National Healthcare Preparedness Programs Teleconference Transcript
Behavioral Health Preparedness for Healthcare Coalitions Webinar

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2:00– 3:30 PM EDT

Operator: Good day, ladies and gentlemen, and welcome to the Pediatric Preparedness for Healthcare Coalitions Call. At this time, all participants are in a listen-only mode. Later, we will conduct a question-and-answer session and instructions will be given at that time. If anyone should require assistance during the conference, please press star then zero on your touchtone telephone to reach an operator. As a reminder, this conference call is being recorded.

I would now like to the turn the call over to Dr. Cynthia Hansen. Ma'am, you may begin.

Cynthia Hansen: Thank you so much and hello to everyone who's able to join us for today's webinar. On behalf of Dr. Nicole Lurie, the Assistant Secretary for Preparedness and Response, Mr. Don Boyce, the Deputy Assistant Secretary and Director of the Office of Emergency Management and Ms. Jennifer Hannah, Acting Director of the National Healthcare Preparedness Programs, I would like to welcome to the sixth in the Series of Technical Assistance webinars hosted by the National Healthcare Preparedness Programs.

Today's topic is Pediatric Preparedness for Healthcare Coalitions. I'm Dr. Cynthia Hansen, Senior Adviser to the Division Director of the National Healthcare Preparedness Programs and a Clinical Child Psychologist with decades of experience in public and private sectors as well as disaster response.

In June of last year, I hosted our first webinar on pediatric preparedness and Dr. Marcozzi, who is the Director of the National Healthcare Preparedness Programs, who's – and who is currently deployed to Afghanistan, at that time Dr. Marcozzi promised you, all of you, that there would be a follow-up call to that call last June of 2013. He said that this was not a one and done event and that we were absolutely committed to strengthening pediatric preparedness in all of the capabilities for disaster preparedness and response.

And you know what, it's a good thing he said that too because we literally ran out of time on the webinar last year. So this year, we're starting exactly where we left off and we focused our speakers and topics on the issues that were raised by the audience

in last year's call. You'll hear about updates, resources, products underway, and lessons learned from real world events. And what you won't hear is the information we covered in last year's call. To access that information, you can go to the website at the end of the PowerPoint slides. It's at phe.gov and all of the webinar is archived, the PowerPoint and the resources are all there for you to review at another time.

So, as you go on, you can see on the webinar, we have the purpose of today's webinar and our shared goals and "our" being all of our partners throughout HHS and the federal family as well as state, local, tribal, jurisdictional healthcare coalitions, everyone working together for these two goals: That all healthcare coalitions include members with pediatric expertise and all healthcare capabilities incorporate pediatrics. And secondly that all hospitals have pediatrics included and exercised in their disaster plan.

In the course of this call, I'll be highlighting areas of the continuation guidance for the Hospital Preparedness Program most related to pediatric preparedness. I will also be updating the list of resources to include those that other – other speakers will update the list of resources. And then we'll highlight a variety of approaches to strengthening the pediatric component of healthcare capabilities.

So, the next slide is really for your reference. Everybody on the call, this is a key joint requirement for the HPP staff and continuation guidance for fiscal year 2014 to develop preparedness and response strategies that address the access and functional needs of at-risk individuals, and at-risk groups include children, which I've highlighted here on this slide. And the page number is at the bottom, page 22 to 23 so you can reference it easily.

On the next slide, you can see that very specifically awardees are required to do specific tasks related to ensuring that structures or processes are in place to meet the needs of children and other at-risk individuals. Specifically, you can see on the third bullet that awardees should engage with the Health Resources and Services Administration's (HRSA) Emergency Medical Services for Children (EMSC) program managers. Because they work on the daily delivery of medical services to children and everything we do in disaster preparedness builds on the daily delivery of care, it's an obvious partnership and we're going to reinforce that throughout this webinar.

If you want more information about these grant requirements, the link on grants.gov is at the bottom of slide five for your future reference.

The next slide, again, is where we're starting. It is where the webinar from June 2013 was posted. And then if you can see here, there's a lot of questions about pediatric coalitions, exercise examples, what are we doing with – to deal with the decreased intensive care experience, what about neonatal and pediatric exercises, and then finally on the next slide, the question posed about pediatric transportation. All of those issues are going to be covered by our speakers in this call, believe it or not. This is a jam-packed agenda and I'm very, very excited to host everyone who is speaking today.

I want to talk first – before I turn the microphone over, I want to publicly thank each of them for their great work and generosity in preparing for this webinar. They're going to squeeze a lot of information into a short amount of time. And all of their slides have links and resources that you will be able to access after the webinar concludes so that we'll have time for some questions and answers at the end of the call.

And with that, I'd like to turn the microphone over to Dr. Dan Dodgen. He is the Director of ASPR's At-Risk, Behavioral Health, and Community Resilience. And he'll be able to give us updated resources on what's happened since last year, Dan.

Daniel Dodgen: Thank you, Cynthia. It is also a pleasure for me to be here. I know I know many of those folks on the line and we just have such respect for the work that people are doing through coalitions and at the state and local level. It's just really exciting to know that you all are out there doing great work even when facing extreme challenges and that you're interested in this issue which, as you know, is close to my heart and it's really important to everybody, I think, to make sure that we're doing the best we can to prepare for everyone in our community, but particularly for children.

So I'm going to ask Cheryl Levine who's our At-Risk Team Lead on my division to talk a little bit, very briefly about the legislation that drives the guidance that Cynthia just described. And then I'll just give you some information about a few resources. So, take it away, Cheryl.

Cheryl Levine: Thank you, Dan. So, just as a general background, ASPR's authorizing legislation, the Pandemic and All Hazards Preparedness Act of 2006, or PAHPA, requires that

ASPR provide special attention to children and other at-risk individuals with access and functional needs during disasters or public health emergencies.

Next slide. There are several ways that PAHPA ensures inclusion of children and other at-risk individuals with access and functional needs including grant guidance. In 2013, ASPR's legislation was reauthorized. The Pandemic and All Hazard Preparedness Reauthorization Act includes the establishment of a new National Advisory Committee on Children in Disasters, or the NACCD.

Members of the NACCD have been selected but the official announcement is forthcoming pending leadership review and approval. Of particular interest to this audience, members of the NACCD will include representation from state, local, territorial, or tribal agencies with experience in pediatric preparedness planning, response and recovery activities. Dan.

Daniel Dodgen: Thanks, Cheryl. So just a couple of other things that I wanted to let you know about – many of you may recall that we did a report a couple of years ago that really summarized all the work that HHS has been doing for children up to 2011. And you can see the first bullet on this page provides the link for that. And, again, when these are posted, you'll be able to click straight through.

We actually just finished our report for 2012 – 2013. I have to tell you, it's now 75 pages. I'm smiling at someone in the room here with me who's just been tasked with reviewing it and putting in the final comments. It's lengthy. But the reason it's lengthy is because amazing work is being done. And I think you'll all be really pleased to see a lot of it. And what I'm going to spend a couple of minutes on in a second is just telling you some of the tools that are described in that.

But before we go to that, I just want to let people know, we will let you know as soon as this report is through clearance and posted. Because, although I'm going to describe some tools now, there are actually even more than what I can describe in a few minutes and really a lot of resources that I think will be very useful at the state and local level both in terms of internal planning tools that you can use as well as potential partners that you might want to reach out so they can help with this work and presumably multiply resources a little bit.

So let's move to the next page and we'll look at some of the tools that are available. Again, these links are going to be available for you when we post everything so I

don't want to spend too much time. But just to give you a sense of some of the things that are out there, obviously the first two I want to encourage everyone to look at, if you haven't already, includes all of the resources that we posted following the June 2013 webinar. And as you can see, there's a number of things in there including how to contact your local Academy of Pediatrics contact, the Administration for Children and Families local emergency contact, the EMSC grantees, that's the HRSA Emergency Medical Services for Children, et cetera. So you can see on the left what's available.

If you go to the next slide, two recent documents that some of you might find useful in your planning activities. First is the new national approach for Post Disaster Reunification of Children that was recently released by FEMA. You can go to their regular fema.gov website for that. And then also our own HHS Administration for Children and Families just recently released this Children and Youth Task Force in Disasters model. And really what that does is describe the way that you could setup a task force following a disaster to address the needs of children in your community. And I think that that would be the kind of activity that would be really great for children – or for the people who are on the coalitions to connect with to make sure that children's needs are addressed.

Again, you can access that through the ACF website. And I can also send the specific URL if people need it. But it was so incredibly long that I didn't want to put it on the slide.

If you to the next slide, a couple of other examples from our partners at CDC, the Centers for Disease Control and Prevention, Caring for Children in Disasters and Coordinating Pediatric Medical Care During an Influenza Pandemic Hospital Workbook. So, again, these are things that are out. They've been published recently enough that I wasn't sure if everyone would be aware of them. So I wanted to make sure that you know that.

A couple more tools, if you go to the next one, this is just the PED Prepared from the HRSA EMSC program. Also, I think, a really good resource for community members and clinicians as well as for healthcare planners. And then if you go to the next page for those of you who haven't been to the NLM page lately, the Resource Guide for Disaster Medicine and Public Health, there is so much good information on there.

There's also now a whole page of apps that you can access through this site. For example, there's several really, really good apps related to mental health and behavioral health in disasters, SAMHSA just put one out. All of these you can find there and many of those you can download on your – on your handheld device whatever it may be or your lap-held device and get really, really good information including, you know, everything from local service providers to tool kits and questionnaires that you can send out, et cetera.

And then the last thing that I wanted to look at – it's just a reminder that, of course, a lot of the children in our communities have additional special needs just over and above being children. We did a webinar recently on preparedness tips for family caregivers, which would include parents of children with special medical needs. And if you go to that URL, you can find some more information there as well.

So those are the tools I wanted to highlight for all of you because I thought they were particularly interesting. I will say again, when this child report that I talked about is released in the next month or so, there will be a number of additional tools including the URLs so we'll send that information out when we've got it. But there's some really good stuff and we hope you're able to take advantage of it.

So, that's all for me.

Cynthia Hansen: Great. Dr. Dodgen, Dr. Levine, thank you so much for a jam-packed summary of new resources out there. I actually know that Dr. Edgerton who runs the Emergency Medical Services for Children program is on travel this week so she couldn't join us. But their group is creating a checklist for pediatric domains related to hospital preparedness that can be used to strengthen or build pediatric capacities at hospitals. So, I know Dr. Edgerton is working hard on that and that should be out by the end of the year. So that's upcoming for next year's webinar.

So I'm going to turn the microphone over to Dr. Mike Frogel and Dr. Espiritu from New York City Pediatric Coalition to tell us about lessons learned from the response to Superstorm Sandy. Dr. Frogel.

Michael Frogel: Thank you very much, Dr. Hansen. We really appreciate being able to speak to so many people out there and realize that there's so much interest which is fantastic. We're going to be talking about Superstorm Sandy and lessons learned.

I first just want to start off quickly by thanking my co-PI George Foltin, Dr. Arthur Cooper, and the Department of Health in New York City with leadership by Marisa Raphael, Jenna Mandel-Ricci and the people we work with closely Wanda Medina, Katherine Uraneck, Emily Raisch and Nora Caplan . And a cast of thousands actually in our Pediatric Disaster Coalition and it's just us doing the presenting but all of us worked together actually pretty nicely in an effective coalition.
So we're going to break this up into a couple of parts. I'm going to very briefly talk about the impact of Superstorm Sandy. Dr. Espiritu will discuss specifically its effect on a neonatal unit that had to be evacuated during the storm. And then we're going to come back to the citywide Pediatric Disaster Coalition response to the storm.

Okay, so the storm hit on October 29th and made landfall in New Jersey but it really devastated the entire East Coast – upper East Coast – New York and New Jersey which are main population centers which created havoc. We call it Hurricane Sandy but it really wasn't. It was really a massive flood. The winds never got above 75 miles an hour, so it wasn't even a hurricane. Think about what would happen if it was with this flooding.

Okay, this is – I actually lived in Hurricane Sandy area and this is the beach. All these houses were completely destroyed. The first house and second house in every block were absolutely demolished. It looks kind of like a warzone, just to show you the power of the water and the impact of the storm. Not only did we have houses destroyed by water, we also had them catch on fire particularly in my area. We had hundreds and hundreds of houses have transformer fires while there was rushing water in the streets. And luckily, we had hero firemen and other people who helped save many, many individuals.

Here's a car sitting in someone's living room, just to show you the power of the storm surge. Twenty-three thousand people sought shelter, 8.5 million customers lost power. That wasn't for a day or two. That was for a very, very long period of time, often two or three months and sometimes even longer. There was $50 billion in damage, 97 people died in New York and only because of the fire department and EMS did we not have more casualties. They did an amazing job using boats and all kinds of other vehicles to save people. We opened 88 shelters including eight for special medical patients manned by the Medical Reserve Corps who did an absolutely fantastic job.

The impact on children, as we discussed in our last webinar, children are not small adults, they are different in hypothermia and very many other anatomical and physiological issues pertain and we think those are extremely important and distinguishes kids. Kids also can't possibly understand at this age what's going on. This is all she's got left from her belongings and who is this scary guy picking me out of the water. Here's a mom and baby in one of the shelters and kids have very significant psychological impacts from disasters and they often are dependent on their parents and will reflect the parent. So we need to look at how the parent is doing psychologically and make sure we are prepared for psychological first aid and all the other outcomes that may develop in kids.

I'm going to turn it over now to Mike Espiritu who's going to talk specifically about the evacuation at NYU Medical Center of the neonatal unit.

Michael Espiritu: I'm going to talk about our experience inside the NYU NICU during Superstorm Sandy and the ensuing blackout and our evacuation of our unit. And I start off with this picture of one of our babies being put into an ambulance because I think this sort of captures what – the amount of teamwork and coordination that was – that was involved in, you know, in taking care of our parents during this disaster – or patients during this disaster and the – and the good outcome that, I think, came at the end of the evacuation with all 21 of our patients surviving.

As everybody knows, the – our NICU was affected by a power outage as a result of flood waters during Hurricane Sandy at around 8:00 PM on October 29th was when we lost power and the effects of that in our unit were not just the lost of light and some other electrical equipment but really a whole lot of systems that were necessary for continued clinical care like our electronic health records, all the medical equipment that we use in the neonatal ICU, incubators, monitoring equipment, ventilators, our medication lockboxes which are electronically controlled, our communication with the outside world via our telephones, and even access to our unit with our electronically secured doors and our elevators that go up to our unit on the ninth floor of our hospital.

And so, without power, without working ventilators, without working equipment, we were faced with a number of important challenges and tasks at that moment that we had lost power up until we started evacuating. And that included, first and foremost, establishing a clear command structure within our – within our unit. We had decided beforehand that the person in-charge in any sort of emergency was the senior medical

clinician onsite which happened to be our unit – our division chief that night who had a direct line to the hospital incident command center and coordinated everything that was happening on a local level.

Continuing medical care of our patients, we were – you know, we were sort of fortunate that this happened around the time of change of shifts so we had a – twice the complement of nurses and other ancillary staff who could continue scheduled feedings and medication and ensuring thermoregulation of our – of our premature babies. And we also had to cover our labor and delivery service. We actually were called to attend one delivery that was done by flashlights.

Establishing communication within the hospital – our command center using walkie-talkies and our own personal cell phones to talk – to call units outside of the hospital which is important for finding alternate beds for each of our 21 babies that night using a resource directory of the various NICUs in the region that our disaster coalition had put together the year before.

And transferring the medical – the key medical information without our electronic medical record handy. And this was something that our residents took charge of using their notes during the day, handwriting – handwritten patients' summaries to go with each patient, talking to doctors at different hospitals over their cell phones, giving them essential sign out and arranging the transportation not only from our hospital to other hospitals but also from the ninth floor to the ground floor.

And so determining how best to do this when we can't – we couldn't take our babies in isolettes down the elevators was a challenge. We had – the hospital had bought some evacuation equipment, large Med Sleds, but we did not have the individual infant inserts at the time. And so we determined the best way was to hand carry them which would ensure proper motion stability, thermoregulation and safety of equipment like endotracheal tubes and IVs. And so each baby was carried by a nurse from the ninth floor to the ground level, step-by-step in flashlight lit stairwells, accompanied by staff anywhere from two to six other people depending on how much equipment and monitoring and other IVs were necessary.

And, you know, it took us – it took each baby maybe about 5 to 10 minutes to go from the ninth floor to the ground floor where ambulances were waiting. And these were with, as I mentioned, there were no transport isolettes like we usually use. And so, infants were held by nurses that were secured to gurneys and patients were tracked

at the exit point from the unit and from the ground floor. This is a picture – we don't have any pictures of the infants being evacuated but here's a picture of a group of people evacuating an adult down our stairwells. Here's the picture of the ambulances that – the contract ambulances that had been lined up along the – along the street waiting for each patient. And one of our nurses carrying an infant going into an ambulance that had been – that had been in the city from Northern California.

And so some of the lessons that we learned from this experience is that – or that there are several big rate-limiting steps in an evacuation like this. One is arranging the transportation which thankfully was taken over by the hospital level and the regional level. On the local level in the unit, our biggest challenge was actually finding the beds, calling individually each hospital which themselves had different procedures for accepting patients. In some cases, the on-call neonatologist said, "Sure, I'll take these – I'll take those patients." In other cases, they would tell us that our command center had to talk to their command centers. So it's a laborious process without any sort of central clearing house of beds.

Planning for a power failure and knowing what other hazards might affect your hospital is important. Having backups not only in terms of equipment and power but also contact lists for parents so that you could, you know, somebody that could be contacted in the event of a disaster. Using checklists is very helpful in this regard. Make sure there's adequate staffing and a clear command structure and communication coordination not only within the hospital but outside of the hospital, coordination among regional agencies and flexibility.

And with that, I'll send it back to Dr. Frogel.

Michael Frogel: Thank you, Mike. That was a quick summary of an amazing project getting 21 babies down nine flights of stairs with no morbidity or mortality. It was – we certainly had God's help but you guys did a really fantastic job. And we all thank you.

Michael Espiritu: Thank you.

Michael Frogel: I just want to, you know, expand this now, you know, this was an individual hospital, one NICU unit but the entire city's medical infrastructure was really devastated. You can see the storm – right at the storm, cars under water, a waiting room in Long Beach Medical Center completely devastated. And it was really a lot of devastation to the medical infrastructure.

So how did the Pediatric Disaster Coalition respond? We got our members together which basically our stakeholders – the hospital, the disaster medicine experts, physicians, nurses, governmental agencies, Office of Emergency Management, fire, the Department of Health, of course, and we got the community groups involved as well. And we provided a forum for people to discuss what to do acutely and started to collect the lessons learned. And this was very helpful both in operationalizing things during the storm as well as culling the lessons learned for the future.

We presented a very important conference with all the major players. Dr. Marcozzi attended on the federal level, Commissioner of Health, et cetera. And this is posted actually on our website and you can actually go through the entire conference. And then we produced a report of the lessons learned so that, should this happen again, we'll do it even better than we did before. And these are just some quick highlights of it and some of it is a little bit duplicative because Mike went through it on a micro level, but of course it has to be done on a macro level as well.

Key issues are bidirectional communications, it's got to go both ways. Mike in the NICU needs to be able to communicate to the citywide agencies that they need ambulances to bring the kids, as well as to the hospitals. The hospitals need to communicate with their clinical people in the field to be able to help and mobilize them. And it's got to be bidirectional. It's a challenge. What do you use? Some places are recommending getting Ham Radios for every hospital. Sometimes you have to use runners if nothing is working between the incident and command centers.

Informational sharing and situational awareness is key, so you know what's coming and you can deal with it. Pre-disaster risk assessment is to look at the infrastructure, see where those generators are, see where the fuel source is and prepare for a future storm or other eventuality. Backup systems are key and they need to be battery backup systems. In a NICU, you need suction units and you need ventilators and these need to be prepositioned and preplanned. It's important to have paper records, I prepared a paper printout of my talk today just in case all my electrical systems went down and I just had a phone. I think I learned a lot. So patient records, action sheets, manuals, resources, parent's phone numbers, all should be available on paper.

Coordination of aid is essential between the site that's transferring the children and the accepting site, maybe they can utilize their personnel in getting the appropriate transport. Individuals need to have fuel in their cars at all times we recommend. And it would be great if there were pediatric-specific ambulances with available expertise

which we do have in New York actually. We have two major centers that provide pediatric-specific transport for neonates and PICU patients. And it's great to try to wrap them up into the response.

Mental health issues are paramount. We had pretty few casualties, thank God, in the medical way but psychologically, you know, we had thousands and thousands of people. We need to all know about psychological first aid and how to triage the kids who really need further help. And of course, we all need to share resources between all the different agencies, the community-based organizations who did an amazing job and were willing to take care of the population before their federal and citywide resources got there.

So basically what we learned is that a true event is more than a drill. You need to take it and do the best you can, but most importantly learn for the next time and try to rework your plan as you would during a drill. And take all those lessons learned and put them into an operationalized plan for the future.

Okay.

We're ending up with neonatal planning, our response was to enhance our neonatal planning, include all the lessons learned and we've actually conducted a pediatric neonatal exercise at Maimonides Hospital which is a very big center with 7,000 deliveries. And it took nine months in planning but many, many, lessons learned. And we believe we need to do this countrywide. And the last thing we're doing is developing a plan for obstetrics for women in labor and newborn babies along the same guidelines as our neonatal planning.

I'd like to invite everyone to look at our website and contact us for further information. We'd be happy to share all the things we've learned and all of our guidelines, plans and templates with you. Thank you very much.

Cynthia Hansen: Dr. Frogel, Dr. Espiritu, thank you so much for a compelling story of why we're in this business and why we're doing this work with the children, the parents, the caregivers, and all of our medical responders and their support team.

So, Mr. Kevin McCulley, you are on next after this story. And I know you have a great story to tell about how you pull everyone together to put a preparedness plan in place. So that if the worst were to happen, you were ready to go.

Kevin McCulley: Sure and thank you very much for this opportunity. Although it would be nice to think that we have everything ready to go, I feel like we're still in the position of many other states that I have talked to is that we have some pretty strong pieces but we're still in the process of putting all those pieces together. So I'm going to discuss – my points today are going to be more from the state level Department of Health perspective including how do we incorporate pediatric concerns into the overall management of the HPP program and also how we start to leverage our regional coalitions to address some specific pediatric concerns.

First off, I wanted to talk a bit about some of our vulnerabilities that we have identified in our state. We have two state-level priority threats and those include earthquake and pandemic. And actually even today, we have our Region 8 regional emergency coordinator and a FEMA staff in town to talk to our advisory committee about strengthening our ESF-8 or health and medical response plan for an earthquake.

We know that about 80 percent of our population is within a stone's throw of the Wasatch Fault area which is from basically north of Salt Lake to south of Salt Lake just to our east. We also know that our percentage of population, 33 percent of our population is age 18 or under. That's almost 950,000 kids age 18 or under compared to the U.S. at about 25 percent. Even if we drill down a little bit more into Salt Lake County, we have about 314,000 kids and within the county itself, some of our zip codes in Salt Lake County are up to 44½ percent children. We also know that 58 percent of our schools were built before 1975 which is when seismic regulations began coming into building codes in the state of Utah. And then finally, as a result of a windshield or rapid survey, a rapid visual screening, it was noted that over a third of schools have a 10 to 100 percent chance of collapse in a large earthquake. So we do recognize that our vulnerabilities are significant.

We have had recent challenges over the past few years that have highlighted some of these vulnerabilities, fortunately not to the level at which we've had to deal with a massive pediatric medical surge. However recently, down in Montezuma Creek and you can see on the screen, both of these events took place in the southeast corner of our state where there is limited healthcare capacity on a day-to-day basis. But at a school in Montezuma Creek, we had 43 children sickened, fortunately, only three hospitalized. And that was 350 miles from the Pediatric Trauma Center in Salt Lake City.

A few years back, we had a ski bus crash in Mexican Hat, also in the southeast part of the state, that resulted in nine fatalities and over 40 people that were thrown out of the bus into the snow. These folks, a mix of adults and children, were distributed to 13 medical facilities in the four corners states. And, again, we experienced barriers not only the road, 350 plus miles, but at that the time of the ski bus crash, there was no air transport available due to the weather.

We recognize also that we have some limited pediatric surge capacity in the state. We have two children's hospitals in Utah, both of which are in Salt Lake County: Shriner's Hospital for Children, 45 beds with a focus on orthopedics, burn, and spinal injuries, and Primary Children's with 289 licensed beds. It's our trauma one for children and all major services are offered. And you can also note from the map, you can see the very big white space all around us where Primary Children's catchment area includes all or part of seven states in our mountain west.

If we include the surge beds for these two facilities, that really only puts us at about 400 beds – 400 children's hospital beds for over a million kids. If we include the pediatric beds in the general hospitals in the state, that's still only puts us at about 900 beds for a million kids which is about one hospital bed per 1100 children. Again, the limit to the surge capacity is quite evident to us.

So when we talk about some of the things that we have done from our level to start to chip away at the vulnerabilities, the limited capacity and the threats that we have, we have a few solutions or a few projects that we've put in place including the development of pediatric EMS Strike Teams. These are based on a DMAT model where it's three teams of 9 to 12 individuals – including pediatric trained physicians, nurses, EMTs, paramedics, respiratory therapists – that can be activated as state employees if deployed. We've also prepositioned Strike Team trailers, which are stocked to care for up to 100 pediatric patients, provide basic and advanced life support, splinting, suturing, and other minor to moderate care so these trailers are prepositioned around the state with a goal of being no less than three hours from any scene.

Some of the activities that the Strike Teams can conduct include augmentation of hospital staff in caring for children, providing on-scene support during an event that might have a pediatric impact, and then certainly assisting with any burn surge events that might take place. Each of these Strike Team members, they receive a great deal of training to create their eligibility to be on the team including your, you know, your

basic courses of ABLS, BDLS, ADLS, PALS, and they also are frequent participants in activation drills and in functional and full scale exercises.

We have started to, as most states, develop and continue to work on our crisis standards of care plan, you know, as required by the HPP grant. However, we recognized that the general plan may not be as effective in talking about special or unique population such as pediatrics. So back during H1N1, we had a team that got together to develop hospital and ICU triage guidelines for pediatrics as a result of a pandemic. That actually is leading us to development of the pediatric annex to the base crisis standards of care plan. We recognize, as was said before, the needs are extremely different for children and we have also seen through the EMS for Children Pediatric Readiness survey that was done last year that there are certainly gaps that remain in general hospitals in terms of their ability to provide care for kids.

So, the pediatric annex rollout is actually going to be based on a completed burn surge crisis standards of care plan that we completed in 2014. It was a very successful model, we felt, that has a lot of similarities to the pediatric challenges including limited capacity and a multi-state range. And the activities for this burn surge and for the pediatrics annex will be planning, equipping, training, and exercising and addressing it at the hospital and healthcare facility level and also with our EMS partners.

We have been selected and we're very fortunate and very thankful that CDC and the ORISE Institute selected Primary Children's Hospital for a pediatric medical surge workshop that's going to be held in July 2014. The goal of this workshop is really to advance planning between pediatric and general healthcare systems to address the delivery of healthcare in a pediatric surge event. There are some intended outputs from this event that include the development of tools to inform other community plans and policy organizations, drive additional work with partner agencies on pediatric medical surge, and to begin and continue our engagement with surrounding states on regional coordination.

And in the end, we certainly hope to increase the engagement of our medical providers and other sectors such as schools in surge planning. And if there's an additional opportunity that would come out of this workshop from my perspective, it's actually that we hope we can start putting the pieces together that I've described into a coordinated response model to address the needs of kids in the state and in the Intermountain West.

So regional medial surge coalitions, as you can see in the map, we have fully regionalized in the state of Utah. We have seven regions in operation. And we have various tasks extracted from the HPP that regions focus on each year. One of those tasks is that each region – each grant year, each region chooses a special population on which to focus. And several of these regions have chose – have chosen children to focus their planning and their training and their equipping and their exercising on. The regions have an opportunity to collaborate with their local child service agencies. And they really have opportunities to identify gaps and needs that might be unique to the substate areas.

We like to – we see the inclusion of pediatric providers and the care for pediatric populations in each of the regional response plans. And as was noted before, especially the communication component of these regional response plans are critical so that those entities that provide care to pediatric populations can understand and be a part of a coordinated response. There's certainly ongoing awareness training that's conducted within the region and inclusion in exercises as available.

And then finally, one example in our SST or Salt Lake Summit Tooele Region, we were able to conduct a tabletop exercise with a school for children with disabilities around evacuation and sheltering. And even participation in the tabletop identified critical gaps that need to be met not only with the healthcare facilities but between the coordination of healthcare, EMS and fire.

So I'm more than happy to share any of these plans. Again, I think that we are right on the verge of having all of these different pieces start to come together to synthesize and to actually be able to affect an appropriate pediatric response as needed. So, that is all for my section. I thank you very much.

Cynthia Hansen: Thank you so much, Mr. McCulley. Just getting a sense of the percentage of children in Salt Lake County and the Intermountain region as a starting point for your planning is kind of mind blowing. Here from the D.C. area, we're all packed together so tightly. So, thank you so much for bringing that perspective to our planning and preparedness community.

Kevin McCulley: Yes.

Cynthia Hansen: Next…

Kevin McCulley: And when in – and when in doubt…

Cynthia Hansen: Yes.

Kevin McCulley: …we return back to hazards and risks assessment. It's never a bad way to go back and circle back around to where you started.

Cynthia Hansen: Absolutely, I think that's a – that's a great message to carry forward to everyone listening to the call. And so, now I'm going to turn the call over to Dr. Wilson and Ms. Berg who are speaking – or who will speak to the Los Angeles County Pediatric Surge Plan under development and all of the activities that they've begun in order to exercise this plan in summer of 2015. So, Dr. Wilson, Ms. Berg.

Millicent Wilson: Good afternoon and thank you for having us. This is Dr. Millicent Wilson of the Los Angeles County EMS Agency. I'm here with my colleague, Bridget Berg, from Children's Hospital Los Angeles, and we'd like to tell you today about the Pediatric Surge Plan which was recently developed here in Los Angeles County. The Pediatric Surge Plan was developed to address how we would handle an event that disproportionately impacts children. Today, we want to focus your attention on three key areas essential to the development of this plan.

First, we want to highlight how we have used our existing systems and structure to develop a plan that would double our pediatric inpatient capacity. Secondly, we want to highlight how we've engaged our partners in the development and vetting of the plan. And lastly, we hope that some of the tools and resources we have developed will be applicable and useful to your area or facility.

Today we will share with you an effort and a journey we have been on since 2011. Let me take you back to 2009. The first cases of H1N1 were seen in March 2009. Early on in the pandemic, cases of flu were being seen in young children with the first confirmed case in a 10-year-old boy from San Diego County here in Southern California. Cases of this novel flu were later confirmed as H1N1 in a 9-year-old girl and a 4-year-old boy from Mexico. The H1N1 pandemic disproportionately impacted children.

A review from the Center for Disease Control and Prevention showed that children age 0 to 4 years old were hospitalized at a rate of 4-1/2 times that of the adult population aged 25 to 49. There was a lot of discussion regarding surge particularly related to the shortage of ventilators and the capacity at our children's hospitals.

Following that pandemic, my director, Kay Fruhwirth and Dr. Jeffery Upperman, Trauma Medical Director from our Children's Hospital here in Los Angeles were reviewing the H1N1 situation and quickly realized that the need to address situations where children were disproportionately impacted. This, in addition to the CDC funded task force for pediatric emergency mass critical care, was the impetus for this plan.

Today we will review the background of our existing system and resources, our plan development, plan implementation, and our plans for evaluation.

To give you a sense of the Los Angeles Country area, let me tell you a little bit about the existing system and its resources. Los Angeles County is a vast geographic area approximately 4,000 square miles or roughly the same size as Rhode Island. The 88 cities and 140 unincorporated areas that comprise the county vary in population density, but overall we have approximately 10 million people. Similar to the United States, the proportion of children within our county is about 2.8 million or roughly 25 percent of our total population.

This map demonstrates our pediatric population density with a range of colors from white to green. The darker green colors indicate areas within our county populated by more children. Now reference the legend where you can see that the pediatric population on this map is mapped by the number of children per zip code and the range of children per zip code is from 0 to 35,000 children per zip code area. You will also notice all of the little red circles. These reflect the Hospital Preparedness Program participants within Los Angeles County. Each red dot is a hospital.

One of the things you will immediately notice from this map is that our hospital resources are centralized in the metropolitan areas of our county. For example, 31 percent of the pediatric beds are located in the metropolitan service planning areas. Additionally, our county has larger numbers of children in our eastern and northern areas. This is very similar to other geographic regions such as New York where you have centralized services with large numbers of pediatric citizens living in the suburbs.

Our county is serviced by 107 acute care hospitals. Currently, 82 of these hospitals participate in the hospital preparedness or HPP program. We wanted to leverage our existing resources when we designed this Pediatric Surge Plan. Therefore, we relied

upon all of our Hospital Preparedness Program partners. We leveraged our existing trauma system which includes 13 trauma centers and the emergency departments approved for pediatrics, or EDAP, as a way to maximize our capabilities and resources for children.

The Disaster Resource Center, or DRC program, was developed to assist our healthcare community work together regionally on emergency preparedness and response. Thirteen of our hospitals are designated as DRCs working within 10 geographic regions located throughout the county. Each DRC region is assigned 8 to 10 umbrella hospitals that they work with in planning, training, exercises, and facilitating a regional disaster plan.

One of the key elements in operationalizing this Pediatric Surge Plan is the coordination by the Medical Alert Center, or MAC, at our Los Angeles County EMS Agency. Our Medical Alert Center would be responsible for directing pre-hospital providers to different tier one or tier two hospitals, as Bridget will described later, as well as coordinating secondary transfers should this plan be activated. Our Medical Alert Center on a daily basis serves as a sort of mission control or communication hub to coordinate the transfer of patients from private hospitals to county hospitals and to track bed availability and the diversion status of 911 receiving hospitals 24 hours a day. This communication nexus is the linchpin to allow our system to work every day but is especially – but especially to facilitate regional communication in a potential disaster.

All of these functions I've described will be used to support the activation and operation of the Pediatric Surge Plan. I've given you a sense of the size of our population and our existing systems and resources for healthcare within Los Angeles County. I'd like to thank HHS and ASPR for inviting us to present our work here today. And now, I'm going to turn it over to my colleague, Bridget Berg, to explain the plan development, the plan itself and our plans to exercise next June.

Bridget Berg: Thank you, Dr. Wilson. We began this project with three goals. First, we wanted to determine the pediatric capabilities and capacities within our county, we wanted to double our pediatric inpatient bed capacity, and third, we wanted to use a tiered system approach to support this plan and also support those hospitals by providing supplies and associated training. We started with an assessment of pediatric capacity and capabilities and this included a 38-question survey focused on peds capacity, staffing, training, equipment, supplies, and existing pediatric surge provision. This

was sent to our Hospital Preparedness Program hospitals and we attained a 94 percent response rate.

To supplement this data, we also collected licensed and staffed bed capacity that's available through our state. With this data, we began to create a tiered system that would leverage our existing resources. A key element to this plan development was the engagement of our emergency managers and clinical representatives from the hospitals. And in total, we brought together three focus groups which were really used to solicit input on the training and supplies that each tier would need to support a surge of children and to also solicit feedback on the creation of our tiered system.

You'll see on this slide, this is an overview of our final tier system for the Pediatric Surge Plan. Our strategy is really to send the youngest, most critically injured or critically ill patients to our tier one and tier two hospitals. And this plan would allow for decompressing those hospitals so that they could accommodate the youngest and most critically ill or injured.

Let me walk you briefly through these six tiers. The first tier is really those providers that provide full pediatric services including pediatric intensive care, pediatric acute care and neonatal intensive care. Our tier two hospitals are adult trauma centers that do normally care for critically injured children. Tier three provide pediatric inpatient care and most have emergency departments approved for pediatrics. Tier four hospitals are those that have emergency departments approved for pediatrics but may not provide pediatric inpatient care. And as you can see, our tier five hospitals include about 21 of our hospitals within the county. They do not provide inpatient pediatric care and they're not emergency departments approved for pediatrics. Our tier six either do not have emergency departments or are specialty hospitals, for example, a cancer center.

Our focus groups really discussed that link, the age, and the types of patients that could be seen at each of these tiers. And they elected to use the age of eight years old as a distinguishing age for hospitals that do not normally provide care to children. In our plan, we will ideally send children over eight years of age who are stable to a tier four or five hospital. For example, a nine-year-old with an isolated fracture. This plan would be activated by the Medical Alert Center and they would be involved in the primary and secondary transfers of these patients between these tiers.

The Pediatric Surge Plan was approved following presentation at our countywide Pediatric Advisory Committee and Medical Advisory Group. Following approval, the Los Angeles County EMS Agency sent commitment letters to the chief executive officers of the hospitals describing the plan and their role in supporting this pediatric surge. These commitment letters were separate from their Hospital Preparedness Program contract.

To support the implementation and really among those hospitals that do not provide care for children, we implemented a two-prong approach. We supported them by providing equipment and supplies including Broselow kits – or carts – and C-spine collars. And those were recommended by our focus group participants.

Secondly, we developed a training and medical refresher course and a pediatric surge quick reference guide which is a quad-fold that highlights the clinical values for children. The training itself included an overview of the plan, safety and security of children and a medically focused-course on the key differences for caring for children. And the concept really was that at some point in time, our clinical providers have had some pediatric knowledge and we really need to provide those tools to support them in case this surge happens.

Our courses were taught by hospitalists or surgery fellows from our hospital. And we conducted six trainings and reached 326 staff. This training is also available in a DVD format which was provided to our hospitals. And we're working on getting that online to be more accessible.

Another element of the plan included training our EMS providers since the activation of this plan necessitates a waiver on the destination policy that we have currently in place. Over this next year, hospitals will be developing their facility-specific surge plans that align with this overall system-wide plan. And although we've completed this formal training, in my experience from speaking to some of our frontline clinicians, I know we still have a ways to go in terms of supporting those frontline clinicians and emergency managers to make this plan functional.

The current phase that we're currently in is an evaluation of this plan. And we will be conducting a tabletop and functional exercise in June of 2015 really to test this plan, really assessing the hospital capability to accept the surge of children, testing our medical alert center in terms of being able to distribute patients, and looking at the reunification and safety of children in this overall countywide plan. What we'll do is

we will use this information to update our surge plan based upon the after action report.

If you're beginning a similar project like many of the other presenters have said, you don't need to start from scratch. There's tremendous resources available on the LA County website (http://ems.dhs.lacounty.gov/) and our website, (www.CHLA.org/DisasterCenter), you'll find links to the full Pediatric Surge Plan, the Pediatric Surge Quick Reference Guide, and additionally there are other tools on the site that you can navigate on our left hand side resources specific to healthcare providers. And we also have a listing of references to other sources for pediatric-specific emergency planning and response.

In closing, I just want to highlight three important elements that I think that were critical to this. One, understanding your existing systems and resources similar to Utah and it sounds like our New York partners are doing that as well. And engagement, second, engagement is really crucial. The partnership between the local EMS Agency and our hospital is essential to developing this plan. And so, really calling upon your children – your primary providers for children to partner with either your medical and health coordinator or your local EMS Agency in developing something specific.

And lastly, resources are available. We're happy to share with you the process which we undertook. And as I mentioned, there are many websites available to you. There's a lot of work being done in this area and we're happy to be leading and contributing to this field. So, on behalf of the Los Angeles County EMS Agency, Dr. Wilson, Roel Amara and Kathleen Stevenson, our Emergency Manager, my supportive director, Trauma Medical Director, Dr. Jeffrey Upperman, thank you all for your time.

Cynthia Hansen: Thank you so much to the team from Los Angeles County, Dr. Wilson and Ms. Berg. It was just getting a sense of the level of effort required to move things from a strategic to a very, very tactical level to the specific equipment to be purchased for the facilities that don't treat pediatrics – it's an incredible span and breadth of effort. And I, for one, am really looking forward to hearing how the exercise goes and the after action report from that.

So let's move on to our folks from Alaska who just completed the Capstone Exercise. They're going to give us some information about their experiences with that event. It will be Merry Carlson and Andy Jones. I'll turn the microphone over to you two.

Merry Carlson: Thank you. This is Merry Carlson, I'm the Section Chief for Emergency Programs, Division of Public Health, Department of Health and Social Services, State of Alaska. And I'm here with our Incident Commander and Head of our Health Emergency Response Operations, formerly known as Preparedness. I think you'll see why we made that name change as we go through this presentation.

We'd like to share with you our work on Alaska Shield 2014 which, as she just said, was our National Capstone Exercise. It was an exercise so large that it literally brought to us thousands of people – over 600 agencies. And so we want to focus just on the health and medical components. We actually called it a Hale Borealis or "Healthy North" to distinguish it from all the other activities that were going on as part of the Capstone Exercise.

And we were really interested in focusing on three things because we knew that in a catastrophic event such as a re-creation of the 9.20 earthquake we experienced in 1964, that we would need to be ready to respond in Alaska with our own resources while we waited the 72 to 96 hours for federal support to arrive. So the exercise was coincident with the 50th anniversary of the '64 earthquake and it was that scenario which we exercised. We looked at hospital decompression and specifically our ability to stand up the Alaska Medical Station to do in-state patient movement under state control and to exercise out-of-state patient movement. As you could imagine, this was a huge effort of multiple partners that involved eight hospitals which is over one-third of our 22 facilities in Alaska, four healthcare coalitions, multiple federal partners including U.S. Transcom and HHS, both of which have critical roles in patient transport, and our non-governmental organizations, big, big organizations, Samaritan's Purse.

What I haven't mentioned here is the work of our health EOC, our Department of Health and Social Services, our Alaska RESPOND, Alaska's Healthcare Professionals which is our ESAR-VHP capability, and our many citizen volunteers who participated in this exercise.

Now, in a catastrophic earthquake scenario, where you have a 9.2 earthquake, we're going to see that all of our everyday challenges are multiplied greatly. You see here

the map of Alaska transposed onto the U.S. map to see our vast geographical distances and the challenges we face. The red lines are our road system. Everything else is accessible only by air or sea. So any of the shortages that we've had in staff, space or information would be impacted by a disrupted infrastructure.

Our normally limited medical air and ground transportation would be even more compromised, the fact that we only have a level two facility and our other facilities are level four facilities. That our nearest level one is in Seattle. And the limited options that we all share for holding and staging patients, staff and equipment are all challenges that we needed to address in this exercise and to really look at that balance between our ability to hold our patients in-state and provide care there and balance that with decisions to move them out-of-state were things that we wanted to accomplish simultaneously.

I also wanted to mention that all the pictures you see here are from the actual exercise.

So our Alaska Medical station is actually a federal medical station that was transferred to Alaska. We're the first states to own and operate one. It's really a capability to hold low acuity patients who are somewhere between a congregate shelter and a hospital in terms of their needs for care. What we learned in doing this was that our pediatric capability was determined by a combination of staff, training equipment and supplies and that we needed to put significant effort into matching skills to our volunteers. We staff – our staffing plan included using our Alaska-1 DMAT team, our Alaska RESPOND Licensed Healthcare Professionals and other resources that we brought together. We don't have a standing team that can staff the 250 beds within Alaska or a federal medical station.

We learned that children that arrive with families or without them and we have to have arrangements that may be non-medical to provide for their care if the children aren't requiring medical treatment and that if we give our medical staff two or three or four non-medical folks who can be scribes or runners that we multiply the capacity of our medical teams so they can focus on patient care. We also learned that it was a good decision to mirror our pharmaceuticals to the federal cache, but to increase the number of pediatric medications we had on hand. We have a slightly higher pediatric population than the U.S. average.

A suggestion here for doing an exercise, if you can do it over two days, you can reset at the end of the first day so that you incorporate lessons learned into your second day. So we operated the medical station over a 7-hour period that was stretched across two days. We ran 356 patients through the medical station and provided triage and treatment. You see several pediatric patients here.

Now we knew that it's not enough just to provide low acuity care so we worked with Samaritan's Purse, which has the capability to do international disaster relief, they have disaster medical teams that work abroad. Most recently back in the Philippines in November, and we asked them to stand up their field surgical hospital and locate it immediately adjacent to our medical station. Because we knew that, no matter what we said the admissions criteria were for the medical station, that people would come if there was medical care available. And so, we – in using this capability, so it affected the ability of the medical station itself to address patient flow and we had to rebalance how that whole process worked which was a huge lesson learned for us.

Another thing that we learned was that our international partners bring experience in working in austere conditions and in crisis standards of care and that's how we're going to look to them to finalize all of our models. One great success for us is that we were able to immediately license our medical teams for Alaska Disaster RESPOND beginning when they were original licensed in Alaska because our statutes allow for that in a disaster situation.

And…

Andy Jones: All right…

Merry Carlson: …so over to our Incident Commander, Andy Jones.

Andy Jones: All right. So one of the things in Alaska is we have limited capabilities. We are geographically displaced 1500 miles as the crow flies to the highest level one care facility. In the past, it's always been local movement and then goes right to federal movement so what we've done in the last two years is develop our own state movement process and we tested it in Alaska Shield at the local level using what we call (EMAC), Emergency Management and Assistance Compact so we used some other state partners.

We have developed what we call an Aeromedical Coordination Group, we're following kind of the federal model but tweaking it to fit Alaska. It's made up of

flight surgeons, validating flight surgeons, trauma nurses, dispatchers, our local air medical providers and hospitals. So, what happens is we get a list of patients from a hospital and we prioritize where those patients will go to around the state or out-of-state. It's kind of nice, it bridges that gap between private to federal. We did move up to 35 patients live on our own using unconventional methods, meaning a C-130 with non-medical equipment in it and hospitals bringing equipment on.

Next slide. For the hospitals, the states to realize out-of-state patient movement, there are some things you need to consider. It is not an easy process. A national disaster medical system, patient movement, great people, they know what to do but it's a very complex system. We moved up to 245 patients in two days. Some things that states and hospitals need to realize, build your own state process. You understand your state better that the feds will ever understand it. If you build a process, they will come in and support you. Work with your healthcare facilities to build a systematic process that removes the burden. Really it needs to be a streamlined process.

This is critical. You need to understand the NDMS federal system. If you don't understand that and they come in, it is so complex and you can really – it can really limit your movement. You need to understand their concept of operations, not just HHS but also Transcom and what they can do. Understand your in-state capabilities, where are your gaps. You really need to know that. That will tell you a lot about building your plan. And you need to be flexible. Flex to the occasion. A lot of the times, things will be kicked back to you and you got to forget what you're going to do. We are very limited. We moved 245 patients with two ambulances and an AmbuBus which is a health mover and a VA bus. So it was very – it was very successful for us. We got a lot to learn.

Next slide. The next thing is events. Real quick, you know, what we've done to help with the vulnerable populations, especially children, is last year we had big floods in one of our rural communities. And we actually couldn't find two foster children right away and realized that is not appropriate. So, we have worked with Office of Children Services and the Attorney General's Office and our EOC receives information on vulnerable population children around the state when we even think an event is going to occur. So, for example, we had some of the largest fires in the country a few weeks ago and we were tracking foster families and making the decision if we should relocate and evacuate before the event ever happens.

So, you know, looking at that vulnerable population component especially in children, this has really built our capability out. It's only one little piece but it's a critical piece. And so, I just wanted to share that with the group.

And then the last slide, Merry, go ahead.

Merry Carlson: So we just wanted to wrap it up by saying if you're – if you think smart you can take all of your activities and put them together so that you build your pediatric capabilities. What we're doing is we work with our tribal health consortiums and our coalitions to develop that pediatric capability. With tribes we work with them in the events that you saw on the previous slide. We're changing all of our funding streams so that they prioritize pediatric care. And we have regulations in play right now that are in process of being approved that require pediatric training for our EMS providers.

So, if you – if you work thoughtfully, as you've seen with the other presenters, you can continue to develop that pediatric capability. You can find more information at the website listed here. Thank you.

Cynthia Hansen: Ms. Carlson and Mr. Jones, thank you so much for an absolutely fascinating presentation. Really thinking through the transportation challenges and how that it – that connects with all of the resources and teams coming in – the NDMS teams, all of that just – it is a fantastic glimpse into an exercise that was really so recently conducted. I'm impressed that you've gotten enough sleep to analyze it for all of our benefit.

Thank you. So, thanks to everyone – all of these speakers for just packing so much information into a short amount of time, very stimulating presentations. And I have to tell all the listeners on the call right now that I just keep getting pinged from each of them wanting me to tell you how passionate they are about sharing their expertise and their resources. It would make their day if you would e-mail them or call them and use some of the information that you know that your community needs in order to strengthen pediatric preparedness. That is – that's the action to take away from this call right now. There's lots of people, just really chomping at the bit to help you. And, as you can tell from this call, they have phenomenal expertise.

So, I'm going to – I also want to acknowledge, by the way, that there are even more ideas and resources than we could squeeze in to our allotted time today. There's a lot

of work going around the nation and hopefully – and the plan is to have another call next year and to highlight those as well in the – in the ongoing growth in activities. So, I just want to acknowledge all that and all of the folks who support the folks who are on the call today.

So with that in mind, we're going to open up the call to callers. There's two ways to ask a question of any of the speakers. The first one is to type your question in to "All Panelists" in the chat section. And the second one is by teleconference. And, operator, would you please instruct the listeners how best to answer a question – to ask a question.

Operator: Sure. Ladies and gentlemen, if you have a question at this time, please press the star then the number one key on your touchtone telephone. If your question has been answered or you wish to remove yourself from the queue, please press the pound key.

Our first question comes from the line of Chris McCarthy. Your line is open.

Chris McCarthy: Hi, sorry you guys, it was wonderful. I was wondering if this webinar will be available. I'm sorry if I missed that if you've already said it.

Cynthia Hansen: Actually, thanks for reminding. We're going to push the slides forward, you can see where the webinar will be posted. And the webinar that we conducted in June 2013 and all of the other NHPP webinars are posted at that same site. It's a wealth of information.

Operator: Again, ladies and gentlemen, if you have a question at this time, please press the star then the number one key on your touchtone telephone.

Sue Larkins: We do have one question that came in, I believe during the New York City presentation regarding – could you ask where at the state level the neonatal committee lives? Is there a certain department such as a maternal/child services?

Michael Frogel: Okay. So the New York City Disaster Coalition is centric to New York City although we certainly want to spread everything we do to anyone willing to listen and can benefit from it. So the – our neonatal committee is a New York City Committee. However, we have many participants and leadership at the state level who participate in our committee. And it's a statewide neonatal committee that's responsible for setting the different levels of the – of the neonatal units and ensuring that the needs match the resources that are available in the city and in the state.

Cynthia Hansen: Okay, great. Thanks. Did we have another question in the room?

Daniel Dodgen: So, this is Dan Dodgen and listening to the folks in New York but I think others as well, the question that I had is, you know, anytime – I'm also a child psychologist, anytime I've been in a NICU or a PICU or just a regular ED, there's always a lot of parents and adults figures around whenever you have a child. And I just was curious if maybe the New York folks could talk about sort of how you plan for accommodating the needs of parents that are so often accompanying children. But I also would like other folks from Alaska or from anywhere else – I know it was in your bullet point but if you could just elaborate a little bit on how parents are included in the planning.

Michael Frogel: Yes, this is Mike Frogel. You know, we've recommended and George Foltin did a lot of work, we have something on our website about preparing for disasters that there be a family information setup immediately if there's a major disaster involving children. That would be a place where the parents would be able to go to. There would be social workers. We recommend that there's a medical team there as well. You never know the adults could get sick as well. A walking well person could all of the sudden collapse. So, we believe that that's extremely important, the family information center and a place where the walking well would go and be able to get appropriate care and communication.

They would then screen the parents, make sure they're okay and try to reunite them with the kids. We're also concerned that the kids might come in alone during an episode and that's one of the things we found in our eight drills that we've done so far. It's very important that you have babysitter function. There need to be people available to watch a two, three, four-year old. You can't send a two-year old in a crib to CT scan and then just leave them there. And we found that in almost every drill the capability is not necessarily there.

We also think you should take photos, if possible, digital photos of all the victims of trauma because that becomes very helpful. It can be put up on a website that's centric to your hospital. Or we would hope that we could get a statewide kind of system as exists in other countries. We could post pictures confidentially for people seeking persons and be able to unify them, the kids with the parents. It's a lot of work and you need a lot of different kinds of people to interact but it's very, very important.

The other main point I think is security. You need to control your hospital and your situation. You need to have one entry point basically. You need to be able to triage the parents, the press, the walking well versus the trauma patients and security needs to really be there because otherwise it creates havoc in these situations.

Andy Jones: Yes, this is Andy in Alaska. I'd second everything that just said. You know, for the Alaska Medical Station, the federal medical station, we actually had more pediatrics than we almost did adults. And one of our lessons learned was, one, we just didn't have enough staff and we were over numbered. I mean, an adult is one thing but when you have a whole bunch of peds running around, it really increases your staff capability just to manage the situation.

The other thing we do at the state level is we really rely on our other sections and agencies. And we have developed Strike Teams or task forces that have behavioral health specialists, children service teams in there. And that's a new concept that we're building right now as we speak so we can deploy them anywhere in the field for any disaster. So that's some of the stuff we're doing.

Merry Carlson: And some of the best practices in Cordova, they stood up a family information center simultaneously with their staff recall. They also had capabilities to provide daycare for their staff as well as to provide resources for survivors and their families. So those are some of the things that worked really well at the local level.

Michael Frogel: Yes, just one more comment from New York. We, in the PDC, many of us have also been involved in an initiative with a grant from Americares to setup a pediatric disaster mental health initiative. And we feel very strongly that first responders and anyone dealing with kids or adults needs to know psychological first aid and needs to be able to triage patients who are just having normal acute stress reactions or reactions that are perfectly okay versus those who need further psychological support. And we believe that the entire infrastructure needs to be able to respond to the psychological issues as well as the medical needs and the environmental needs. And we saw that during Sandy, you know, in certain populations, they were having very severe problems for weeks and months afterwards.

Bridget Berg: This is Bridget from Los Angeles County. One of the questions that came to me that relates to this topic is, are we actually going to be using live victims, live children in our exercise and moving them throughout our county. We're currently under discussion with that and like all the other panelists mentioned, it does take a

tremendous number of resources to manage these children and ensure their safety and security. So what we will be doing in our functional exercise is using victims at our hospitals. So the current plan is not to convene them in a central event location and then distribute them just with the liability of movement and everything and we'll be working with our hospitals to get live children victims at their sites locally.

Andy Jones: And this is one last thing from Alaska. I can just recommend to anybody, you know, we used live pediatrics throughout our event in a lot of areas and it really – it really tests your capability, you know, by doing notional with adults saying, "Hey, they are pediatric." It really doesn't test your capability. So I always encourage healthcare facilities, because sometimes that's the hardest place to have that play occur for them to do that because it really, really stresses.

Cynthia Hansen: Andy, where did you get your children from?

Andy Jones: We actually – we did a massive outreach campaign. Everything from the girl scouts and then we had an online website that people could sign up and we used a contract vendor to help manage. So, multiple families came in, girls scouts with a troop leader would come in. So imagine 30 girl scouts and one troop leader – yes, we had –all over the state. It was pretty amazing. Even our Office of Children's Services, people who weren't working, they brought their kids in to kind of analyze how we handle pediatrics in a medical station environment.

Michael Frogel: This is Mike…

Cynthia Hansen: Great.

Michael Frogel: …Frogel – this is Mike Frogel, we reached out to local schools when we did hospital drills and were very successful in getting real pediatric patients. And I would also recommend that you throw in some simulators. And if you really want to test the capabilities of taking care of a really sick kid from the ED through surging to the PICU, a simulation mannequin with a real scenario is really –pushes the envelope on the drill side. I'd recommend the mixture of real kids, some actors and also simulators.

Cynthia Hansen: This is just – this is great and such valuable advice. Thank you all so much. Do we have anyone else in queue, operator?

Operator: Yes. We have a question from Pat Frost. Your line is open.

Pat Frost: Hi, this is Pat Frost. I'm the founder and co-chair for the California Neonatal and Pediatric Disaster Coalition. This has been a great presentation. I'd like to get personally in touch with all of you to make sure that we have our coalition members benefiting from your lessons learned and your resources. I know that Dan Dodgen is on the call as well. Dan, you know, we have that pediatric disaster resiliency work group that is helping each of the state people and coalition leadership facilitate dialogue and share resources. It would be great to get all these people added to that list if they can participate. It would be a wonderful networking opportunity.

Daniel Dodgen: Great, thanks. I agree. I mean, I don't know, this is really a – I don't know if you have a specific question Pat or if you just want to say – I do think that's – the information is on the website.

Pat Frost: Yes.

Daniel Dodgen: And then also, the person who has been hosting that call is actually our colleague Jeff Stiefel with the Office of Health Affairs in the Department of Homeland Security. If people are interested, we can certainly send that information.

Cynthia Hansen: Absolutely. So that posting where you see PHE.gov/abc is the place where you can get the resources that Pat Frost is referring to. And it's a link directly to that team's work. Again, I have to acknowledge, there's a lot going on around the U.S. But unfortunately, we couldn't have a speaker for everything this year but there's always the year to come.

Daniel Dodgen: And do – the website…

Cynthia Hansen: Yes.

(Daniel Dodgen): …that Cynthia mentions has a lot of really good pediatric information on it.

Cynthia Hansen: Yes. Is there one more question? Oops.

Michael Frogel: I'm sorry. I'll speak just quickly speaking for New York, this is Mike Frogel. We'd be happy to be – and share any of our expertise with any committees or groups about neonatal and women and infants obstetrical planning. And we're starting to do drills and we already have in place templates and guidelines for hospitals and we are trying to get those installed in all the units in the city. So we'd be happy to work with you.

Cynthia Hansen: And, operator, do we have anyone else in queue?

Operator: Yes. So we have one more question from Ann Vanremmen. Your line is open.

Ann Vanremmen: Hi, I'm from Children's Healthcare of Atlanta and I have a question for Bridget. What parameters or guidelines did you use to find out what type of patient is appropriate for each tier in your system?

Bridget Berg: Thank you, Ann. We really used those focus groups to provide input into what types of patients could be seen. And the reason why the age of eight was kind of a deciding factor, everybody kind of came to consensus around the PALS, or Pediatric Advance Life Support. And the differences, you know, at that age, children are starting to become more similar to an adult and really wanted to ensure that the hospitals that we were sending patients to are something that they're used to caring for. And so that – it was primarily a discussion and then the PALS information.

Cynthia Hansen: Okay, great, thank you. Well, we are at the end of the hour. And once again, we have – we have more questions in queue than we're able to respond to. If you would either e-mail your questions to me or anything that's already come on the chat function of the webinar, we will roll it up and put them in an FAQ sheet that the speakers will all convene next week. The speakers and I will convene and we will – we will get those answers posted for all of the listeners. So if you have an important question to ask, please don't consider the end of the webinar the last opportunity to do so.

With that in mind, we have four upcoming NHPP webinars that I'd like to call your attention to. On July 17th, we will focus on Healthcare Systems Recovery. On September 18th, Coalitions in Response. November 20th, we'll be hosting our second Rural Healthcare Coalitions and Preparedness call. And finally, on January 15th, we'll be hosting a call linking the National Disaster Medical System with the Hospital Preparedness Program just as Andy Jones mentioned from Alaska how important that is.

So I'm talking really fast because I know we're at the end of the hour. I thank you all for your attention. Thanks to – many, many thanks to the speakers for wonderful presentations. And I look forward to continuing this work in the coming year. We're out here. Thank you.

Operator: Ladies and gentlemen, thank you for participating in today's conference. This does conclude the program. You may all disconnect. Everyone have a good day.