NACCD NATIONAL ADVISORY COMMITTEE ON CHILDREN AND DISASTERS

NACCD Public Teleconference Meeting Summary

Date: Thursday, November 13, 2015
Time: 3:00 - 4:00 pm ET
Toll-free:1-888-989-6485 Pass-code: 5885755

NACCD Voting Members Present:
Michael Anderson, Chair
Robin Gurwitch
Lauralee Koziol
Linda MacIntyre
Mary Dianne Murphy
Scott Needle
Georgiana Peacock
Mary Riley
Jeffery Upperman
Anne Zajicek

Call to Order, Conflict of Interest Rules, and Roll Call:
CDR Jyl Woolfolk, MPH, Acting Designated Federal Official, NACCD
U.S. Department of Health and Human Services
Office of the Assistant Secretary for Preparedness and Response

CDR Jyl Woolfolk called the meeting to order. She provided an overview of the Federal Advisory Committee Act (FACA) and conflict of interest rules. CDR Woolfolk also provided information on how to access the webcast for the presentation slides of this meeting. She proceeded to take roll for all National Advisory Committee for Children and Disasters (NACCD) members present via teleconference. CDR Woolfolk confirmed that a quorum was present.

Welcome and Agenda Overview:
Michael Anderson, MD, Chair, NACCD

Dr. Anderson acknowledged and thanked the NACCD members for joining the call today and he thanked the Healthcare Preparedness Working Group (HCPWG) for their hard work on creating their proposed recommendations in response to the Assistant Secretary of Preparedness and Response (ASPR) task letter on healthcare preparedness to care for large numbers of children in a disaster. Dr. Anderson also gave thanks to the ASPR's National Advisory Committee Team led by CAPT Charlotte Spires. Dr. Anderson

then provided a brief overview of the meeting's agenda and introduced the HCPWG Co-Chair, Dr. Upperman to begin the presentation of the HCPWG recommendations.

NACCD Healthcare Preparedness Working Group Presentation:
Michael Anderson, MD, Co-Chair, HCPWG
Jeffrey Upperman, MD, Co-Chair, HCPWG

Dr. Anderson began by thanking the HCPWG Co-Chair, and then thanked the HCPWG members for their work and dedication to responding to the ASPR's task letter. He began his presentation by introducing the major areas for consideration found in the ASPR's request to the NACCD:

- The current state of healthcare (both pediatric and non-pediatric) facility preparedness to care for children in mass disasters. Examples of variables may include site management, surge, transport, medical countermeasure capabilities, workforce development, innovative programming, communications streams, and partnership/coalition-building.
- A review of best practices, recommendations of potential long-term strategies, and a summary of practical tools to improve the ability of healthcare coalitions to effectively care for children after disasters.
- A summary of potential mitigation strategies for identified gaps.
- An assessment of current granting structures for pediatric healthcare capacity building.

Dr. Anderson listed and thanked all of the HCPWG members: Michael Anderson, Sarita Chung, Terrie Crescenzi, Elizabeth Edgerton, Michael Frogel, Lisa Kaplowitz, Lauralee Koziol, Dianne Murphy, Scott Needle, Sarah Park, Georgina Peacock, Sally Phillips, and Anne Zajicek. Next he described the sources of information used to address the task including expert opinion and experiences of the HCPWG members, discussions with national Subject Matter Experts (SMEs) and the available published literature, and public policy documents.

The first major section of the report focused on partnerships and coalition building. The HCPWG had eight main recommendations in this section as described by Dr. Anderson:

A) HHS/ASPR should support the utilization of a Pediatric Disaster Coalition model to develop and coordinate a comprehensive, integrated, multi-disciplinary, regionalized, team approach to plan for and manage disasters involving children by matching needs to resources for the pediatric population (i.e., a special needs group that comprises approximately 25% of the US population) and thereby, obtain optimal outcomes before, during, and after the events.

B) HHS/ASPR should support the development of guidance for managing pediatric surge and evacuation that includes requiring an addendum to the hospitals' annual Hazard Vulnerability Analysis/Exercises and the CDC's Cities Readiness Initiative Exercises.

C) HHS/ASPR should expand the definition of first responder for disaster preparedness to include all individuals who are qualified and poised to give care, including school nurses and child care providers. This expansion could occur initially within federally funded entities; however, the public sector could also encourage its partners in private jurisdictions to consider any worker who has child contact responsibilities as a response asset.

D) HHS/ASPR should support the removal of a silo approach to pediatric disaster management by facilitating the incorporation of all entities that care for children in disasters into coalitions. This includes, but is not limited to, first responders, local, state and federal governmental agencies, pediatric national organizations, and both for-profit and nonprofit community-based organizations, including those not in the health-care sector.

E) HHS/ASPR should work to establish within the National Disaster Medical System (NDMS) a cadre of pediatric professionals who would have the requisite training and expertise to serve on Department of Defense (DOD) aircraft to treat and stabilize pediatric patients with high acuity (e.g., evacuation of NICUs, children's hospitals).

F) HHS/ASPR should support the education and engagement of alternate caregivers in advocating for children in a disaster.

G) HHS/ASPR should support the development of a process to operationalize pediatric disaster management by creating a guideline and template best practice plan for regional pediatric disaster coalitions that can be customized and utilized by all coalitions to provide a standardized approach and best outcomes for children in disasters.

H) HHS/ASPR should allocate, whenever possible, and provide appropriate funding support for comprehensive pediatric disaster planning and management that includes support of pediatric disaster coalitions. Furthermore, the Secretary /ASPR should promote — and when possible, facilitate — acquisition of other funding resources from the public and private sectors that include grants and financial support from corporations, foundations, non-governmental organizations, and others.

The second major section of the report addressed workforce development. This section included 12 recommendations from the working group as described by Dr. Upperman:

A) HHS/ASPR should work with appropriate organizations to develop pediatric disaster training standards for:
   1. Physicians
   2. Nurses
   3. School Nurses
   4. Federal Response Teams

B) HHS/ASPR should explore tasking the NACCD (with guidance from subject matter experts at the CDC, AAP, and other interested parties) to develop

recommendations that will guide curriculum development for a pediatric disaster preparedness training program.

C) HHS/ASPR should include all appropriate types of first responders in education and training for pediatric disaster preparedness, including school nurses and child care providers.

D) HHS/ASPR should develop and deliver a bystander disaster training curriculum to address personnel shortages in a large-scale disaster.

E) HHS/ASPR should assess the need for a dedicated organization to house a center for healthcare disaster modeling.

F) HHS/ASPR should continue to disseminate best practices in facility and site management for pediatric care in disasters.

G) HHS/ASPR should develop a national strategy, together with both public and private partners, to improve pediatric emergency transport and patient care capabilities for disasters, including to or from alternate healthcare facilities such as school sites.

H) HHS/ASPR should assess the state of existing technology to aid in tracking and reunification, including identification of significant gaps. HHS should develop and fund competition-style programs (e.g., similar to the XPRIZE), "hackathons", and other programs of the type currently being used by the technology sector to promote innovation in order to encourage remediation of these gaps.

I) HHS/ASPR should incorporate pediatric-specific standards into the Healthcare Preparedness Capabilities guidance document and should assess pediatric preparedness in Hospital Preparedness Program (HPP) applicants and funding recipients.

J) HHS/ASPR should promote Incident Command System training and exercises/drills for healthcare professionals and other facilities that provide care to children to improve crisis coordination and communication.

K) HHS/ASPR should recommend the development, testing, and regular use of communications strategies and capabilities as a vital component of coalitions. CDC's public health communication training and related resources are examples of best practices that HHS/ASPR should promote and disseminate.

L) HHS/ASPR should work with the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to improve the Crisis Counseling program. Specifically, the program should have the flexibility to address preexisting mental health conditions that might be exacerbated by disaster.

The third and final section of the report explored medical countermeasure readiness. The HCPWG developed 11 recommendations in this area. Dr. Anderson shared them as follows:

A) HHS/ASPR should collaborate with federal partners to provide anthropometric tapes and the necessary training to use them correctly.

B) HHS/ASPR should collaborate with other federal partners to promote the development of weight bands for dosing to more readily estimate emergency drug doses. By this method, a range of child weights could be designated a single drug dose, depending on the specific drug. This method could reduce safety concerns regarding larger doses. Extensive training on this equipment will be critical as well.

C) HHS/ASPR should promote the development of alternative drug delivery methods that are facile for any responder to use with minimal potential difficulties, e.g., an alternative to utilizing pumps to maintain flows or drips.

D) HHS/ASPR should collaborate with other federal partners to prioritize grant funding for studies to define how adult auto-injectors might be adapted for use in the pediatric population.

E) HHS/ASPR should prioritize and allocate funding for the immediate development and production of solid oral dosage forms which are palatable, orally dissolvable or dissolvable in small amounts of liquid, in pediatric strengths and sizes.

F) HHS/ASPR should raise awareness of EUA/EUI/IND practices, clearly delineating distinctions between these mechanisms wherever possible. First responder personnel especially need to be aware that medications can be used off-label in an emergency with appropriate authorization, and have access to existing instructions on the appropriate uses of EUA/EUI in pediatrics.

G) HHS/ASPR should thoroughly review the legal and ethical issues surrounding distribution of investigational agents prior to an event, and promote the availability of this information (along with overall guidance on the process) to those who will be administering these MCMs under a special authorization. Information on EUA's and EUI's — both general and legal/ethical — should be known and readily understood by clinicians, pharmacists, nurses, and emergency responders.

H) HHS/ASPR should develop and pursue collaborations among the Biomedical Advanced Research and Development Authority (BARDA), FDA, and NIH, or among BARDA, Defense Advanced Research Projects Agency (DARPA), FDA, NIH, and the pharmaceutical industry to develop improved pediatric drug formulations in the CHEMPACK or Strategic National Stockpile (SNS), using the NIH-FDA Formulations Platform as a model.

I) HHS/ASPR should facilitate a collaboration among key stakeholders (e.g., American Academy of Pediatrics [AAP], CDC, FDA, American Pharmacists Association) to develop a standard list of medications and devices (e.g., face masks, needles, and syringes for children) which should be stocked in pharmacies for chemical and biologic emergencies.

J) HHS/ASPR should facilitate the collaboration of key partners (e.g., AAP, CDC, and FDA) and public health law experts to consider, review, and

develop innovative emergency consenting methods that focus on rapid delivery of care.

Dr. Anderson concluded the presentation by acknowledging and thanking the 18 SMEs who shared their experiences and knowledge with the working group. Finally he thanked the ASPR National Advisory Committee Team for their support and hard work.

Public Comment Check:

Michael Anderson, MD, Chair, NACCD

Dr. Anderson confirmed with CDR Jyl Woolfolk that there were no public comments received by email by the closing deadline before today's meeting.

NACCD Vote on HCPWG Report:

CDR Jyl Woolfolk, MPH, Acting Designated Federal Official, NACCD

CDR Jyl Woolfolk repeated the roll call and asked each voting members of the NACCD to voice their approval or their disapproval of the report. The ten NACCD members in attendance unanimously approved the HCPWG report with proposed amendments that were discussed.

Wrap-Up and Conclusions:

Michael Anderson, MD, Chair, NACCD

Dr. Anderson acknowledged without exception the full approval by the NACCD of the Healthcare Preparedness Working Group Report. He provided words of both congratulations and encouragement to the NACCD's ability to produce another outstanding report. He also noted that the NACCD continues to have much work to do, and that the HCPWG chose to address three major areas in its report, but that there are still other very important topics for future NACCD working groups to tackle. Dr. Anderson mentioned the need to examine the role of funding, transport, human services, and mental health as they relate to children in disasters.

CDR Jyl Woolfolk adjourned the meeting at 03:39 p.m. Eastern time.