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Learning from H1N1

Pediatric, public health leaders discuss how to improve states' pediatric preparedness

by **Alyson Sulaski Wyckoff** • *Associate Editor*

With waiting rooms overflowing, inadequate vaccine distribution and rapidly changing advice, pediatricians faced many frustrations during the height of the H1N1 crisis in 2009.

To help avoid a repeat of these problems, about 70 representatives from AAP chapters and public health agencies spent two days in April discussing how to improve pediatric preparedness based on fresh memories of their 2009 H1N1 experiences.

A rare gathering of pediatric and public health personnel, the meeting "Enhancing Pediatric Partnerships to Promote Pandemic Preparedness" was sponsored by the Academy and the Centers for Disease Control and Prevention (CDC).

One of the speakers was Georgina Peacock, M.D., M.P.H., FAAP, medical officer, National Center on Birth Defects and Developmental Disabilities, CDC. She said children were the central focus of concern during the pandemic. Children and young adults up to age 24 accounted for as much as 73% of all U.S. H1N1 cases and 56% of H1N1 hospitalizations. Two-thirds of the 300 children under 18 who died from H1N1 had underlying pulmonary or neurological conditions.

A pediatric desk was established at the CDC to handle all the inquiries related to H1N1.

States reveal biggest challenges

After participants heard an overview of H1N1 and efforts to contain it, the AAP-CDC meeting moved on to sharing ideas from 10 state teams. There were two pediatric and two public health representatives from California, Florida, Georgia, Illinois, Michigan, Missouri, New Mexico, Texas, Utah and Virginia. The teams, which were selected from 29 state chapters that had applied to attend the conference, discussed their state models and challenges before finalizing plans to improve preparedness efforts.

Prioritizing for high-risk groups, communications and messaging, and incorporating pediatricians into state decision-making were key topics.

Common challenges during the pandemic included:

- ineffective distribution of vaccines;
- problems reaching all providers and key parties (schools, child care, pharmacies, etc.), especially in large states with remote regions;
- frustrations in areas where patients had greater health disparities;
- underuse of immunization registries;
- lack of pediatrician involvement in pandemic planning (due in part to lack of a relationship between pediatricians and public health departments);
- inadequate staffs and facilities to meet demand; and
- lack of a single source of communication, sometimes due to poor media relationships.

Planning for the future

Virtually all teams indicated they intended to become more involved in promoting children's needs in planning for future pandemics; develop two-way communications systems with all pediatricians in the state; cultivate relationships with public health and other key groups; make use of school-related immunization opportunities; and maximize use of registries.

Other ideas included:

- identifying a pediatric champion at each adult hospital/emergency department who can participate in the communications and prepare his or her facility for pediatric overflow (Georgia);

What AAP chapters can do now to improve pediatric preparedness

Following is a summary of ideas from 10 state pediatric-public health teams participating in the AAP-CDC meeting, "Enhancing Pediatric Partnerships to Promote Pandemic Preparedness":

1. Educate peers about what was learned at the meeting.
2. Create a chapter committee on pandemic/disaster readiness.
3. Develop relationships with state and local public health departments and emergency response planners.
4. Form a pediatric advisory committee in partnership with public health leaders.
5. Learn about and link with stakeholders and existing emergency/disaster preparedness efforts.
6. Partner with local children's hospitals and community hospitals to improve emergency and disaster readiness.
7. Advocate for effective use of statewide vaccine registries.
8. Develop an information dissemination network with a single contact.
9. Maintain proactive relationships with media.
10. Connect with the state volunteer agencies such as the Medical Reserve Corps.
11. Collaborate with the state department of education and local schools to ensure they have a functional, coordinated disaster plan.
12. Participate in local public health meetings.

- creating a safety net for high-risk children by enhancing their emergency care plans to include contingencies for local care and home care during mass medical emergencies (Michigan); and
- developing vehicles to support physician-public health relationships at the county level, such as webinars or lunch-and-learn sessions (Missouri).


Dr. Krug

Based on the plans and suggestions, a to-do list for states was developed (see sidebar).

Steven Krug, M.D., FAAP, chair of the AAP Disaster Preparedness Advisory Council, said the meeting generated a lot of ideas and helped to conceptualize lessons learned after H1N1 and some best practices. "There was a great synergy among the groups," he said. "I was extremely gratified."

While pediatricians were urged to attend meetings of local and state health departments or emergency management entities to become more involved, Dr. Krug said there is a role for individuals as well: "Pediatricians also can make a personal difference by discussing preparedness issues with patients' family members. Data indicate that families are more likely to be prepared as a result of those discussions."

RESOURCE

AAP Disaster Preparedness Advisory Council Web site, www.aap.org/disasters/index.cfm