specific mass casualty and surge incidents, a survey was conducted involving all hospitals that routinely manage pediatric patients in their emergency departments, to better understand the preparedness levels for these facilities.
Method: This is a retrospective analysis of data collected in 2014 and repeated in 2021. Our focus included one predominantly rural state in the United States of America (USA). We examined results from surveys conducted where facilities self-reported objective criteria that resulted in a readiness score (as it relates to pediatric readiness). Reporting stratification reflected the annual pediatric ED volume with groups of; Low (<1800/year), Medium (1800-4999 /year), Medium to High (5000-9999/year), and High (>10,000/year).
Results: Low-volume hospitals scored (Mean=59/Median=56), Medium volume hospitals scored (Mean=62/Median=60), Medium to High volume hospitals (Mean=67/Median=65), and hospitals with High volumes (Mean=82/Median=83). All hospital volume ranges had outlier hospitals that scored between 82-97. The general tendency, lower volume hospitals had a lower level of readiness, and higher volume hospitals had a higher (to much higher) level of readiness.
Conclusion: Pediatric disaster readiness needs to be improved at the community level. It is encouraging that pediatric disaster readiness has been addressed in the larger medical centers. Yet, it should be noted that even very low-volume hospitals (had outliers with) scores as high as 94 indicating that with ample support, and resources, pediatric disaster preparedness is achievable in every hospital regardless of size or volume. The results point to a need to develop, improve, and distribute resources and support local hospitals with pediatric disaster readiness.

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The New York City Pediatric Disaster Coalition Pediatric Intensive-Care Response Team (PIRT)

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Introduction: Children represent 25% of the population, have special needs, and are often over-represented in disasters. The New York City Pediatric Disaster Coalition (NYC PDC) is funded by the NYC Department of Health and Mental Hygiene (DOHMH) to improve pediatric disaster preparedness and response. PDC worked with a network of pediatric intensivists to create the Pediatric Intensive-Care Response Team (PIRT). PIRT consists of volunteer pediatric intensivists that currently practice in New York City.
Method: Secondary transport may be requested by hospitals due to a mismatch of resources to needs for patients requiring critical and/or subspecialty care. The team is activated when a disaster involves a significant number of pediatric patients. In the proposed plan, the PIRT physician on-call will triage/prioritize the patients based on acuity and need for services and relay the necessary information to the transport agency. PIRT is designated to provide subject matter expertise and resources during real-world events. PIRT maintains a 24/7 on-call schedule with backup. The PIRT system was tested in four call-down communications drills and a tabletop exercise for prioritization of pediatric mass casualty victims.
Results: The call-down drills demonstrated the ability to contact the on-call and backup physicians by email or text within 20 minutes and others within one hour. In the tabletop, PIRT members were given 15 patient profiles based on a scenario and asked to prioritize patients based on their injuries/medical needs. This was accomplished in less than 30 minutes, followed by a review and discussion of the rank order. A number of lessons learned were identified and will be presented.
Conclusion: The NYCPDC has developed and tested a PIRT that is available 24/7 to prioritize patients for secondary transport and offer subject matter expertise during pediatric mass casualty events. This model can be utilized to enhance pediatric disaster preparedness.

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Can Social Media cause Needed Health Care Transformation to Occur? The STRONGERR Project

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Introduction: The key cripplers of health care are:

1. Fragmented Patient chart
   Possible solutions:
   • single cloud-based chart that is owned by the patient protected by the government
   • information uploaded by a certified care provider (or they don't get paid)
   • Maintained by a patient navigator who organizes information
   • linked to self-care directions and
   • tele-support clinicians

2. Disparate and rapidly changing medical treatments of variable support with evidence
   Why can't we integrate all guidance into one set of current recommendations so that when you put your information into the patient's EMR, guidance pops up and you follow that.
   Not only will that lead to consistency, you are essentially entering a patient into a clinical trial of sorts as this data can be reviewed later.

3. CME
   • Fragmented, disparate, inconsistent.
   • Make it a paid part of our salary making it mandatory, and consistent

4. Telemedicine
   Create a Provincial or State or Regional Virtual hospital that Offers 24/7, Full hospital e-consultant services.
   a. Tier one, e-Consultants support acute care issues.They help you decide regardless of where you are working the

management and connect with a regional hospital bed registry so you can move your patient from your ED to a hospital with beds.

b. Tier two, e-Consultants who support in-patient rounds virtually in rural/remote settings with hospitalists. For example, an Internist could support and monitor a regional virtual ward and do rounds with in-house hospitalists on patients across the region.

C. Tier three would be the equivalent of an outpatient clinic, done virtually.

Method: A STRONGERR website using Social Media tools will be created to determine if social media can be used to accelerate health care transformation to create a unified delivery system.

Results: Website will be up by Dec 2022. Results April 2023.

Conclusion: To be determined.

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Using a Multi-Agency Response Framework During COVID19 by Emergency Managers in a Healthcare Organization

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Introduction: The paper provides the perspective of emergency managers within a healthcare service, using a multi-agency framework to coordinate a regional response to COVID 19. While health services play a role in the planning, response and recovery to major emergencies they are rarely the lead in coordinating the response. The exploration of existing research through Pauchant and Mitroff Onion Theory is combined with the challenges and experiences faced by emergency managers during the COVID 19 response in Ireland. The research mirrors the experience of emergency managers that preparedness and relationship building are key to quickly establishing a response. However the experience of emergency managers was that although shared situational awareness is critical a flexible system framework is required, particularly in a prolonged pandemic situation. A hierarchical command and control system can negatively impact on strong local relationships and problem solving capability. The experience of emergency mangers concurs with research that the development of a learning organization is pivotal in information preparedness before and during the response and recovery phase. The challenges of implementing lessons learned across a national health service can be challenging especially during an extended response phase.

Method: A deductive manifest analysis approach was adopted to carry out a qualitative thematic content analysis of exercise reports and emergency debrief reports.

Results: Research Questions

Lessons learned in the five years prior to COVID 19 enhanced the response to the pandemic emergency–yes there are several examples of how lessons learned can improve response to seemingly unrelated emergencies.

The principals of the MEM Framework in Ireland are applicable to a pandemic emergency–yes but this is dependent on local arrangements and relationships to allow flexibility in the implementation of the framework.

Conclusion: Regular training and exercising as well as a debriefing of exercises and real emergencies enhances preparedness for emergencies.

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The Surge Capacity Applied to Migration Crises: "The Need for a Conceptual Framework for Emergency Medical Teams"

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Introduction: Migration and forced displacement are reshaping the globe today. More people are being displaced by conflicts and natural disasters than ever before, and climate change is playing a pivotal role as a contributing factor for migration and conflict.

While there is a growing literature regarding provision of care for migrants in hosting countries there is no evidence on the use of the surge capacity model to support preparedness, readiness, and response to migration crisis by local health services, or medical teams.

Method: A scoping review with a narrative summary relevant to disaster medicine, looking at two major migration routes (Central/Eastern Mediterranean and South/Central America) was performed to determine if the surge capacity model has been applied by medical teams responding to migration crises, and how this has affected the adaptation of health services.

Results: Preliminary analysis demonstrates variations on the use of the term "surge capacity", and the imperative need to better define its application when preparing to or responding to any type of disaster, here specifically migration crisis. Thus far, there is no evidence on the use of the surge capacity model for the conformation of national/international medical teams when responding to this type of crises, and its relation to the adaptation of health services. This is particularly relevant, as the surge capacity model can support building and/or strengthening the capacity and capability of national and international medical teams.

Conclusion: There is an imperative need to design a conceptual framework based on the surge capacity model for the conformation of fit-for-purpose medical teams, that ensures preparedness, readiness, and appropriate response to migration crises guaranteeing adaptation of health services depending on context needs, and that defines skills and competencies of the responders. Additionally, this provides a conducive platform for operational research activities to foster evidence coming from the field.

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