national HAN are disseminated to all levels of the pediatric healthcare community in the field. 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.
- States should establish toll-free hotlines for the public to make inquiries about current health concerns related to a pediatric event in the state and specific localities.
- States should engage their EOCs or Incident Command Systems in advance to facilitate ongoing children's preparedness communications to the following groups during an event: schools/departments of education (including messaging in ASL and non-English languages that are spoken in the community), child care facilities/home child care centers and the Indian Health Service. However, state planning efforts should include the administration of a survey to determine current capacity to deliver messaging in ASL and specific non-English languages.
- States should collaborate with the extensive pool of social media experts within the AAP Council on Communications and Media to rapidly communicate up-to-date children's preparedness information to the public through Facebook, Twitter and other platforms.
- States should allocate resources to local schools and their partners to establish a reverse 911 system in advance to respond to questions by families during a pediatric event.
- States should allocate hospital preparedness program and other funding to localities to conduct tabletop exercises that specifically focus on gaps in children's preparedness and related communications.
- States should engage local law enforcement and attorneys in preparedness discussions to address legal issues related to the quarantine of children during an emergency.

*What strategies could be implemented to optimize plans for distributing and dispensing MCMs that are suitable for pediatric care and relevant to the smallpox scenario?*

- States should conduct exercises that include actual case studies in which MCMs were distributed and dispensed to children in previous pediatric events.
- States should establish formal MOAs/MOUs with pharmacies and large businesses to distribute and dispense MCMs to children.

- The CDC SNS support teams should develop and disseminate a clear and succinct list of pre-screening guidelines to assist in properly dispensing MCMs and preparing adult formulations for children. For example, ACAM2000™ is the only smallpox vaccine that the FDA has approved for use in the United States, but the product is contraindicated for persons with atopic dermatitis. Purified or distilled water rather than tap water should be used as a diluent to reconstitute amoxicillin for children. The guidelines should be widely available to pediatric providers on CDC, AAP and state health department Web sites.
- States should identify the most appropriate site (e.g., health departments, hospitals or Medical Reserve Corps stations) to distribute and dispense MCMs to children and conduct follow-up.
- States should implement a rapid notification process to inform local pediatric providers of the delivery and availability of SNS assets from the CDC.
- States should engage law enforcement, attorneys and social services to address legal and other specialized issues related to administering MCMs to children.
- The CDC should continue to collaborate with the AAP to inform its membership of pediatric health care providers across the country as to whether AEs from vaccines (eg, MVA, a smallpox vaccine that is not licensed for use in the United States), would be covered by NVICP.
- All states, particularly those with large rural areas, should establish a protocol in advance for EMS providers who have a special scope of practice to administer smallpox or other vaccine during a pediatric event.
- The CDC should clarify two issues: whether the SNS maintains information related to MCMs for pediatric care beyond crushing directions of adult medications for children's dosages and if true pediatric doses will be included in the SNS in the future.

#### *Other Comments*

- The five TALON states have a well-established collaborative history of addressing preparedness issues, but this type of partnership is not common in most other regions.
- The PIOs should be extensively engaged in Module 3 (smallpox vaccination).
- The EMS representatives should be included in all disaster preparedness efforts.

## Closing Session

Dr. Dziuban announced that the AAP/CDC Exercise Planning Team would convene a series of children's hospital teleconferences for all-hazard preparedness. The first teleconference will be held on February 9, 2016 and would include a synopsis of key outcomes from the Tabletop Exercise. He asked one pediatrician and one public health official from the state teams to participate on the teleconference and provide their individual feedback.

Dr. Krug explained that the next steps would be to determine how best to replicate national public health/pediatric clinical partnerships in states and localities. An evaluation survey would be

administered to the state teams to provide additional feedback. Efforts would be made to develop a virtual, less resource-intensive tabletop exercise for states and localities to conduct to improve their children's preparedness capacity.

Dr. Peacock thanked the state teams for providing their thoughtful insights and perspectives on preparing for and responding to a smallpox scenario at state and local levels that involved children. She hoped the state team members would sustain their new relationships and maintain ongoing communications over time to improve the health of children during an emergency.

Drs. Krug and Peacock asked the participants to join them in thanking and commending several groups and individuals who played an instrumental role in the Tabletop Exercise.

- The AAP/CDC Exercise Planning Team was applauded for organizing an excellent and productive Tabletop Exercise.
- Drs. Fisher and Schonfeld were applauded for developing and facilitating the five smallpox scenario modules.
- Dr. Petersen was thanked for serving as the smallpox SME for the Tabletop Exercise.
- The state team members were thanked for remaining highly engaged over the course of the Tabletop Exercise and providing AAP and CDC with outstanding input.
- The CDC was applauded for providing AAP with solid expertise, ongoing support and funding. The CDC also was thanked for its national leadership in and ongoing commitment to engaging professional associations and other private-sector partners to improve public health, especially in regards to children's preparedness.



## Attachment 1: Participants' Directory

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## Attachment 2: Glossary of Acronyms

AAP	American Academy of Pediatrics
AEs	Adverse Events
ASL	American Sign Language
CDC	Centers for Disease Control and Prevention
DRCs	Designated Regional Coordinators
ED	Emergency Department
EMI	Emergency Management Institute
EMS	Emergency Management Services
EMSC	Emergency Medical Services for Children
EOC	Emergency Operations Center
FDA	U.S. Food and Drug Administration
FEMA	Federal Emergency Management Agency
GOHSEP	Governor's Office of Homeland Security and Emergency Preparedness
HAN	Health Alert Network
HCPs	Health Care Providers
HHS	U.S. Department of Health and Human Services
HPP	Hospital Preparedness Program
LRN	Laboratory Response Network
MCMs	Medical Countermeasures
MOAs; MOUs	Memoranda of Agreement; Memoranda of Understanding
MVA	IMVAMUNE®
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NVICP	National Vaccine Injury Compensation Program
OPHPR	Office of Public Health Preparedness and Response
PCR	Polymerase Chain Reaction
PHEP	Public Health Emergency Preparedness
PHEs	Public Health Emergencies
PIO	Public Information Officer
SMEs	Subject-Matter Experts
SNS	Strategic National Stockpile