Summary of Proceedings

Pediatric Healthcare Response to Pandemic (H1N1) 2009 Influenza

Stakeholder Meeting

Centers for Disease Control and Prevention's
Division of Healthcare Quality Promotion

September 9–10, 2009
Atlanta, Georgia

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The Oak Ridge Institute for Science and Education (ORISE) is a U.S. Department of Energy (DOE) institute focusing on scientific initiatives to research health risks from occupational hazards, assess environmental cleanup, respond to radiation medical emergencies, support national security and emergency preparedness, and educate the next generation of scientists.

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Executive Summary 1

Background 3

Opening Plenary Session 9

Breakout Group Work 11

Summary of Breakout Group Work 12

Pediatric Office H1N1 Influenza Plan Template Development 12

Planning Guide for Vaccinating Pediatric Patients Against 2009 H1N1 Influenza in Primary Healthcare Settings Development 13

Community H1N1 Influenza Communication Coordination Resource Development 15

Hospital Based Tools and Resources Development 17

Closing Plenary Session 19

Finalization and Publication of Tools and Resources 23

Appendix

A: Agenda 24

B: Participant List 25

Executive Summary

The Centers for Disease Control and Prevention's (CDC's) Division of Healthcare Quality Promotion (DHQP), in coordination with the National Center on Birth Defects and Developmental Disabilities (NCBDDD), hosted the *Pediatric Healthcare Response to Pandemic (H1N1) 2009 Influenza* Stakeholder Meeting in Atlanta, Georgia, on September 9–10, 2009. The meeting was conducted by the Oak Ridge Institute for Science and Education (ORISE).

The goal of the meeting was to bring together subject matter experts to develop tools and resources for use by the pediatric healthcare community in response to 2009 (H1N1) pandemic influenza activity during the 2009 influenza season. The concepts for these tools and resources were developed through a series of discussions conducted with pediatric stakeholders prior to the meeting.

Experts were invited from one or more of the following areas:

- Primary pediatric office-based healthcare
- Pediatric disaster preparedness and pandemic influenza planning
- Pediatric emergency medicine
- Pediatric critical care
- Pediatric infectious diseases
- Hospital administration
- Hospital emergency management
- Immunizations

Sixty-five participants representing a wide variety of national associations, federal agencies, and private healthcare entities attended the meeting.

The meeting began with presentations from CDC subject matter experts on important issues for those offering pediatric care during the 2009 influenza season, such as the epidemiology of pandemic (H1N1) 2009 influenza virus, the pediatric populations at high-risk for 2009 H1N1 influenza, antiviral treatments for 2009 H1N1influenza, and an overview of influenza A (H1N1) 2009 monovalent vaccine guidance. These presentations summarized the latest CDC guidance and gave participants common information to use during the meeting. Participants had the opportunity to question presenters and to offer comments.

Following the presentations, participants were divided into four facilitated breakout groups based on their preferences, experience and subject matter expertise. Each breakout room was tasked with developing one of the following tools or resources:

- A pediatric office H1N1 influenza plan template
- A pediatric office-based vaccination guide for physicians
- A communication resource for community-wide coordination of pediatric H1N1 influenza healthcare information
- A tool to address the coordination of pediatric influenza-like illness medical care across a community.

Breakout groups were allotted the afternoon of the first day and the morning of the second day to develop drafts of the assigned tools or resources. The groups presented their drafts to all meeting participants during the final afternoon session.

After each presentation, participants were given the opportunity to ask questions and offer comments. In addition, the participants had the opportunity to volunteer to serve as post-meeting reviewers for any of the tools and resources as they were developed into final versions.

This Summary of Proceedings document provides an overview of the project background, the presentations given at the meeting, and the work that took place in the breakout groups. This document is to provide a meeting record for participants, as well as record comments and issues expressed at this meeting and is not intended for general dissemination. This document also includes appendices that further clarify the events of the *Pediatric Healthcare Response to Pandemic (H1N1) 2009 Influenza* Stakeholder Meeting.

Background

Introduction

Prior to the emergence of the pandemic (H1N1) 2009 influenza virus, The Centers for Disease Control and Prevention's (CDC's) Division of Healthcare Quality Promotion (DHQP) had begun work with pediatric healthcare stakeholders in an effort to increase preparedness for a pandemic influenza surge on the United States healthcare system. Subsequently, a pediatric stakeholder meeting was scheduled to take place in 2010 as part of DHQP's ongoing series of healthcare stakeholder meetings.

The appearance of the pandemic (H1N1) 2009 influenza virus increased the need for DHQP to concentrate response and preparedness efforts on pediatric populations. In a June 26, 2009 press briefing regarding 2009 H1N1 influenza, Dr. Anne Schuchat, Assistant Surgeon General, stated, "most of the impact of this new virus is affecting younger people compared with what we see with the seasonal flu … The highest rates [of 2009 H1N1 influenza illness] are in those under 25." In the same briefing, CDC reported that the average age of those hospitalized due to 2009 H1N1 influenza was 19 years[1].

Pandemic (H1N1) 2009 influenza virus vaccination planning recommendations from CDC stated, "Evidence to date suggests that population immunity to this virus is low, particularly among the young. Widespread susceptibility to this virus among young persons creates the potential for large numbers of cases with more hospitalizations and deaths among younger age groups than would be expected for a typical routine seasonal influenza virus …The virus has also caused numerous outbreaks in schools and summer camps."[2]

During this time, the National Center on Birth Defects and Development Disabilities (NCBDDD) sought out DHQP to discuss the impact of 2009 H1N1 influenza on children and the pediatric healthcare system. Based on these discussions, DHQP and NCBDDD began working together to escalate the time frame for the proposed stakeholder meeting to September 2009 to address 2009 H1N1 influenza issues in the pediatric community.

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[1] CDC Telebriefing on Investigation of Human Cases of Novel Influenza A (H1N1 Influenza). Retrieved July 17, 2009, from Centers for Disease Control and Prevention Web site: http://www.cdc.gov/media/transcripts/2009/t090626.htm

[2] CDC Recommendations for State and Local Planning for a 2009 Novel H1N1 Influenza Vaccination Program. Retrieved July 22, 2009, from Centers for Disease Control and Prevention Web site: http://www.cdc.gov/h1n1flu/vaccination/statelocal/planning.htm/?breaknews

Input from multiple divisions within CDC, many nonfederal stakeholders, and key leaders from the pediatric community were valuable in defining meeting objectives and deliverables.

Gathering Pediatric Input on H1N1 Influenza Concerns

CDC Partner Input

In pre-meeting discussions between multiple divisions at CDC, NCBDDD expressed concern about how high-risk pediatric patients would be affected by H1N1 influenza and how the healthcare system would offer care to this vulnerable group in the midst of a surge scenario. Thus, this important issue became the first major topic identified for inclusion in the stakeholder meeting. DHQP also indicated that a stakeholder meeting should facilitate the development of tools designed to assist in addressing potential healthcare delivery surge response.

Pre-meeting Subject Matter Engagement

Prior to the meeting, the Oak Ridge Institute for Science and Education (ORISE) engaged many key leaders from within the pediatric community who had expertise and extensive experience in one or more of the following areas.

- Primary pediatric office-based healthcare
- Pediatric disaster preparedness and pandemic influenza planning
- Pediatric emergency medicine
- Pediatric critical care
- Pediatric infectious diseases
- Hospital administration
- Hospital emergency management
- Vaccine administration in pediatric offices

Experts were asked to provide their thoughts on many topic areas, including their role(s) in the pediatric medical community, experiences with 2009 H1N1 influenza, and opinions on what resources or tools they might need to manage a surge on pediatric medical services caused by the 2009 H1N1 influenza pandemic.

Several reoccurring themes emerged from these discussions.

- A wide range of pandemic planning levels existed among pediatric offices. Some offices had done high levels of planning and some had a moderate level of planning. However, many had not completed any pandemic planning. Those office managers who did not have a pediatric plan expressed interest in learning practical tips and ideas from those with high levels of planning in place.

- Many organizations with prior pandemic planning in place were caught off guard by a mild pandemic strain such as pandemic (H1N1) 2009 influenza. Their plans had been written with the assumption that a pandemic would be caused by a severe influenza strain such as the H5N1 virus.

- Pediatricians were concerned about the administration of a 2009 H1N1 influenza vaccine. They had many logistical concerns about trying to give the 2009 H1N1 vaccine in addition to the pediatric vaccines they routinely provide in their offices.

- Miscommunication and inconsistent public messaging in the spring resulted in inefficiencies in healthcare service delivery and frustration on the part of patients and caregivers.

- CDC provided ample amounts of information regarding 2009 H1N1 influenza, but two difficulties arose in implementing CDC guidance: (1) the information changed so quickly that keeping up with the latest updates was overwhelming and (2) the guidance was often not specific enough or was not in alignment with clinical realities.

- Pediatricians were concerned about high-risk pediatric populations but had difficultly identifying specific tools or resources that would help them care for these groups. Many wanted clarification on which pediatric groups truly were at high risk for 2009 H1N1 influenza.

- Pediatricians were concerned about supply issues. Many had difficulty obtaining adequate personal protective equipment in the spring and were worried about stockpile needs and costs for the fall.

- Pediatricians were concerned about the perceived broad recommendations for antiviral treatment. Some believed that, in order to follow CDC guidance, they would have to overprescribe antiviral drugs in instances where their clinical judgment did not see the prescription of drugs as warranted. For legal reasons, they were hesitant to practice "outside of CDC guidance," despite language in the guidance allowing for clinical judgment.

- Any tools or resources developed for the pediatric community needed to be specific and easy to implement. Clinicians anticipated being too busy in the upcoming fall to allocate time to customize or clarify broadly written tools or resources for their staff.

As these conversations took place, the concepts for three tools emerged.

1. A pediatric office plan template
2. A vaccine guidance document for pediatricians
3. A communication guide for the healthcare system in relation to pediatric issues

Pre-meeting Stakeholder Feedback

Participants were sent the list of prospective tools for review and comment. These items were discussed in a pre-meeting telephone conference on August 19, 2009. Participants indicated there was a clear need for an objective to address hospital issues.

Using Feedback to Refine Objectives

Based on the process of gathering input from pediatric stakeholders, four objectives emerged.

1. Create operational plan templates for three sizes of medical offices (based on number of clinicians in the practice) that will be caring for pediatric patients during the 2009 H1N1 influenza pandemic and have no existing pandemic influenza plan.

When gathering stakeholder input, it became evident early on that primary pediatric clinics had widely varying levels of pandemic planning in place. Many clinics had no type of pandemic influenza plan and were in need of a template plan that could be implemented quickly prior to fall/winter flu season. The overall opinion was that physicians wanted to learn from other practices that had good pandemic plans in place. When many of the available existing planning checklists were mentioned, several interviewees replied that they were too vague or too brief. Furthermore, these checklists required a prohibitive amount of time to actualize into a plan.

It was decided that the pediatric office template would capture operational advice from physicians with pandemic planning experience for quick implementation by practices with no plan in place. The document was not intended to capture the larger planning issues or collaboration strategies with public health and community planning efforts, nor was it

intended to capture steps that would be lengthy to implement. Instead, it would serve as a "just in time" pediatric office 2009 H1N1 influenza plan[3].

2.

a. Identify best practices for physicians administering Influenza A (H1N1) 2009 monovalent vaccine to pediatric patients, including strategies for addressing medical surge.

b. Develop suggestions for integrating physicians and other healthcare providers into public health planning for community-based vaccine administration.

Clinicians expressed strong and varied opinions on the topic of how best to administer Influenza A (H1N1) 2009 monovalent vaccines to children. Providers expressed concern about the disruption the vaccine distribution would pose to their practices, their ability to provide an additional vaccine to patients, and the surge in patients they anticipated. These concerns made this topic an appropriate one for the stakeholder meeting.

[3] It should be noted this "just in time" emphasis, specific to the pandemic (H1N1) 2009 influenza activity , differentiated this tool from the Primary Care Providers Stakeholder Meeting Pan Flu Organizer (PFO) that was scheduled for development from a separate meeting prior to the Pediatric Stakeholder meeting. The objective of the PFO is to capture the internal and external planning processes a practice would go through to be fully integrated into community general pandemic planning efforts.

3.

a. Describe the essential pediatric H1N1 influenza information needs for communications within the medical community and with the public, regardless of community size.

b. Identify public message topical areas on H1N1 influenza pediatric care targeted at reducing public actions that run counter to the overall medical response.

c. Identify roles and responsibilities for coordinating the dissemination of information on pediatric care during an H1N1 influenza outbreak.

This objective was formulated in response to the nearly unanimous concern the pediatric community expressed about communication both within the healthcare community and with the public. On the pre-meeting telephone conference, the communication topic generated the most conversation out of the list of proposed objectives.

Participants voiced concern about a possible lack of coordination and communication between health care entities even when good pandemic plans are in place. This situation may cause patients to go from one provider to another until they receive the treatment they want.

Participants emphasized the need for a centralized source of messaging within a community. They raised concerns about the need for other "voices" to help reinforce public health messaging (such as schools, sports leagues, or faith-based organizations) and to ensure that the messages were appropriate for the intended audiences. These concerns were used to expand the concept of a communication tool into the third objective, as stated above.

4.

a. Identify and prioritize hospital issues as they relate to care for pediatric patients during the 2009 H1N1 influenza pandemic.

b. Develop recommendations to address selected hospital issues regarding pediatric patient care during 2009 H1N1 influenza pandemic scenarios.

Based on participant feedback in the pre-meeting telephone conference, a general objective for a tool or resource specifically intended for hospitals was created. The objective for the tool or resource was initially left broad due to the short amount of time between the decision to focus on hospital issues and the beginning of the meeting. As participants for the fourth breakout group had extensive experience in hospital settings, meeting planners decided it would be best to convene the group and let them prioritize hospital the issues they could feasibly undertake with the assembled expertise.

Opening Plenary Session: CDC Presentations

Wednesday, September 9, 2009
8:00 a.m. to 12:00 noon

Opening Remarks

Freddy Gray, Project Manager, ORISE, welcomed the group to the workshop and thanked them for their participation.

Dr. Deborah Levy (Captain, US Public Health Service), Chief of the Healthcare Preparedness Activity, DHQP, explained the project background and the role the meeting played in the larger stakeholder meeting series conducted by DHQP and ORISE. She briefly explained the project emphasis on tool development and implementation. She introduced participants to the tools that have come out of prior meetings and thanked participants for their work in helping to develop tools at this meeting.

Dr. Edwin Trevathan, Director, CDC-NCBDD, briefly explained NCBDDD's role in the pediatric stakeholder meeting and his concern about the possible effects of H1N1 influenza on the pediatric population, especially those at highest risk.

Introductions

Participants were asked to introduce themselves to the group by telling everyone their name, title or position, the agency or organization they represented, and their city and state.

CDC H1N1 Influenza Update Presentations

Epidemiological Update: 2009 H1N1 Influenza Update. David Swerdlow, MD, Senior Advisor, Office of the Director, CDC National Center for Immunization and Respiratory Diseases (NCIRD).

Dr. David Swerdlow provided an update on epidemiologic information available for pandemic (H1N1) 2009 influenza. His presentation began with a background on influenza viruses and pandemics, including the inception of "swine-origin" H1N1 influenza and a timeline of its spread. He then outlined the national response to 2009 H1N1 influenza from the Strategic National Stockpile (SNS), the initiation of enhanced surveillance, the distribution of testing kits, and virus characterization.

Dr. Swerdlow also presented a detailed analysis of currently available epidemiologic data (e.g., hospitalizations, affected age groups) and then concluded the presentation with a discussion of rapid influenza diagnostic tests; current recommendations for infection control, such as personal protective equipment (PPE); and upcoming challenges.

High Risk Pediatric Populations: 2009 H1N1 Influenza. Edwin Trevathan, MD, MPH, Director, National Center on Birth Defects and Developmental Disabilities (NCBDDD).

Dr. Edwin Trevathan presented a detailed analysis of pediatric populations at higher risk for complications from infection with pandemic (H1N1) 2009 influenza. He provided background information on influenza-related pediatric deaths and 2009 H1N1 influenza mortality rates for children less than 18 years of age. He also discussed the underlying conditions that accompanied 2009 H1N1 influenza in hospitalized influenza patients. Additionally, he discussed the severity of bacterial and influenza co-infections.

Dr. Trevathan summarized that even healthy children can have severe or fatal outcomes after an influenza infection, and he stressed the importance of early recognition of 2009 H1N1 influenza in high-risk children.

2009 H1N1 Influenza Monovalent Vaccine: Implementation Overview. Suchita A. Lorick, DO, MPH, Vaccine Implementation Team.

Dr. Suchita Lorick presented an overview of the implementation of the Influenza A (H1N1) 2009 influenza monovalent vaccine. She began her remarks with a summary of the key epidemiologic findings and then outlined the recommendations by the Advisory Committee on Immunization Practices (ACIP). These recommendations are referenced at http://www.cdc.gov/h1n1flu/vaccination/professional.htm

Dr. Lorick described the clinical trial basic design concepts for licensed manufacturers and the objectives and methods of the safety monitoring response, including the use of the Vaccine Adverse Events Reporting System (VAERS).

Antiviral Treatment Update for 2009 H1N1 Influenza Virus. Lisa Rotz, MD, Division Director, CDC Division of Bioterrorism Preparedness and Response (DBPR).

Dr. Lisa Rotz presented an update on antiviral treatment for pandemic (H1N1) 2009 influenza. Dr. Rotz outlined the revised 2009 antiviral guidance and treatment recommendations (summarized at http://www.cdc.gov/h1n1flu/vaccination/professional.htm). She included in her discussion a description of oseltamivir (Tamiflu) and zanamivir (Relenza) and detailed information such as methods of administration, side effects, precautions, and resistance.

Dr. Rotz discussed groups at higher risk for complications, outlined the recommendations on the appropriateness of post-exposure prophylaxis, and concluded her presentation with a discussion of investigational medications and investigational formulations of approved medications.

Additional participant comments

Over the course of the Pediatric Healthcare Response to Pandemic H1N1 Influenza Stakeholder Meeting, participants were encouraged to fill out a comment card anytime participants felt their concerns were not adequately addressed by a speaker or when discussion had to move on to the next topic due to time constraints. Numerous comments were made regarding guidance documents produced by CDC and their federal partners. Participants expressed questions or concerns regarding how to interpret or implement clinical treatment and prophylactic recommendations for children and asked that revised guidance consider including defining "high-risk" "populations with more specificity or further stratifying risk within these "high-risk" pediatric populations. In addition, many comments were received regarding the implementation of CDC infection control guidance, particularly as it related to the appropriate selection and use of personal protective equipment (e.g., N95 masks/respirators). Vaccination questions/concerns included concerns about implementation of mass vaccination clinics; improving awareness of reporting to existing vaccine safety monitoring systems or immunization registries; improving understanding of payment mechanisms and explaining potential financial barriers that pediatricians could face as vaccine administrators; improving the uptake of vaccination among healthcare workers; and protecting clinicians against legal actions related to clinical treatment decisions or vaccine administration.

Participants also offered numerous comments and suggestions on how to improve local response including suggesting how to clarify planning assumptions and identifying potential communication messages that CDC and local/state public health partners should consider important to relay to clinicians and the public.

Breakout Group Work

Wednesday, September 9, 2009, 1:00 p.m. to 4:30 p.m.
Thursday, September 10, 2009, 8:00 a.m. to 11:30 a.m.

Summary of Breakout Group Work

During the afternoon of the first day and the morning of the second day, participants were separated into breakout groups for facilitated work on their respective group's meeting objectives. Participants were divided into breakout groups based on their preferences, experience, and subject matter expertise.

The following sections summarize what occurred in each breakout room based on each group's objectives, outcomes and activities. From these descriptions, the progress toward achieving the meeting objectives as described in the background section of this report can be followed.

Pediatric Office H1N1 Influenza Plan Template Development

Pediatric Office H1N1 Influenza Plan Templates: Breakout Group 1

OBJECTIVE:
Create operational plan templates for three sizes of medical offices that will be caring for pediatric patients during the 2009 H1N1 influenza pandemic and have no existing pandemic influenza plan.

Before beginning work, participants shared their pediatric healthcare roles and experiences in responding to 2009 H1N1 influenza with one another. In accordance with plans made prior to the meeting, two of the participants were asked to present more detail about their work to the group. Laura Aird, American Academy of Pediatrics (AAP), demonstrated AAP's online office disaster-planning tool that was made available on September 1, 2009. Then Dr. Diane Dubinsky, Medical Director of Fairfax Pediatric Associates, PC and consultant to the Fairfax County Health Department, shared with the group how she led her clinic through a pandemic planning process that was tested and refined by her experiences with H1N1 influenza during the spring of 2009.

Following those presentations, participants were given an overview of the Pediatric Stakeholder project background and existing pandemic influenza tools for pediatric offices. Participants then reviewed information garnered from a previous DHQP stakeholder

meeting that focused on the integration of primary care providers into pandemic influenza planning, medical office pandemic plan examples, and a compilation of input from pre-meeting contact with participants. Through a large group discussion of these materials, participants agreed on topics that should be included in a pediatric office H1N1 influenza plan template outline.

After the first day, ORISE staff refined the template outline and inserted relevant sections from resources selected by the participants for use the following day. After reconvening, participants divided into small groups to focus on modifying and expanding sections of the outline corresponding to that small group's expertise. The small groups added action steps and useful resources to the outline. Special notes were made when the actions differed for various size offices.

After completing their small group work, participants reconvened to discuss each small group's actions with the entire breakout group. Once the H1N1 influenza draft template was finalized, the group prepared to present it to the plenary session.

Planning Guide for Vaccinating Pediatric Patients Against 2009 H1N1 Influenza in Primary Healthcare Settings Development

Vaccine Administration for the Pediatric Population: Breakout Group 2

OBJECTIVES

- Identify best practices for physicians administering Influenza A (H1N1) 2009 monovalent influenza vaccine to pediatric patients, including strategies for addressing medical surge.

- Develop suggestions for integrating physicians and other healthcare providers into public health planning for community-based vaccine administration.

The facilitator began the session by asking several members of the CDC's H1N1 Influenza Vaccine Implementation Task Force to discuss the most recent versions of CDC vaccine guidance and related articles from the American Academy of Pediatrics.

Next, the facilitator shared a Palm Beach Health Department information sheet that had been used to survey clinicians in Palm Beach about their willingness and capability to provide the Influenza A (H1N1) 2009 monovalent vaccine. The breakout group was interested in this tool and discussed how something similar could be modified for other communities.

Following that discussion, participants were asked to read and respond to a *Summary of Healthcare Opinions on H1N1 Influenza Vaccination,* which is a summary of the vaccine specific viewpoints offered during the pre-meeting call series (see Appendix C). In addition to this opinion summary document, participants reviewed CDC's *State and Local Vaccination Guidance* and *Guidelines for Large Scale Influenza Vaccination Clinic Planning Activity.* Based on these documents and discussions, participants identified categories of topics that must be addressed in a best practices document designed to assist physicians with vaccinating pediatric patients for H1N1 influenza.

Participants split into small groups after compiling the list of categories. Each group suggested best practices for addressing a subset of the identified categories. From these best practices, ORISE and CDC developed a planning checklist framework for the group to work on the following day.

At the beginning of the next day, the facilitator asked participants to work individually on making changes to the planning checklist framework that was developed during the previous day's sessions. Participants then took part in a large group discussion of the planning checklist framework in order to capture additional comments/suggestions. These changes were adapted to the master version of the framework, which was duplicated for the large group to review in the plenary session presentation.

Participants were then asked to identify issues with current planning for 2009 H1N1 influenza vaccine administration conducted in community settings (schools or public health vaccination clinics) and private healthcare settings (medical offices or clinics). Many clinicians discussed activities in their localities. Their experiences were varied and dependent on local health departments.

Healthcare providers in this group believed children’s primary care physicians should be actively involved in child vaccinations because they are best able to care for their patients. Clinics are considered the “medical home” of pediatric patients. In cases where a community has chosen school-located vaccination, several physicians strongly believed that using the vaccine registry system should be mandatory. School nurses replied that this would be difficult due to the lack of staff availability. Physicians believed they could better monitor their patients for reactions and prevent vaccination duplications through the immunization registry.

The facilitator led a discussion of physicians’ concerns regarding coordinating with other healthcare and community partners for vaccine administration taking place outside of physicians' offices. They were asked, "Given what you learned from the process of developing best practices, are these still the most important issues to consider?" From this last discussion, a list of issues regarding coordination with other healthcare and community

partners was identified for inclusion in the vaccine guidance product developed by this group.

Community H1N1 Influenza Communication Coordination Resource Development

Coordinated Pediatric Information/Communication Guide: Breakout Group 3

OBJECTIVES

Develop a guide that will

- Describe the essential pediatric H1N1 influenza information needs for communications within the medical community and with the public, regardless of a community's size.

- Identify public message topical areas on H1N1 influenza pediatric care targeted at reducing public actions that run counter to the overall medical response.

- Identify roles and responsibilities for coordinating the dissemination of information on pediatric care during an H1N1 influenza outbreak.

The breakout room began its first session by discussing the lessons learned from the spring pandemic (H1N1) 2009 influenza outbreak. The facilitator asked participants to focus on identifying public health communication gaps and needs.

Participants were then asked to come to consensus on what information is needed by the medical community regarding pediatric care during an H1N1 influenza outbreak. Lessons learned from the spring were used to identify this information. The group was asked to answer five questions, which are listed below.

1. What is the makeup of the medical community with regard to pediatric care during an H1N1 influenza outbreak?

2. If a member of that community needed a tool to show what information they may need to share with others or who to call for information, what would that tool look like?

3. What information needs to be made available to the medical community regarding pediatric care and H1N1 influenza? Be specific.

4. What is the source(s) of this information? Who is the decision maker(s)? For example, if information on testing protocols is needed, who decides what these protocols will be?

5. What is the best way to coordinate the sharing and communication of pediatric-related information among members of the medical community during an H1N1 influenza outbreak?

By the end of the first session, participants had compiled a list of information needs for the medical community and a list of suggested sources of that information.

The main objective for the second session was to determine the essential information requirements of the public with regard to pediatric care during an H1N1 influenza outbreak. This differed from the discussion in the first session, which focused on the information needs of the medical community.

Participants were asked to name the most critical information needs of the public about pediatric care during an H1N1 influenza outbreak. Then they noted the source(s) of that information. This discussion focused on the following four questions:

1. Who is the public with regard to pediatric care? Who needs to be informed about pediatric-related information?

2. What is the best way to reach this audience? What are the best modes of communication with each member of this audience?

3. What information should be shared with the public with regard to pediatric care and H1N1 influenza?

4. Taking into account what has been discussed thus far, what is the best way to coordinate informing the public of pediatric-related information during an H1N1 influenza outbreak?

While discussing these questions, the group was asked to identify members or groups of the public. For each member/group, participants were asked what they believed are the best ways to reach this audience.

During the next session, participants were asked to identify scenarios that occurred in the spring in which public actions may have interfered with the medical response to the H1N1 influenza outbreak. For each scenario, they were asked what could have been communicated to the public to prompt actions that are more desirable. Methods of communication and parties who could assist with communication were proposed.

Participants produced a list of unwanted actions taken by the public during the spring H1N1 influenza outbreak, suggestions for preventing such unwanted actions, and a list of methods for communicating these suggestions.

By the end of the session, participants developed a list of key internal and external communication issues, a framework and path forward for the communication tool, and a presentation on the tool for all meeting participants.

Hospital-Based Tools and Resources Development

Hospital Contingency Planning for Pediatric Care: Breakout Group 4

OBJECTIVES

- Identify and prioritize hospital issues as they relate to care for pediatric patients during the 2009 H1N1 influenza pandemic.

- Develop recommendations to address selected hospital issues regarding pediatric patient care during both mild and severe H1N1 influenza pandemic scenarios.

To begin, the facilitator gave an overview of the objectives of Breakout Group 4 and reviewed the handouts given to participants at registration. Handouts included CDC's *Interim guidance for Infection Control for Care of Patients with Confirmed or Suspected Novel Influenza A (H1N1 Influenza) Virus Infection in a Healthcare Setting* and the Department of Health and Human Services' (HHS') *Hospital Pandemic Influenza Checklist.*

After reviewing these documents, the facilitator led a discussion regarding 2009 pandemic (H1N1) influenza experiences in the spring, with a focus on healthcare issues. Participants identified the issues of most concern to pediatric and non-pediatric hospitals during a pandemic influenza scenario.

Initially, ORISE anticipated that Breakout Group 4 would create recommendations and resources for mild and severe pandemic influenza scenarios. When presented with this suggestion, participants stated that they felt the categorization of “severe” versus “mild” issues was not an effective way to frame the discussion. Instead, participants decided to prioritize issues hospitals might face during an influenza pandemic and the resources they might need without focusing on severity.

The facilitator asked participants to determine which of these issues they had time and expertise to address during the three subsequent sessions. Issues considered outside the scope of the breakout group included ethical, financial, and legal concerns. The group decided it had the expertise and ability to create recommendations and resources to help address the top three prioritized concerns, which were:

- Triage in the Community (i.e., addressing community pediatric surge capacity)

- Identification and Management of High-Risk Patients
- Education and Cross-training of Healthcare Workers

At this point, the breakout group was subdivided into three working groups. Each group was assigned one of the specific hospital issues relating to pediatric care during the H1N1 influenza pandemic. Through small group discussions, participants were asked, based on their knowledge, expertise, and experience with the spring H1N1 influenza outbreak, to develop recommendations and resource or tool ideas for the hospital issues they agreed to undertake.

The Triage in the Community Group developed a comprehensive list of possible solutions to address community triage and pediatric surge issues. This list served as the basis for the proposal of two tools to the stakeholder meeting at large: a "*Coordinating Pediatric Medical Care During an Influenza Pandemic Hospital Workbook*" and a whitepaper on community data elements that would provide information to planners utilizing the workbook.

The Identification and Management of High-Risk Patients Group began developing the *Identification of Outpatient Influenza-Like Illness Algorithm*. The purpose of the algorithm would be to give community based pediatric primary care providers and non-pediatric health care providers a one-page assessment tool that can assist in determining appropriate care management for high-risk pediatric patients with influenza-like illness.

The Education and Cross-Training of Healthcare Workers Group outlined a proposed nine-module training course that could be developed. This training would be internet-based and designed for role-specific pathways of learning.

As the breakout session ended, the small groups finalized their proposals and created a short presentation for the plenary room. The proposed resources are listed below and will be further discussed in the plenary session presentation section.

- Coordinating Pediatric Medical Care During an Influenza Pandemic Hospital Workbook
- Algorithm: High-Risk–Identification of Outpatient Influenza-like Illness (ILI) Patients
- Education and Training–Education and Training Module

Closing Plenary Session: Breakout Group Presentations

Thursday, September 10, 2009 1:15 p.m. to 4:00 p.m.

Presentations of Tools and Resources

Members of each breakout group were allotted 45-minute time periods to present draft versions of the tools or resources they developed, answer questions from the group at large, and take comments on the utility of the tools or resources. At the end of each presentation, meeting participants were given the opportunity to volunteer as a reviewer for the presented tool or resource.

Breakout Group 1 Presentation: Pediatric Office H1N1 Plan Template

The first breakout group presented to the plenary session a completed template outline, with a draft version of some of the document content. The presenter discussed the process the breakout group used to identify the topics and some of the resources that were used to guide the content. The Pediatric H1N1 Pandemic Plan Template document outline is shown below.

1) Decision Making/Structure
2) Surveillance/Detection/Reporting
3) Points of Contact
4) Staff
    a. Training
    b. Occupational Health
    c. Policies–Sick Leave/Absences
    d. Vaccination
5) Infection Control
6) Patient Issues
    a. Flow (including triage, surge capacity, and transfer referrals)
    b. Treatment (including immunizations, antiviral usage, and testing)
7) Supplies/Equipment
8) Communication
9) Finances
10) Legal
11) Resources
12) Appendices

After the meeting, participants and reviewers continued to contribute to the content of this document. The final version was formatted in a workbook style and was posted in its final format on the CDC Web page. Please see page 23 for links to all posted meeting materials.

Breakout Group 2 Presentation: Planning Guide for Vaccinating Pediatric Patients Against 2009 H1N1 Influenza in Primary Healthcare Settings

The second breakout group presented a draft version of a planning tool intended to provide guidance on preparing for and conducting vaccination of pediatric patients with the Influenza A (H1N1) 2009 monovalent vaccine in private healthcare settings.

It guided clinicians through a two-part process. The first step helps clinicians determine if they can offer H1N1 influenza vaccination services to their pediatric patients. For those who decide they can offer H1N1 influenza vaccination, the second step provides recommendations and information to consider as they prepare to do so. An outline of the main topic headings from both parts of the planning guide is shown below.

Part 1: Initial Planning Checklist

- Step 1: Learn more about your potential role as a provider of the 2009 H1N1 influenza vaccine.
- Step 2: Learn more about what H1N1 influenza vaccination services other providers will be offering.
- Step 3: Complete a needs assessment.
- Step 4: Address financial concerns related to H1N1 influenza vaccine administration.
- Step 5: Determine how H1N1 vaccine administration would affect staffing needs.
- Step 6: Consider the legal issues related to H1N1 vaccine administration.
- Step 7: Determine storage capacity for H1N1 influenza vaccines.

Part 2: Moving Forward Checklist (for clinicians who decide to vaccinate)

- Placing vaccine orders
- Storage and capacity to store
- Billing/reimbursement

- Human resources/staff planning
- Vaccine safety monitoring

After further refinement and review, the planning guide was posted in its final format on the CDC Web site as a resource for clinicians. See page 23 for links to all posted meeting materials.

Breakout Group 3: A Coordinated Approach to Communicating Pediatric-related Information on Pandemic Influenza at the Community Level

The third group used a PowerPoint slide show to present its work to the plenary session. The slide show contained information that was later reformatted and expanded to create an H1N1 influenza communication resource for communities. The purpose of this document is to provide an approach to communicate pediatric-related information on pandemic influenza at the community level in a step-by-step manner. An overview of those steps is listed below.

- Step 1: Identify trusted sources of information
- Step 2: Identify "the voice" of the community
- Step 3: Identify those who need the information
- Step 4: Identify the information needed
- Step 5: Condense the information you want to communicate
- Step 6: Identify the methods of communication

After the meeting concluded, Breakout Group 3 used conference calls and an e-mail review process to finalize the document. The communication document has been posted on the CDC H1N1 website.

Breakout Group 4: Hospital Based Tools and Resources Development

The fourth group divided its presentation into three sections to reflect three main issues it addressed. Each issue was presented to the plenary session with a tool or resource proposed by the breakout group.

The first section of the presentation focused on an algorithm proposed by the High-Risk subgroup that could be used by hospitals to triage pediatric patients in order to identify the correct level of treatment. Triage of high-risk patients had been identified by the group as a major concern for hospitals facing an H1N1 influenza pandemic. After review and

finalization, this algorithm was incorporated into the Pediatric Office Plan Template as well as into the second tool developed by Breakout Group 4.

The second section of the presentation was conducted by the Triage in the Community subgroup. Subgroup members shared an outline for a workbook, which has since developed into the *Coordinating Pediatric Medical Care during an Influenza Pandemic Hospital Workbook*. Its purpose is to assist hospitals in the process of coordinating pediatric influenza-like illness medical care across a community. The workbook is divided into two sections, one for pediatric hospitals and one for general hospitals. It guides them through the process of sharing information and integrating their facilities' pandemic planning with that of other hospitals within the area. At the time of this writing, the workbook is in CDC clearance.

Breakout group 4 then presented two tool proposals developed by the Education and Training subgroup. They presented a just-in-time online training outline, which could be developed to help increase surge capacity by providing non-routine pediatric medical providers with specific information about caring for children with H1N1. This training outline has since been included in the *Coordinating Pediatric Medical Care during an Influenza Pandemic Hospital Workbook*. In addition, the subgroup proposed a data tracking system that would equip hospitals with real time data during a pandemic in order to help them implement needed response measures and match patients with appropriate healthcare facilities. This data tool proposal was also subsequently incorporated into the *Coordinating Pediatric Medical Care during an Influenza Pandemic Hospital Workbook*

Concluding Remarks

Dr. Deborah Levy offered closing remarks to participants. She explained the anticipated finalization, review, and clearance processes for the tools and resources developed and presented by participants at the meeting. She expressed appreciation for the quality and quantity of work accomplished over the two-day meeting. In addition, she thanked participants for their work at both the meeting and in the future review process.

Post-Meeting Follow-Up: Finalization and Publication of Tools and Resources

At the time of the writing of this summary report, resources and tools have been submitted to DHQP for review and clearance. Three have been published on the CDC H1N1 Web site, and two others are in final clearance processes. A summary of those documents is shown in the table below.

Tool/Resource	Status (as of 8/2/2010)
Planning Guide for Vaccinating Pediatric Patients Against 2009 H1N1 Influenza in Primary Healthcare Settings	Posted at: http://www.cdc.gov/H1N1flu/vaccination/pediatricpatients.htm
Decision Tree (abbreviated version of vaccine guidance)	Posted at: http://www.cdc.gov/H1N1flu/vaccination/decisiontree.htm
A Coordinating Approach to Communicating Pediatric-related Information on Pandemic Influenza at the Community Level	Posted at: http://emergency.cdc.gov/healthcare/pdf/hospital_workbook.pdf
Coordinating Pediatric Medical Care During an Influenza Pandemic Hospital Workbook	Posted at: http://emergency.cdc.gov/healthcare/pediatric.asp
Triage Algorithm	Finalized, will be included in the Hospital Workbook
Just-in-Time Education and Training of Healthcare Workers Outline	Finalized, will be included in the Hospital Workbook
Pandemic Influenza Pediatric Office Plan Template	Posted at: http://www.cdc.gov/h1n1flu/guidance/pediatrics_tool.htm
Hospital Issue List	Finalized (not for publication)
Triage Issue List	Finalized (not for publication)
Data Needs for a Community Flu Tracker	Proposal finalized (not for publication)

Appendix A: Agenda

DAY I

7:00 a.m. to 7:45 a.m.	**Registration**
7:00 a.m. to 7:45 a.m.	**CONTINENTAL BREAKFAST AND NETWORKING**
8:00 a.m. to 9:00 a.m.	Welcome • Welcoming Remarks and Introductions (ORISE) • Welcoming Remarks and Introductions (CDC) • Participant Introductions • Workshop Overview & Administrative Announcements
9:00 a.m. to 9:30 a.m.	**Presentation:** H1N1 Influenza Epidemiological Information Update
9:30 a.m. to 10:00 a.m.	**Presentation:** H1N1 Influenza High-risk Pediatric Populations
10:00 a.m. to 10:20 a.m.	**BREAK**
10:20 a.m. to 11:05 a.m.	**Presentation:** H1N1 Influenza Vaccine Guidance Update
11:05 a.m. to 11:50 a.m.	**Presentation:** H1N1 Influenza Antiviral Guidance Update
11:50 a.m. to 1:00 p.m.	**Working Lunch**
1:00 p.m. to 2:30 p.m.	**Breakout Groups:** Facilitated Work on Group Objective
2:30 p.m. to 3:00 p.m.	**BREAK**
3:00 p.m. to 4:30 p.m.	**Breakout Groups:** Facilitated Work on Group Objective
4:30 p.m.	**Dismiss from Breakout Group**

DAY II

7:00 a.m. to 7:45 a.m.	**CONTINENTAL BREAKFAST AND NETWORKING**
7:45 a.m. to 8:00 a.m.	Move to Breakout Groups
8:00 a.m. to 9:30 a.m.	**Breakout Groups:** Facilitated Work on Group Objective
9:30 a.m. to 9:45 a.m.	**BREAK**
9:45 a.m. to 11:30 a.m.	**Breakout Groups:** Prepare for Afternoon Presentation
11:30 a.m. to 12:30 p.m.	**Working Lunch**
12:30 p.m. to 1:15 p.m.	**Plenary Session:** Group #1 Presentation of Deliverable, Response to Questions
1:15 p.m. to 2:00 p.m.	**Plenary Session:** Group #2 Presentation of Deliverable, Response to Questions
2:00 p.m. to 2:45 p.m.	**Plenary Session:** Group #3 Presentation of Deliverable, Response to Questions
2:45 p.m. to 3:00 p.m.	**BREAK**
2:00 p.m. to 2:45 p.m.	**Plenary Session:** Group #4 Presentation of Deliverable, Response to Questions
2:45 p.m. to 3:45 p.m.	**Breakout Groups:** Discuss Feedback and Next Steps for Completing Deliverables
3:45 p.m. to 4:30 p.m.	**Plenary Session:** Concluding Remarks

Appendix B: Participant List

Pediatric Healthcare Response to Pandemic H1N1 Influenza
Stakeholder Meeting
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