

COCA Call: Coordinating Pediatric Medical Care Across the Community During an Influenza Pandemic

Date/Time: September 22, 2010 (3:00- 4:00 PM ET)

Presenters:

Sherline Lee, MPH - DHQP, CDC

Sarita Chung, MD - Children's Hospital Boston

Molly Dunn, RN - CentraCare Clinic Women and Children

Tom Schrup, MD - CentraCare Clinic

Michael R. Anderson, MD - University Hospital of Cleveland.

Coordinator: Welcome and thank you for standing by. At this time, all participants are on a listen-only mode. After today's presentation, we will conduct a question and answer session. To ask a question, you may press star 1. You will be prompted to record your first and last name. Today's conference is being recorded. If anyone has any objections, you may disconnect at this time. I'd now like to turn the conference over to Miss LeShaundra Cordier.

LeShaundra Cordier: Thank you. Good afternoon. I'm LeShaundra Cordier and I'm representing the Clinician Outreach and Communication Activity, COCA, with the Emergency Communication System at the Centers for Disease Control and Prevention, CDC.

Welcome to today's COCA conference call, Coordinating Pediatric Medical Care Across the Community During an Influenza Pandemic. We're pleased today to have five subject matter experts discussing strategies and sharing tools to help clinicians plan for and respond to pediatric emergency care across their community.

Today's Webinar will consist of presentations followed by a question and answer session. As mentioned, please dial star 1 to put yourself into queue for

**Coordinating Pediatric Care Across a Community During an Influenza Pandemic
Wednesday, September 22, 2010, 3 – 4PM (Eastern Time)**

questions. We are using a PowerPoint presentation that you can access via Live Meeting at the link provided on our Web site. That's emergency.cdc.gov/coca. You can click on "conference calls" and the link and slides that can be found under today's date.

Please feel free to listen in only mode if you're unable to access the Webinar. Our objectives for today's call are that participants will be able to discuss how primary care and multi-specialty clinics can work collaboratively to manage pediatric emergencies during a widespread H1N1 pandemic.

Our second objective is to describe steps which can be taken to promote infection control in an outpatient setting and identify elements that should be included in healthcare facility's emergency plan to address a surge in pediatric patients.

This presentation will not include the discussion of the unlabeled use of products under investigational use. CDC, our planners and presenters wish to disclose that they have no financial interest or other relationships with the manufacturers of commercial products, suppliers of commercial services or commercial supporters. There is no commercial support for this presentation.

Our moderator for this Webinar is Miss Sherline Lee. Sherline Lee has been an epidemiologist in the healthcare preparedness activity at the Division of Healthcare Quality Promotion of CDC since January 2004. She's been actively involved in pandemic influenza planning at the federal interagency level, has helped plan healthcare-related workshops for communities, developed tools for community planners, provided review of local and state pandemic influenza plans and responded to multiple emergencies in the CDC Emergencies Operation Center.

**Coordinating Pediatric Care Across a Community During an Influenza Pandemic
Wednesday, September 22, 2010, 3 – 4PM (Eastern Time)**

At this time, please welcome today's COCA call moderator, Miss Lee.

(Sherline Lee): Good afternoon, everyone. This is Sherline Lee from the Division of Healthcare Quality and Promotion. I have the distinct pleasure of introducing our four presenters on this call who were part of a multiagency, public and private stakeholder meeting held on September 9 and 10 of 2009.

These assembled stakeholders provided the input and expertise that resulted in the development of several tools and resources that were used by the pediatric healthcare community during the 2009 novel H1N1 influenza pandemic.

These tools or resources are listed here on the slide and include the planning guide for vaccinating pediatric patients against 2009 H1N1 Influenza in primary healthcare settings, the healthcare providers and facilities decision tree for 2009 H1N1 vaccination, the pandemic influenza pediatric office plan template and the coordinating pediatric medical care during the influenza pandemic hospital workbook.

The first two items are archived at our CDC site at www.cdc.gov/H1N1flu. The second or the last two items on the slide are archived and available to you, the callers, at emergency.cdc.gov/healthcare. And in your PowerPoint slide there should be a direct URL link from which you can access the tools.

This afternoon, the presenters will use several of the tools developed from this meeting and their experiences during the pandemic to discuss issues relevant to clinicians and community planners who care for pediatric patients. The speakers will be highlighting issues that private practices and hospitals may face in the future while preparing for an increased volume of pediatric patients

**Coordinating Pediatric Care Across a Community During an Influenza Pandemic
Wednesday, September 22, 2010, 3 – 4PM (Eastern Time)**

and will also be sharing which strategies and tools that they feel could address these issues.

First, this afternoon we will have a presentation from Dr. Sarita Chung on Disaster Preparedness Initiatives, followed by Molly Dunn and Dr. Tom Schrup on the Pediatric Office Response to H1N1. Dr. Michael Anderson will give the final presentation on pediatric surge hospital readiness.

As we conclude the presentations, we will open this call to questions. During that portion of the call, we will also be joined by Laura Aird from the American Academy of Pediatrics and Dr. Georgina Peacock who is a pediatrician at the National Center for Birth Defects and Developmental Disabilities who works on child health issues here at CDC.

With that final note, I'd like to now turn the presentation over to Dr. Sarita Chung from Children's Hospital, Boston.

Sarita Chung: Thank you, Sherline I'm Sarita Chung, member of the Disaster Preparedness Advisory Council and a Pediatric Emergency Room physician at Children's Hospital, Boston. I am delighted to discuss with you the disaster preparedness initiatives from the American Academy of Pediatrics, and I have nothing to disclose.

The American Academy of Pediatrics, the AAP, is an organization of more than 60,000 pediatricians committed to the attainment of optimal physical, mental and social health and well-being for all infants, children, adolescents and young adults.

The AAP has been actively involved in disaster preparedness and response efforts for many years. In 2006, the AAP identified disaster preparedness as one of seven strategic health priorities. Also recently, the AAP established a task force on the Vision of Pediatrics 2020 to review trend data and developed megatrends that are likely to influence the profession of pediatrics in children.

Eight megatrends were identified and one being the effects of natural, man-made disasters. The overall goals for the AAP in disaster preparedness include: ensure that children's issues are addressed as early as possible in the development of disaster programs and activities; involve pediatric experts in all levels of disaster planning and response and support AAP members and other child health providers to integrate pediatric issues into state plans.

In order to accomplish these goals, the AAP established the Disaster Preparedness Advisory Council, the DPAC, in 2007. The council is a multidisciplinary group consisting of pediatricians with backgrounds in primary care, mental health, infectious disease and emergency medicine. The council also worked closely with federal partners to advocate for children's needs, which include the Department of Homeland Security, Centers for Disease Control and Prevention, Food and Drug Administration, the National Institute of Child Health and Human Development and the Department of Health and Human Services, Assistant Secretary for Preparedness and Response.

In addition, the council has established a network of 50 pediatric disaster experts and 600 academy members who are interested in disaster medicine. The following is a list of activities and accomplishments of the DPAC and its network in the last year, among which includes working closely with the National Commission of Children and Disasters. Three of the commissioners

are AAP members, including Dr. Michael Anderson who you will hear from today.

Quickly recognizing the impact that H1N1 had on the pediatric population, the AAP established a leadership team that worked closely with the pediatric desk of the CDC. Many AAP members participated in CDC shareholders [stakeholders] meetings to help understand the evidence and recommend changes to the guidelines based on their local experience.

Collaboratively, the AAP and CDC developed documents that define which children are at greater risk for influenza, clinical algorithms, and practice guidelines for primary care offices and hospitals.

This is an example of the triage algorithm for children with influenza-like-illness, which was developed by the CDC and AAP. Applications of this algorithm to primary care will be discussed later in this session.

One of the tools presented at the CDC stakeholder meeting was the online tool Disaster Preparedness for Pediatric Practices, created by Dr. Scott Needle, whose primary care practice was affected by Hurricane Katrina. This tool has been updated to include lessons learned from the H1N1 pandemic and steps and strategies to promote infection control. This disaster preparedness online tool is available on the AAP Web site.

And in addition, the AAP has created a resource Web site to help families, health care providers and schools discuss disasters and their effect on children. Highlighted this month is preparation for hurricanes and tropical storms and activities surrounding National Preparedness Month.

Thank you. This concludes my presentation.

Tom Schrup: Good afternoon. We are excited to be here today to present one practice's experience in ambulatory pediatrics in response to the 2009 H1N1 pandemic. Since there is such variation in size of practices, I'll just mention at the start that we're a midsize practice of 19 pediatricians and 3 nurse practitioners as part of a large multispecialty clinic. And I'd like to just start out going through the slides by pointing out the first priority in dealing with a public health event is to have a good decision making structure.

I just have - we just have a brief snapshot there of the structure we used. This may not work for all practices. Many small practices may choose to use their existing structures, but for larger practices I think it's nice to include subject matter experts in what we call a flu team.

In our case, we just included a medical director, nurse manager and an administrative lead. You can look at the diagram there to see who their reports were. We found that that was very useful in disseminating information and making decisions. Next slide, please.

The key responsibilities of the flu team are listed there. Most importantly, of course, is leadership. During a public health or any large-scale event, people need to know where to turn to get accurate information and quick decision making. So the leadership team is able to fulfill that role.

Important in being able to do that, however, is the support from both their partners in a private practice or from administration in a larger group. The leadership needs to be able to be empowered to make decisions.

The second point I make there, which I think is extremely important, is the importance of leading by example. Of course, during events there is a lot of time spent on meetings, but it's very important for, in my opinion, for leadership to be on the front lines as well, demonstrating the tools that we use, demonstrating PPE, et cetera. So we consider that quite important.

The next function is communication. And I would say most importantly, development of communication. Communications can be carried out by other people, but the team and subject matter experts really need to be the go-to people to set up and develop the communication items themselves. Internally, we did that communication with providers themselves, nursing and other staff and externally, of course, with patients, public health contacts and others.

And then finally, that team's responsibility was to develop policies and procedures. And I give a couple examples there. Since this structure comes into place when it's not business as usual, decisions need to be made regarding how to segregate well from ill patients, et cetera, staffing changes and one issue that we ran into quite a bit was exclusion from work. And I suspect that others will have comments on that as well.

We had, for example, pregnant workers and many are aware there's specific guidance for them. And so, that was an issue. So those are what we see as the flu team's responsibilities. Next slide.

One of their responsibilities is of course, is developing communications. And that can be carried out through others. We use communication through multiple modes -- some which we use for both staff and patients, as I list at the top there. We had Website updates which was extremely helpful in terms

of not getting bogged down with repetitive questions of the similar type. And that can be used for both staff and patients.

We used telephone messaging, specifically when people are on hold and we used the mass media. For staff alone, Molly's going to talk in a little bit about some of the presentations that she did. And that was extremely important, especially in the early days when staff were fairly frightened about the safety of themselves, their families from catching the illness when it wasn't clear - when the severity wasn't clear, I should say.

We also used email and we used daily briefings prior to work. I'm going to move on to triage and the challenge that we had with that. I've included a slide from the - including the jointly developed triage algorithm that was developed by both the [American] Academy of Pediatrics and CDC.

And we were very pleased to have that tool and greatly appreciate their efforts in providing it. As can be seen from looking at it, it is a - because the guidance itself was somewhat complex at times, it is a fairly lengthy algorithm. And when we had large numbers of people calling in, it was at times a challenge to implement it.

In addition, it's important to point out that private pediatric offices are really not used to being in a role of advising people to stay home if they're concerned and want their child seen. So that's a real frame shift for people and I think any training you can do in advance to discuss that with your staff that manages the phones is useful.

And again, tying the advice that you're giving to local, state, and federal authorities is extremely helpful. It's very distressing for families to get

different advice from different providers and different sources of information. So it's very important to coordinate with others. I can't really overemphasize the importance of that networking in advance.

One thing that happened here specifically in Minnesota which was helpful is the Minnesota Department of Health partnered with a private sector provider to do a statewide flu line which gave out consistent advice. And that did ease some of the pressure on us, so I appreciated their efforts in that area.

Going on to the next slide, just pointing out how broad the case definition is for influenza. In 2009 H1N1, we did not have a rapid, accurate test for H1N1 2009, and so we had a difficult time of course triaging rapidly and had to decide based on case definition.

Unfortunately, that was quite broad. Typically, since triage means literally to sort patients, you'd like to have a tight case definition and/or an accurate test that can help you quickly sort patients. In any event, of course, we didn't have either of those. So what that led to, on our - on the last slide that I have here, is Further Challenges with Triage, which was - which included the broad case definition, large numbers of worried well, both presenting and calling by telephone.

In addition, the challenges were - risk factors in the population were fairly common of course, specifically asthma and the lack of the rapid test and the fact that we had an intermittent - intermediate risk age group at 2-5, where they weren't the highest risk patients, but because of the - because of some literature, because of the guidance, we couldn't consider them completely without risk. And that was a little bit difficult to communicate with families at times.

Overall, however, I felt that the response went very well. And we're going to come back to what went well and didn't go well. I'm going to have Molly talk with you just a little bit about staff education first.

(Molly Dunn): In regards to staff education, we really feel that we should have mandatory staff education sessions so that everyone was able to get the information that was needed. We also really thought emphasis should be placed upon having the same educators for all sites so that the same information was given across the board. So that decreased the amount of confusion.

As well as we really work together with clinics, hospitals - region and state, which I felt was very - which I felt that it was very positive for myself to be able to work with all of these people -- to be able to coordinate together to get the right message across for both staff and patients.

We also put together a Jeopardy PowerPoint, which we actually got the idea from the Minnesota Department of Health and we just put a little bit of our own spin to it. But it seemed to be very effective for education and it also made it fun at the same time.

We also had Q&A sessions at the end of each meeting, which we found very beneficial because we found that a lot of people had questions that needed to be answered. And if we didn't have the answer at the time, we thought it very beneficial to be able to use email to get back to those people within a day or two.

We also had a little part of that education session dedicated to correct usage of PPE and the donning and doffing of that equipment. We found that a lot of

staff, it was very confusing and it was very nice to have people actually standing in front of you to show you how to correctly don and doff your equipment.

We also had, as Dr. Schrup had eluded, that we did do daily updates with our leadership as well as with our staff. And also, I just referred to Page Number 7 of the Pediatric Office Pandemic Plan template, which is very useful when considering staff education. Next slide, please.

Patient education - we thought it was very important to educate our patients as well as our staff. We really wanted to emphasize, of course, hand washing. And with that, we found that signage was very useful. And we also used the Minnesota Department of Health for that as well. And we also have it in multiple languages.

We also taught about the proper use of wearing a mask. Although some patients didn't want to wear a mask, we really tried to encourage them to. However, we couldn't force them to wear a mask. Also, we encouraged to cover your cough and we showed them the correct way to do that.

Also, I encourage you to check out Page Number 10 of the Pediatric Office Pandemic Plan template as well, in regards to patient education. Next slide, please.

In regards to infection control and patient flow, we were very excited actually, to begin what was called and develop a hot zone. What that entailed was segregation of patients. What we had done, was prior to the patient coming in to the clinic when they made their appointment, they actually were flagged per se, to say it possible or rule out H1N1, so that when the receptionist checked

in the patient, they saw that and they were able to give the patient a mask immediately when they came into the clinic.

As I stated before, some patients did not want to wear a mask so we tried to room them immediately, as well as those with masks we tried to room immediately. We also had designated waiting areas for ill and well patients. We really had positive feedback from patients with that as well.

We also, as I stated before, patients were masked and roomed immediately. Our exam rooms were designated as hot zone rooms so the only patients that were in those rooms were those suspected of having H1N1 or flulike illness. We also designated for lab. Lab actually came to the rooms to do the patients' lab draws. Instead of having the patients roaming around the clinic, we thought it was very beneficial to have lab actually come to the room.

As well as, imaging came to pick up the patient at the time of the appointment instead of having them waiting in the separate waiting room with all of the other patients in the imaging area. We had designated hallways in our hot zone areas as you will see two slides ahead, that we found that was very beneficial as well so that we didn't have cross-contamination of patients as they were walking by.

We also had segregation of equipment. We found that to be very helpful, which the equipment stayed in the hot zone rooms only. That equipment was washed in between each patient as well as was the room. We also had a lot of signage, which you will see on the next slide, which refers to our hot zone area. Stop signs, mask and garbage only, mask patients only. We found that very beneficial and the patients thought that was very useful as well, to mark those areas.

I also encourage you to look at Pages 11-14 of the Pediatric Office Pandemic Plan template in regards to patient flow. If we could go to the slide after the signage, I apologize for the busyness of this slide, but we just wanted to show you a little bit of how we had our hot zone set up.

As you can see, the first line to your right is a yellow line. That is where our - that is where the patient checked in, as well as their waiting area. Then they were immediately brought straight back to either one or the other hallways to where the designated hot zone rooms were. This was also close to our lab and imaging, and when the patients had to go there as well.

Tom Schrup: Thank you. So briefly, in summation what went well, as you can see on the next slide, advanced preparation really paid off, particularly in the early days when both staff and families were most concerned about virulence of the virus. The control and consistency of messaging breeds confidence of both the public and the staff. I really can't overemphasize that and I think to develop that, you really have to have those relationships developed over time with public help.

And then finally, patient segregation routing was really beneficial and greatly appreciated by our patients. Not so well, I think this is something we could do better on our end is working on our triage when it's not business as usual. And then, finally we had some challenges in different parts of the organization, not necessarily close by, but in various parts with physician buy-in.

People come to these sorts of events with different perspective and we need to respect that, but also need to have some consistency in the best interests of the

public. We very much appreciate your attention and look forward to taking questions later. Thank you.

Michael Anderson: Thank you, and good afternoon everyone. My name is Mike Anderson. I'm an intensive care pediatrician in Cleveland, Ohio at Rainbow Babies and Children's Hospital. And I'm proud to sort of a back cleanup here and hopefully finish by about 3:45.

I have a number of slides that are really background on children and disasters. And as Sarita said, I'm proud to be on the National Commission on Children and Disasters. We have sort of a broad range of audience members. So if I'm a little bit too remedial, I apologize. I want to cover some high points and then really emphasize the document that was created which is a guide for hospitals in preparing for pandemic and for children.

I have no financial or other conflicts to tell you about. And as I said, I want to talk a little bit about day-to-day readiness. It's great to be prepared for pandemics and for big disasters, but I think we as a nation also have to be prepared better for little disasters. And that's just the single patient, or what we call "the disaster of one". I'll talk a little bit about preparation for mass events in hospitals, potential solutions and then really emphasize, I think, some very good parts of that hospital guidebook that you have available on the web.

Obviously, a pandemic in H1N1 taught us a lot and I think - I want to once again thank the CDC for reaching out to the pediatric community - to the AAP, to NACHRI which is the Children's Hospitals [National Association for Children's Hospitals and Related Institutions]. I really felt the cooperation was second to none. But as I said, and a lot of folks have seen me show this

slide, we want to be prepared for big disasters, mass amounts of children in surge.

But this is a favorite picture of mine of a small kid that presented to a rural emergency department with massive Meningococemia. And I think we as a nation, we as public health planners need to make sure that our rural emergency departments, those places that will potentially care for kids, are really ready day-to-day to take care of children's needs, be they small or large.

So Take Home Point Number 1 for my talk today is if we're really ready day-to-day with the right training, the right equipment, the right transfer protocols in place, the right transport assets at our ready, the right drills. Have we really practiced for the needs of children in crisis? If we've really reached out and become a truly regionalized approach or a regionalized network for children, we're going to be prepared for a bus accident. We're going to be prepared for mass pandemics or surge events.

Take Home Point Number 2, and once again I apologize that this is a remedial slide for folks that do this for a living. Suffice it to say that the kids are very unique patients. And we in urgent care centers and emergency departments and non-pediatric hospitals have to realize that their physiology is markedly different.

And here you just see a couple of brief examples of same. They have a larger head, a higher center of gravity. They become colder quicker. They have access nightmares, very small veins, and obviously it's important to know what kids weigh. It's also important to know that their vital signs vary with age.

If a facility, an emergency department or a hospital is used to taking care of adult patients, these sort of swings or changes in vital signs are really quite difficult to get a handle on. And they obviously have different disease processes and require different triage tools.

So once again, we all know that children are not small adults. I think for those institutions, and especially we saw here in Northeast Ohio, those places that weren't really used to taking care of kids had to sort of dust off the memory banks and do some pretty rapid pediatric refreshers, if you will.

If you turn now to looking at children in disaster situations such as pandemic or other things, God forbid, like nerve-agent attacks or other biological, kids have thinner skin so it can absorb a toxin much more rapidly. If they have a greater body surface area, compared to their weight. They're closer to the ground. They have a faster metabolic and respiratory rate so they can inhale toxins much quicker.

And obviously you think about kids in schools or kids in daycare centers. They're often found in large groups with only one adult to many kids. They're unable to escape and they're often, like I said, found in large groups. So once again, when looking at planning for the next disaster, the next pandemic, both regional and local planners have to take these unique aspects of kids into mind.

Once again, looking at terrible things like biological, we know kids become dehydrated more quicker, more quickly I should say. Smallpox or other sort of vaccines, they have a higher risk of complications and you can sort of read these slides as you will. Once again, kids are not small adults.

They also need the right sized equipment. You have to be able to take care of large amounts of kids. And as we saw with surge, sometimes non-pediatric facilities, so you have to have the right size IV, the right known vaccine, the right dose of vaccine and the right equipment, unlike this child which was obviously a posed picture.

Another example of other equipment that emergency departments, who don't take care of kids, on a regular basis such as the Broselow system, should be a part of every emergency department. And then obviously we have to be prepared for a large number of kids who require either intramuscular injections or intravenous injections as well.

And then finally, before I get to surge stuff, we believe, or we as pediatricians and planners believe that each part of the continuum of care really need to be prepared for kids. On the far left of the slide you see EMS personnel, many of whom were really involved in H1N1 and the pandemic. A DMAT tent is located there on the bottom. Obviously, due to some great efforts at Health and Human Services and the National Disaster Medical System, we're trying to make the nation better prepared for the needs of kids.

But transport professionals and then finally our children's hospital there is seen on the right, all need to be prepared whether it's pandemic, one injured child or a mass casualty event.

So Take Home Point Number 3 is a sobering one. I think it's great that everybody's on this call. I think it's great, the great work CDC has done but it's sort of my assessment - this is my own personal assessment - that we're not as prepared as a nation for children's disasters as we should be.

If you look at our current emergency care system, it's woefully underfunded. Come to northeast Ohio and I'll show you what a crowded emergency department can look like. And once again, the great majority of children in this country are not cared for in children's hospital ERs. They're cared for in adult ERs.

And often times, you know, it's just really benign neglect that children's needs are not really taken into account in those non-pediatric facilities. If you look at once again, our colleagues in EMS, they take care of a lot of kids, but often times have an experience gap or a training gap when it comes to kids.

And as I mentioned, a great majority of kids over 90 percent are cared for in general hospitals. ERs, but those ERs often times don't have the right equipment, the right training or the right folks. Once again, sort of benign neglect, if you will.

And once again the IOM [Institute of Medicine] report from 2006 really had a sobering assessment and identified in very real terms, training gaps, supplies gaps and research gaps. So let's talk about surge, which is really what I was supposed to talk about in the last 10 minutes. This is a picture of Rainbow, my children's hospital in the middle and our six surrounding community hospitals.

Only one of which admits children on a regular basis. When we were in the middle of surge, we really started to reach out to those hospitals and say, "Look, if it gets bad, if we start to be close to full or full in our children's hospital and all our other colleagues in town can't really take any more kids, these institutions are going to have to either admit kids, hold kids in an observation area or figure out some sort of triage."

And to be honest, that sent some panic through that these institutions that are used to picking up the phone and transporting children to their local pediatric hospital maybe weren't able to do that. And that's why I think if you delve into the planning section of that hospital preparedness tool that the CDC has developed, there's some really good practical advice.

If pandemic comes back and non-pediatric facilities are going to need to take care of kids, there's some really good checklists in there that deal with that very intense situation. And once again, that's just a link to those resources.

So let's break it down into a couple different elements. Children's hospitals are seen as the gold standard for pediatric care, but children's hospitals need to really dust off their surge preparedness plans and be prepared to take care of kids.

Area number one, I think that the children's hospitals have to figure out who are the regional hospitals and how do we liaison with them? What's our internal surge? If we go to 110 percent, 120 percent or 150 percent capacity, how are we as a pediatric facility going to do that? Do we have alternative staffing models? What if our staff is either taking care of sick children themselves at home or not able to report to work because they're sick? How do we have alternative staffing models?

How do we get positions and nurses who aren't routinely part of our practice to come in and be a part of our children's hospital? Are we in touch with our local community response? Are we part of the EMA? Are we part of really the disaster preparedness community for our area?

And quite frankly, a lot of children's hospitals aren't as involved as they should be. Are we really practicing family-centered care during a disaster? Do we have resources for families in a very stressed and intense environment? And then finally, this isn't really a topic for today, but do we have triage in place? Are we ready to make some tough potential ethical choices when it comes to limited resources and the care of children?

It didn't come to that, at least in northeast Ohio during pandemic, but I think it's a discussion the nation still has to have as far as the ethics of that and the triage tools we still need to develop.

This is for the local emergency department - the local hospitals. If you're not used to taking care of kids, if you have a simple 5 to 10 perhaps small pediatric board or observation ward, what are the things that you need to do? Once again, there's some better details in the CDC document.

But once again, it's an AAP recommendation that every hospital have a pediatric liaison. That person that is the constant clanging cymbal for pediatric issues and for all things pediatric. So we think developing that liaison is very important. Do you have the ability to care for children in your facility? What if you were called to do so? What's your internal pediatric capabilities and how could you ramp that up if you needed to?

How do you coordinate once again, with the community? Are you part of those disaster preparedness and the EMA sort of network? Can you provide family-centered care? And then once again, the same issues that would affect a pediatric hospital such as triage, and who are the sickest kids that deserve quaternary care and who are the kids that you can really sort of hold on to and observe?

And then finally, the local and regional planners. We believe, and the commission has been pretty forthright about this, and Sarita also outlined it a little bit with the Academy, but we believe that pediatric experts should be at the table when you're talking about disaster preparedness. Kids are 22 percent of the population. I think lumping them into planning documents with vulnerable populations really doesn't give them as much credit as kids really need, and we feel that local and regional planners preparing for the next pandemic or preparing for the next disaster really need to have pediatric expert teams at the table.

And then finally, I think it's important to be integrated into the federal response. And this is a little bit of a busy slide. At the top right, you can see Health and Human Services, which the charge of emergency service function eight, it's one of my beliefs that the non-government organizations such as pediatricians, nurse practitioners, pediatric nurses, really have to figure out better ways to integrate in.

And I really want to thank HHS and NDMS for building some really solid bridges to our pediatric community, as well as the CDC. So my conclusions are, kids are important. They're 22 percent of the population. They have very unique physiology, but I think they're underrepresented in disaster planning and I think that the resources that the CDC have developed for hospital planning, and my colleagues from Minnesota outlined for primary care offices are really quite excellent tools. That concludes my remarks.

LeShaundra Cordier: Operator, we're ready to open the line for question and answers.

Coordinator: At this time, we're ready to begin the formal question and answer session. If you would like to ask a question, please press star 1 on your touch-tone phone. You will be prompted to record your first and last name. Please remember to uncheck your mute button while recording your name. Again, to ask a question, please press star 1. One moment, please.

Sherline Lee: Hi. This is Sherline Lee, and while we're waiting for questions I thought I'd like to ask our presenters just their thoughts and what their next steps were after last year. What were the things that stood out and what have they been doing this year and what will they be doing in the future to prepare for large surge events like a pandemic?

Michael Anderson: It's Mike. I'll start. I think that several folks emphasized the importance of drills. I think that H1N1 taught us a lot of lessons, but I think if you let things - the dust settle on your emergency plan or your surge plan it will become rusty and it will become yesterday's news. So we've had some pretty intense pediatric disaster drills, both with our community hospitals as well as our ped hospitals to continue to push, what if we had a - this is a mass casualty event, but to really continue to drill and make sure that we were ready.

Sherline Lee: Tom and Molly, would you also like to comment? Or Sarita?

Tom Schrup: Yes, this is Tom. Yeah, I would echo what Mike said. You know, we were going to continue to, you know, practice our plans. We're going to really continue to work with the relationships we have both with local and state public health as well as try to reach out to other healthcare providers both locally and within the state because they're - it's just very difficult to have those communications during the time of the event when you don't know

somebody well from previously. So that's what we're going to focus on in the short term.

Sarita Chung: And this is Sarita. I agree with Tom and Mike. I think we did learn a lot. You know, in the emergency departments we did see the surge as well as primary care. And for us, we built an alternate care site. We looked back and looked at the efficacy, and financially how that is and how we can improve it next time. We also worked on, just from the hospital perspective, communication. How can we approve communication signage and as Tom said, it's multi-modality so is it videos? Is it now Twitter, you know? Is it social media that we can use to help get our message across?

Laura Aird: And this is Laura Aird at the AAP. As an organization, we've completed an H1N1 after-action report that includes several lessons learned and about 16 recommendations as of this morning. So we'll be following up over the next year or so to implement some of those recommendations and carry out follow up activities over the next year or so.

LeShaundra Cordier: Thank you. Do we have any questions from the phone line?

Coordinator: At this time I have no questions from the phone lines.

Sherline Lee: This is Sherline. Then I'd like to add another follow up question to our presenters. Of course, here at CDC we represent public health. Is there something that you could maybe recommend for any public health people who may listen to this call or be listening to this later on the archived version? Is there something you could say about coordination in particular?

Maybe I should direct this more to Laura and Georgina.

Sarita Chung: Sherline this is Sarita again. I think what was so great about this pandemic and I think Mike said it so well, is that really the early collaboration. I think initially there were recommendations that were very difficult to implement on the local level by the CDC.

But I think with early collaboration and just examining the evidence, I think we were able to make changes rapidly and to be able to then talk to our fellow physicians, nurses, patients about, you know, these are the changes and this is why it's helpful. So I think that early collaboration with the people that - the boots on the ground was just, I think, very helpful during this pandemic.

Michael Anderson: And it's Mike Anderson. I think that the coordination also tore down a lot of political boundaries. I'm not sure about your area of the country, but sometimes medicine can be a very competitive, full-contact sport. And yet from very early on, the institutions in town got together daily, every other day and really the only interest was what was good for the public health and good for the citizens of the area.

So I found that it really reinvigorated my beliefs that we can tear down political boundaries when it's time to do what's right for the public. So early collaboration was huge.

Laura Aird: Another thing, this is Laura Aird again. The team concept that Dr. Schrup and Molly talked about is very important at the local and community levels. So public health folks can be partnering with pediatric healthcare professionals now, continue to determine ways to facilitate the communication and promote a decision-making structure that can be in place for future pandemics.

Coordinator: I do have one question from the phone line.

Sherline Lee: Thank you.

Sarah Patrick: Hello?

Coordinator: Hello.

Sarah Patrick: Yes, this is Sarah Patrick from the Missouri Department of Health and Senior Services. Thanks very much for the presentations. They're extremely helpful. We've also been going through revisions of our pandemic planning and emergency plans just with lessons learned from the last pandemic.

And one of my questions to the partners on the phone is if any of you had any experience with the CDC clinical consult line and case-reporting line, and I understand that that was predominantly for pregnant women, but it was also following those children that were born through the first year of life.

These were children born to women who were infected with H1N1 during the course of the pregnancy. And I was just curious if anyone on the call had either participated in that call line or had some thought on if that was useful to you as hospitals and clinicians in practice. Thank you.

Georgina Peacock: This is Georgina Peacock. I don't have any information about exactly how the information that came from the call line but I can access the people who could give you that information. I do know that the pregnancy hotline will be in effect this flu season as well. Part of what that's going to do, is it's going to identify women that are then going to be followed through their pregnancy

and then the children are going to be followed after they're born as women that are infected with influenza during pregnancy.

And so that hotline is going to be in effect this season. And I think also, there's a clinical part of that where there is advice that can be given to practitioners who have pregnant women that are very ill. I can - I guess if you email into the COCA email box, they can get that to me and I can get you the contact information if you would like that, from the Maternal Health group.

Sarah Patrick: Thank you. I was just wondering if any of the clinicians had had either patients that were followed up in that or, you know, somebody was talking about the competition between health systems, and I just wondered how having that type of support and report line, if that had either instituted competition or helped reduced the burden of clinical practices. Thank you.

Sherline Lee: Mike, Sarita, Tom, Molly, do any of you have any comments?

Michael Anderson: You know, I wasn't involved in that call in line so I couldn't really help.

Tom Schrup: Yes, we did not have experience with that.

LeShaundra Cordier: Do we have any more questions at this time?

Coordinator: No further questions in the queue at this time.

Sherline Lee: Okay. Well then at this time we'd like to offer our speakers a chance to present any closing remarks or anything they'd like to just pass along before we end the call. And so, I'd like to go ahead and - let's go in the order of presentation and then I'll also let Laura and Georgina do any follow ups.

So, Tom and Molly would you like to say anything? Do you have any remarks?

Tom Schrup: I should - did we start with - we'll go ahead and get started here, yes. You know, I just, I would, I guess like to again echo what Mike said, I think. I was very impressed by the way that the CDC reached out to the pediatric community, including the [American] Academy of Pediatrics. I think, you know, it - I think the country was very interested because although children make up 22 percent of the population, when children are at risk, I think people definitely rally around them.

And I think any infrastructure work we can do behind the scenes before an event will pay off handsomely during the time of the event. So again, I appreciate their interest in working on behalf of children.

Molly Dunn: I guess the one thing that I'd like to say is that I just really encourage everyone to do early planning and really reach out to those resources that you have - public health, regional, state level, CDC. They've all been excellent resources for - that we have used. And it's just been an excellent experience for myself and I really encourage early planning because you just never know when the next one will happen.

Tom Schrup: Thank you.

Sherline Lee): And Mike?

Michael Anderson: Yeah, just briefly, to echo my colleagues comments from up North, I think that this pandemic and other disasters have taught me the best outcomes are

going to be when non-governmental organizations and governmental entities come together even before the disaster strikes, so that professionals from pediatrics and nurse practitioners and across the spectrum are still talking about these issues, still planning for the next one I think is the most important message today, you know.

H1N1's gone or we've moved on to the next crisis but we as planners and advocates for kids know kids, will be affected by the next disaster so we have to remain vigilant and ready. So I think the partnerships have to continue and have to get stronger.

Sherline Lee: Laura and Georgina:

Laura Aird: I think I'll have to go first. This is Laura. I just wanted to mention that the AAP encourages office practices to have a written plan for disasters. And the Disaster Preparedness for Pediatric Practice Preparedness online tool that Dr. Chung referenced provides various options to help practices do that both using a template plan and also a step-by-step action check off box type of opportunity.

And you can actually save your planning notes within an online system and then reaccess it again and update it as needed. And if anybody wants assistance in using that tool, they can reach out to me and I'd be glad to help them.

Georgina Peacock: This is Georgina. I just wanted to let the listeners know that in the spirit of what happened in the pandemic, the AAP and CDC are continuing to work together on flu preparedness activities and will - and we would both be - so Laura's office and then my group would be interested in hearing about things

that would be helpful from a CDC/AAP partnership in this continued planning as we go forward both for preparedness and then for the work in this next flu season. So thank you.

LeShaundra Cordier: Thank you all. On behalf of COCA, I'd like to thank everyone for joining us today, with a special thank you to our presenters Sarita Chung, Molly Dunn, Tom Schrup, Michael Anderson and Sherline Lee. If you have any additional questions for today's presenters, please email us at coca@cdc.gov. Indicate their name in the subject line of your email and we'll ensure that your message is forwarded to them for a response.

Again, that email address is coca@cdc.gov. The recording of this call and the transcript will be posted to the COCA Web site at emergency.cdc.gov/coca within the next few days. Continuing Education credits are available for this call. Those who participated in today's call and would like to receive Continuing Education credit should complete the online evaluation by October 29, 2010 using course code EC1648.

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