SIGNIFICANT EVENT READINESS FORUM

NATIONAL PEDIATRIC DISASTER CONFERENCE

REVIEW - 2022

National Pediatric Disaster Conference (Significant Event Readiness Forum) Review

General Overview of SERFs: The purpose of the Significant Event Readiness Event Forums (SERFs) is to provide an environment for exploring opportunities along the disaster response continuum. The SERFs are not disaster preparedness exercises, but instead are facilitated discussions to foster information sharing and relationship development. The SERFs offer a hybrid approach for bringing together a targeted group of stakeholders that do not always plan together.

For this event, Allen Clark (Director of the Arizona Division of Emergency Management, or ADEM) served as the facilitator.

Tom Shannon (Fire Chief for the City of Scottsdale) served as the conference moderator.

Arizona Department of Health Services Support: The SERFs are funded by the Arizona Department of Health Services (ADHS). Without this support, the SERFs would not be possible.

Oversight Committees: The SERF is a project of the Arizona Department of Health Services (ADHS), Arizona Division of Emergency Management (ADEM), Arizona Department of Homeland Security, Arizona Department of Education (School Safety and Social Wellness), and Arizona Health Care Cost Containment System.

For the national SERF, a national oversight committee was convened, representing a vast array of expertise. The representatives are listed in Appendix A. The Collaborative is deeply appreciative of the contributions made by each of the national oversight committee members, with particular acknowledgement of the staff and financial support by the Arizona Department of Health Services and the Pediatric Pandemic Network (PPN); the outreach by the National Pediatric Disaster Coalition (NPDC); the logistical support by the Arizona Department of Emergency Management (ADEM); the sponsorship of the Arizona Coalition for Healthcare Emergency Response (AzCHER); the scenario development and other guidance offered by the California Emergency Medical Services Authority (EMSA) and California Patient Movement Plan Contractor; and the regional and national military partners.

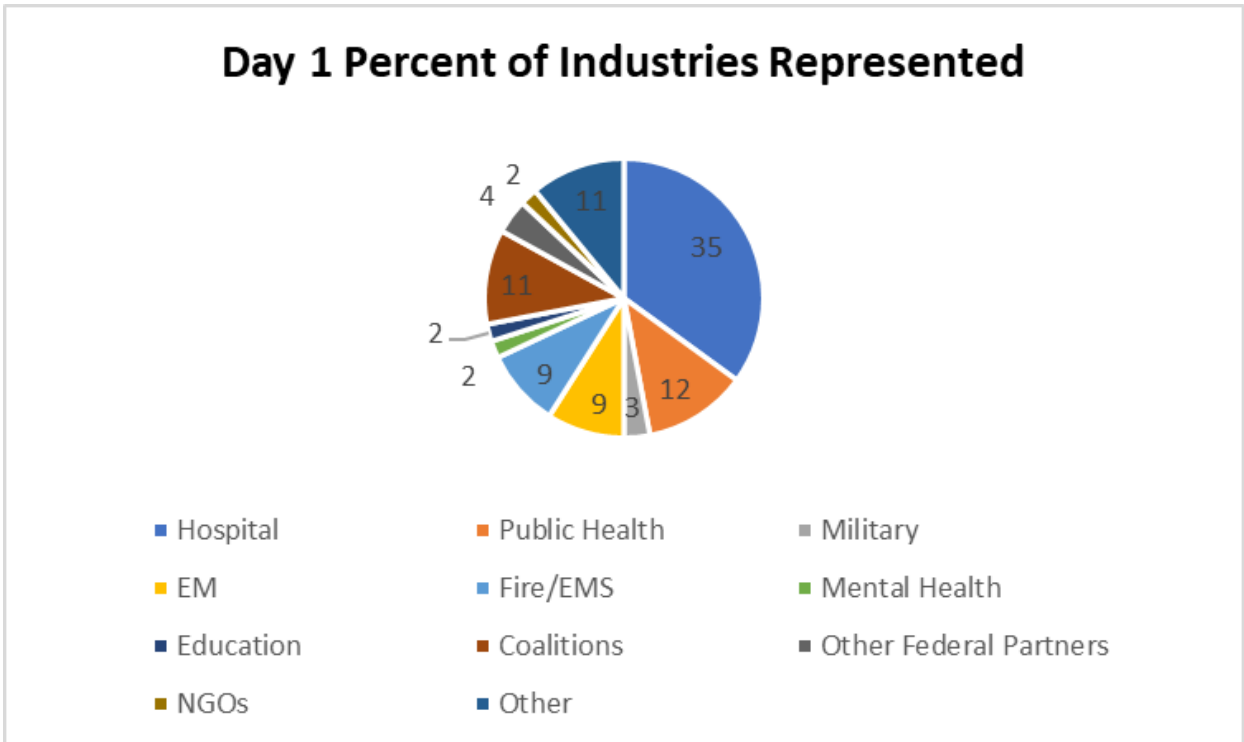
SERF Details: The SERF was held on October 27 and 28, 2022, from 8:00AM to 3:00PM. The event was originally designed to be an in-person conference held at WestWorld in Scottsdale. Due to an anticipated elevation of pediatric patients in hospitals (flu and COVID), a decision was made to move the conference to Zoom. However, presenters and staff met at the Arizona State Emergency Operations Center (SEOC) at 5636 E McDowell Rd, Phoenix, AZ 85008 for coordination purposes.

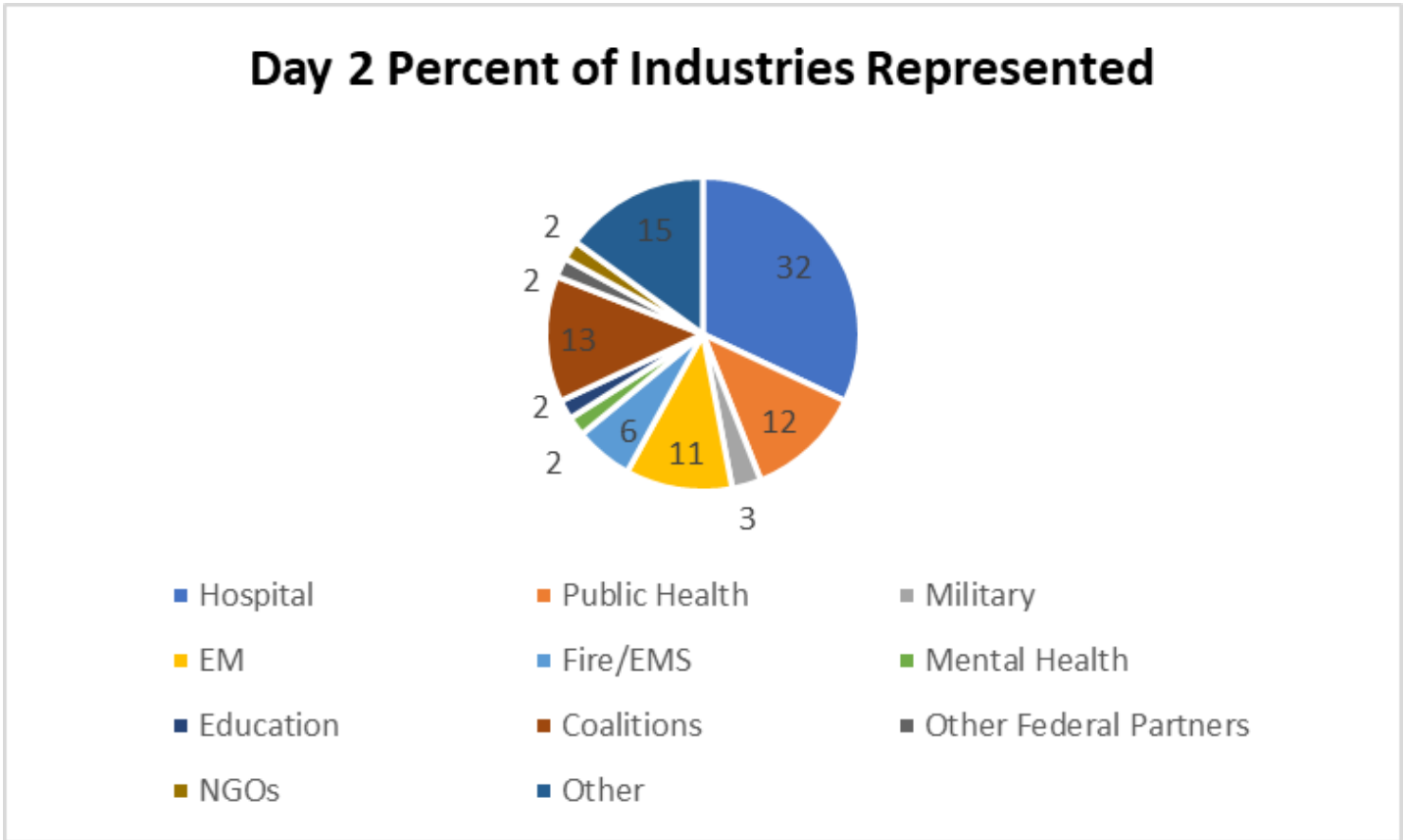
A total of 301 individuals registered for the event. Due to pediatric surges across the nation, numerous registrants notified the Collaborative that they would not be able to attend. Most of the absentees were from hospitals or public health.

Since the event was primarily on Zoom, it was already anticipated that multiple people would use one registration to access the log-in information. A total of 331 people were on the Zoom meeting, and another 29 were at the Arizona SEOC. The total number of participants was 351.

The table below identifies attenders by industry of those attendees who could be captured by industry. The industries represented are also displayed on the two pages that follow.

Industries Represented Each Day	Day 1	Day 2
Hospital	74	49
Public Health	26	19
Military	7	4
EM	19	17
Fire/EMS	19	10
Mental Health	3	3
Education	3	3
Coalitions	24	20
Other Federal Partners	9	3
NGOs	4	3
Other	23	24
Totals	211	155


Day 1 Percent of Industries Represented
35
12
3
9
9
2
2
11
4
2
11
Hospital
Public Health
Military
EM
Fire/EMS
Mental Health
Education
Coalitions
Other Federal Partners
NGOs
Other


Day 2 Percent of Industries Represented
32
12
3
11
6
2
2
13
2
2
15
Hospital
Public Health
Military
EM
Fire/EMS
Mental Health
Education
Coalitions
Other Federal Partners
NGOs
Other

Objectives:

The Goal of Day 1 was to establish a framework for understanding command structure(s) and situational awareness as well as to determine first responder, private sector, and military staging, triage, and transport of pediatric.

Day 1 Objectives:

1. Improved understanding of California's local and state command structure(s), situational awareness, resources, limitations, and resource distribution; and

2. Improved understanding of first responder, military, and private sector staging, triage, and ground and air transport (including routes).

The Goal of Day 2 was to identify legal and mental issues and clarify hospital pediatric evacuation needs, considerations, resources and resource coordination, communications, reunification, and challenges.

Day 2 Objectives:

1. Improved understanding of legal and mental complexities of hospital interstate evacuations during a catastrophic incident.

2. Improved understanding of healthcare capacity status identification, hospital needs assessments, communication strategies, and essential elements of information collection during a catastrophic incident.

3. Improved understanding of the transfer of patient information among healthcare systems during a catastrophic incident.

4. Improved understanding of patient tracking in healthcare systems and agencies supporting family reunification during a catastrophic incident.

5. Improved understanding of hospital pediatric patient reception best practices and challenges during a catastrophic incident.

Scenario Framing the Event:

Thursday, October 20, 2022, at 2:12PM a magnitude 7.7 earthquake hit Southern California. The epicenter is located near downtown Riverside, California. Multiple aftershocks are still being experienced. **The conference is focused only upon the first 24 hours following the event.**

Reports indicate:

- There are mass electricity outages in Riverside, Orange, Los Angeles, and San Diego counties.
- Cell towers are overloaded and/or non-operational.
- Fresh water and sewers have been compromised in the areas directly impacted by the earthquake.
- There are multiple gas line fires and explosions, with significant injuries being reported.
- Many highways and roadways are not accessible north and east of the epicenter due to surface damage, serious accidents, and congestion.

Reports indicate:

- San Bernadino and Riverside airports are non-operational, due to structural damage, and traffic is being diverted.
- All other Southern California international and municipal airports are limited to emergency flights only, but operational.
- The sea ports of Los Angeles, Long Beach, Newport Bay, Dana Point, Oceanside Harbor and San Diego Harbor are reporting operational, but diverting incoming traffic.

Reports Pertaining to Healthcare (perinatal, neonatal, and pediatric population, including those with access and functional needs) indicate:

- A significant number of hospitals in Los Angeles, Orange, Riverside, Southwest San Bernardino, and San Diego counties have reported structural damage, electrical, HVAC, generator, and water outages, and may need to evacuate.
- Numerous California hospital capacities, blood, supplies, and resources are severely depleted and must send some patients out of state; they can't decompress any more.
- Children's Health of Orange County and Loma Linda University Children's Hospital are on fire with significant injuries, many with burns; these hospitals are evacuating.
- An overwhelming number of local victims are arriving at hospitals in California via private vehicle (some are walking wounded, while others are presenting with serious injuries).
- Impacted hospitals have "recalled" staff but are reporting an average of 25% response rates.
- ***Hospitals in states adjacent are triaging patients and sending them east; they are overwhelmed with surges and are anticipating the need for additional resources and supplies.***

National Pediatric Disaster Conference

California Inpatient and Outpatient Facilities on All Fault Lines

Program: The final program list of speakers is listed below. Each presentation submitted is available for download at https://coyotecampaign.org/pediatric-conference. Presentation summaries will not be repeated within this document.

Thursday, October 27, 2022, Speakers on Transport

8:00AM to 8:15AM: ***Welcome***, Teresa Ehnert, Director, Bureau of Public Health Emergency Preparedness, Arizona Department of Health Services.

8:15AM to 8:45AM: ***Opening Remarks***, Dr. Meg Sullivan, Chief Medical Officer, MD, MPH, Administration for Strategic Preparedness and Response (ASPR) and Dr. Michael R Anderson, MD, MBA, FAAP, FCCM, FAARC, Senior Advisor, ASPR.

8:45AM to 9:00AM: ***Significant Event Readiness Forum Summary (SERF), Scenario Review, and Day 1 Objectives***, Chief Tom Shannon, Scottsdale Fire Department and President, Arizona Fire Chiefs Association.

9:00AM to 9:30AM: ***California Local and Regional Medical/Health Coordination (presentation title pending),*** Jeremy Fahey, Senior Disaster Services Analyst, Los Angeles County EMS Agency, Region I Regional Disaster Medical Health Specialist, Los Angeles, Orange, Ventura, Santa Barbara, San Luis Obispo counties.

9:30AM to 10:00AM: ***California State Medical/Health Coordination Resource Coordination,*** Craig Johnson, Chief, Disaster Medical Services Division, State of California Emergency Medical Services Authority.

10:15AM to 10:45AM: ***Arizona Staging, Triage, and Transport Routes,*** Chief Scott Freitag, Central Arizona Fire and Medical and Past President, Arizona Fire Chiefs Association.

10:45AM to 11:15AM: ***Military Assets, Activation Requirements, and Limitations Panel:***

- Ms. Janine Hollenbeck, Defense Coordinating Element, Region IX Chief of Plans (Moderator),
- Lt Col Todd Canale, Emergency Preparedness Liaison Officer to Arizona (Air Force),
- Lt Col Ryan Gabel, USNORTHCOM Region IX Medical Plans & Operations Officer, and
- Mr. Robert Gonzales, Senior National Security Law Attorney, USARNORTH.

11:15AM to 11:45AM: ***Airline Assets, Activation Requirements, and Limitations,*** Chris Rausch, Emergency Manager, Phoenix Sky Harbor International Airport.

12:45AM to 2:15PM: ***SERF Discussion,*** Allen Clark, Director, Department of Emergency and Military Affairs, Division of Emergency Management.

2:15PM to 2:30PM: ***Evaluation and Next Steps,*** Chief Tom Shannon, Scottsdale Fire Department and President, Arizona Fire Chiefs Association.

Friday, October 28, 2022, Speakers on Evacuation

8:00AM to 8:15AM: ***Welcome, Scenario Review, and Day 2 Objectives,*** Chief Tom Shannon, Scottsdale Fire Department and President, Arizona Fire Chiefs Association.

8:15AM to 8:45AM: ***Assessing the Emergency Legal Environment: Real-time Issues and Resolutions,*** Prof. James Hodge, JD, LLM, Peter Kiewit Foundation Professor of Law; Director, Center for Public Health Law and Policy; and Director, Western Region - Network for Public Health Law

8:45AM to 9:15AM: ***Pediatric Crisis Standards of Care,*** Dr. Chris Newton, MD, Trauma director at UCSF Benioff Children's Hospital, Oakland; Principal Investigator, the Western Regional Alliance for Pediatric Emergency Management; and Co-Principal Investigator, the Pediatric Pandemic Network.

9:15AM to 9:45AM: ***Key Behavioral Health Considerations for Initial Disaster Response: You can't wait for Recovery,*** Dr. David J Schonfeld, MD, FAAP, Director, National Center for School Crisis and Bereavement, Children's Hospital Los Angeles and Professor of Clinical Pediatrics, Keck School of Medicine.

9:45AM to 10:15AM: ***California's Pediatric Patient Movement Plan,*** Dr. Rick O. Johnson, MD, MPH, Pediatrician, Health Officer, and Medical Health Operational Area Coordinator, Alpine County, California and Pediatric Surge Plan Contractor, California Department of Public Health.

10:30AM to 11:00AM: ***Health Information Portability in Disasters: What We Have and Where We Are Going,*** Dr. Cullen Clark, MD, Attending Physician, Emergency Medicine; Director of Disaster Preparedness, Division of Emergency Medicine, Nationwide Children's Hospital; and Assistant Professor of Clinical Pediatrics and Emergency Medicine, the Ohio State University College of Medicine.

11:00AM to 11:30AM: ***The Hospital Reception Site Template: Addressing the Challenges of Hospital Reception during Disaster***, Dr. Anna Lin, MD, Clinical Associate Professor, Division of Pediatric Hospital Medicine, Stanford University; Pediatric Hospitalist, Lucile Packard Children's Hospital Stanford; and Assistant Medical Director, Office of Emergency Management, Stanford Children's Health and Stanford Health Care.

11:30AM to Noon: ***Patient Tracking: The Critical Data needed for Reunification***, Kevin M. McCulley, Chief Operations Officer, Pediatric Pandemic Network, and David McCarthy, Arizona Coordinator, Western Regional Alliance for Pediatric Emergency Management; Drills & Exercises Project Manager, Pediatric Pandemic Network; and Member, Hospital Incident Command System National Advisory Committee.

1:00PM to 2:30PM: ***SERF Discussion,*** Allen Clark, Allen Clark, Director, Department of Emergency and Military Affairs, Division of Emergency Management.

2:30PM to 2:45PM: ***Evaluation and Next Steps,*** Chief Tom Shannon, Scottsdale Fire Department and President, Arizona Fire Chiefs Association.

Recap of Discussion: The SERF summaries of the discussions are reported by industry and presented in chronological order of discourse.

Day 1 Recap:

Facilitator: What is the command and communication structure?

California EMSA: The State Operations Center (SOC) and State Medical Health Coordination Center (MHCC, or medical "arm" of the SOC) would be activated. California EMSA would manage transport decisions. The California Office of Emergency Services (OES) would be at the SOC. The California OES is the State lead for disaster response and will activate the SOC, including the Emergency Support Functions (ESFs).

Intel from news outlets with social media and agency situational reports from impacted regions would be crucial. Next, planning would occur to respond to resource requests, such as strike force teams and triage support. The SOC and the MHCC would gather situational reports and work to meet statewide needs, such as deploying medical teams, Ambulance Strike Teams, and other resources to support local requests.

The operational area coordinators would connect with the impacted medical facilities for each county to obtain needed information. This would be relayed to the SOC. California EMSA would begin to pre-stage resources. The state would reach out to federal partners for resources, and the Governor's Office would be kept informed of progress.

Facilitator: When California knows patients must be moved, how will other states be notified? Does California OES have a communications' plan for reaching other states? Would the Emergency Operations Centers (EOCs) from California reach out to the other state EOCs?

COVID taught the states how to use contracts for medical support. If volunteers are sent across with pediatric patients to other states, how would we legally cover them to travel? Are they under an Emergency Management Assistance Compact (EMAC) system? Have we thought about that?

California EMSA: California was able to approve over 75,000 out-of-state medical professionals to work in the state to support medical facilities. Additionally, California utilized the Disaster Healthcare Volunteer system to deploy over 7,000 local medical volunteers. Volunteers are sworn in as Disaster Service Workers for liability protection. California EMSA also bolstered the California Medical Assistance Team (CAL-MAT) program by increasing the number of members from under 200 to nearly 2,000 during the peak of COVID. When activated, CAL-MAT members become state employees and are provided the necessary liability coverage to care for patients.

Facilitator: What would other states seek from California?

Arizona Department of Health Services' (ADHS) Bureau of EMS and Trauma Services: Communications would go through region IX coordination.

ASPR Region IX Regional Emergency Coordination: ASPR can help coordinate between states, but the primary mechanism for one state to request assistant from another is Governor to Governor through EMAC.

ADHS Bureau of Public Health Emergency Preparedness: We would need to access bed polls.

It is important to remember that the receiving hospital will manage discharge. Going across state lines is complicated. Obstacles were observed during Katrina pertaining to the return of patients once they were discharged from other states to return home (who pays?).

Facilitator: The National Disaster Medical System (NDMS) emerged as a topic this morning. NDMS does not seem to have much support for pediatrics.

Military: The Department of Defense is not equipped or trained for pediatric transfers. NDMS is funded primarily for patients ages 18 and over. There are some pediatricians and experts with women's health.

ASPR Region IX Regional Emergency Coordination: Once the FEMA ambulance contract is activated with American Medical Response (AMR), assets will begin to arrive within 18 hours. This includes 25 aircraft and 300 ambulances (60/40 ALS/BLS). By 36 hours, all of these assets should have arrived at their staging areas.

Facilitator: Ambulances may not be able to get through due to congested highways and bridges. What are the "aha" moments that go through your minds?

Los Angeles County EMS Agency, Region I Regional Disaster Medical Health: The damage would only go so far. Maybe we do a chain of custody ambulance to the airport. Maybe we explore a mid-way solution (leapfrog transports). The Coast Guard, National Guard, and other military partners could be used, but it "comes down to the familiarity with pediatric patients.

Facilitator: There would be a federal declaration and – for the military – Immediate Response Authority would be enabled. What is the National Guard availability? Should we consider having the National Guard in EOCs?

California EMSA: The SOC convenes the Unified Coordination Group for senior-level decision making and resource allocation. The California National Guard has a seat at the table. In coordination with the California OES, the governor can activate the National Guard in California.

Facilitator: Local EMS would not be available as they would be busy responding to emergencies in the state. Would California have enough resources to deal with the situation on its own?

Los Angeles County EMS Agency, Region I Regional Disaster Medical Health: Ingress and egress would be disrupted. Damage will not impact the whole state, however. Regional airports could be tapped to move patients.

Facilitator: Would patients be moved to outer areas of California for ease of transport via aircraft? For example, could Palm Springs serve as a patient distribution center?

Los Angeles County EMS Agency, Region I Regional Disaster Medical Health: There are limited air resources. Some air resources may be able to transport, but utilization would require significant changes to accommodate pediatrics.

International Association of EMS Chiefs (IAEMSC): Pediatric patients with pre-existing health conditions – pediatrics on ventilators, for example – would require specific types of equipment. Furthermore, they would need to go to hospitals that could manage the health conditions (some hospitals may not be able to do this). There would also need to be special needs Where would these be? Pertaining to the bed-bound, adult patients would add to the stress on response and care.

California just stood up a Children's Health Insurance (CHIP) project, a pilot project conducted by ASPR (in partnership with CMS), which is similar to emPOWER, but which includes children's information pertaining to at-risk populations. The pilot provides guidance and technical assistance to help states and territories create emPOWER datasets from their state-operated Medicaid and CHIP data. The CHIP Data Pilot Project helps communities better anticipate needs and the health of children based upon their specific access and functional needs.

Buses could work for some of the population, but not for others. For instance, there are pediatrics on investigative therapies; how could these trials be continued when the patients are transferred to other hospitals? How would the investigators get access to the data needed or would there need to be a decision to stop the therapy?

Some EMS have supplies and assets to address pediatrics, while others may not.

During Katrina, a courtesy call was made to FEMA to notify the agency that private transportations resources would be used to evacuate Tulane University. FEMA said "no." However, the solution worked and the site was evacuated in less than 24 hours. We need to explore when private transport services can and cannot be used.

Lessons learned from COVID demonstrated that 80 percent of the resources received from state and federal government were administrative or were contracted resources. Some of the resources were hospital employees who left the hospitals to work with a contracted service provider. We need to have a better understanding of the national assets available and where they're coming from.

Some of the hospitals in California have transport contracts that would assist them in moving patients.

The Strategic National Stockpile (SNS) has not been replenished from COVID surges. Also, some of the SNS resources didn't work when these were received.

Facilitator: When Arizona activated the National Guard, we found that we were "pulling" nurses and doctors from hospitals that already needed their help.

Under Incident Command, rotary and fixed-wing assets could be availed, but who would coordinate all of the air assets as well as the landing zones?

Scottsdale Fire Department: The Department of Fire and Forestry Management is best at managing aircraft, and they are mobile. From a rotary air asset point, wildland can manage the aircraft. There are not a lot of fixed-wing assets pertaining to fire departments, except for those used for fire suppression.

Tempe Fire Department: In urban areas, this is accurate.

Facilitator: Is there any "body" that could manage all of the aircraft (military and civilian assets)?

California EMSA: The California SOC has an air group that can be stood up during emergencies. The military would participate in the group.

Military: If the FAA needs assistance, the Department of Defense could manage the aircraft. The challenge is that there are very limited capacities pertaining to communications between military and civilian aircraft; the two don't talk to each other.

Scottsdale Fire Department: Is there a common Department of Defense radio frequency that could be used in this type of scenario?

Military: There is a radio frequency the military can go to in a disaster.

However, it is not that simple to write a process. An exercise was conducted in San Francisco that looked at civilian landing of a marine helicopter. There were a lot of lessons learned.

ASPR Region IX Regional Emergency Coordination: Another thing to consider is when stars like John Travolta device to fly in their own private aircraft into the area for transport.

Facilitator: It appears there must be military and civilian aircraft coordinators sitting next to each other to facilitate the communications.

Is there a common radio frequency that could be used to connect the two? While there isn't a protocol to do this yet, wouldn't that be valuable?

Military: There would be more to it than that. However, this task is something that can be worked on.

Other countries will want to take patients back to their own countries. That means there would be even more aircraft involved.

ADHS Bureau of Public Health Emergency Preparedness: We learned that the embarkation piece needs and ambulance and triage as well as communications established. From hurricanes, we learned that premature babies are not easily moved; they take a lot of resources. When there are pediatric patients with tubes and other equipment/supplies required, there is tremendous stress on the children.

The Family Assistance Centers will be crucial in helping with this. Resources like the Ronald McDonald houses would be important to have. There are certain common themes, but there are issues that aren't fixed yet.

Facilitator: There are a lot of charitable organizations that may be accessed to help, such as the Red Cross.

National Pediatric Disaster Coalition (NPDC): With all of the road closures, we need to consider pediatrics in incubators and how we are going to bring neonatal assets to local (and safe) areas in California. Locations need to be identified in close proximity to the disaster for triage and care. We also need to understand the pediatric assets and subject matter experts that would be available to support these sites (triage, transport, staging areas, communications and dispatch management).

In the Haiti response – and we're talking about thousands of children who needed medical care – Israel established a field hospital somewhat near the disaster site. This field hospital gave life-saving

care before transport occurred. The Israeli model is worthy of consideration for replication pertaining to the siting of field hospitals.

Facilitator: How do we track the patients? Could a civilian be on a military aircraft?

Military: Let's not look at exceptions as we figure this out, so we have a baseline to start from.

Facilitator: Who would have thought we would use military assets during COVID? COVID opened our eyes to see there are opportunities to explore the military in discussions about other disaster response support.

Military: It may be prudent to add a military nurse to transports using military aircraft. However, this wouldn't be likely, and we need to be prepared for if a civilian nurse shows up with a pediatric patient.

Currently, the Department of Defense brings outside resources in the back of a C130 aircraft. However, providing medical support is a bit different (unique training and skill set).

Facilitator: Maybe we look at a military training program to enable education of the military on pediatric patients.

Military: The key is to engage elected officials in the discussion.

Credentialing was an issue during COVID for the military. However, there is a quick fix if we place a pediatrician on the military aircraft.

Day 2 Recap:

Facilitator: What comments does anyone have regarding this morning's legal presentation?

Dr. Rick Johnson (Contractor for the California Pediatric Surge Annex): There is more awareness of legal protections for Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). Prof. Hodge has been an incredible legal advocate.

Tempe Emergency Manager: There is an opportunity to establish new relationships with the legal information presented.

Pediatric Pandemic Network (PPN): Many lessons were learned about the intersection of state public health, emergency management, executive branch, and legislative branches during the COVID response. We must continue to engage elected leaders during preparedness activities, be they planning, training, or exercising.

National Center for School Crisis and Bereavement: The audience seemed a bit surprised by the legal findings presented by Prof. Hodge. Perhaps it would be a good idea to distribute his presentation to hospitals across the nation.

Facilitator: Perhaps there should be a "Roadshow" presenting all of the legal protections. It seems that interstate movement of volunteers is covered legally.

Western Regional Alliance for Pediatric Emergency Management (WRAP-EM): The legal findings from Prof. Hodge may be found on the WRAP-EM website at: https://wrap-em.org/.

National Center for School Crisis and Bereavement: Is there a way we can ensure people have access to this document? Can the Administration for Strategic Preparedness and Response (ASPR) require "sign off" by hospital leaders pertaining to reading the information?

Pediatric Pandemic Network (PPN): Many services may be restricted due to lack of knowledge about the legal protections.

ASPR Region IX Regional Emergency Coordination: Perhaps we can start by distributing the information throughout Region IX. Then we can look at other regions of the nation.

The Emergency Management Assistance Compact (EMAC) system provides protections.

Dr. Rick Johnson (Contractor for the California Pediatric Surge Annex): ESAR-VHP provides liability coverage when there is a declaration.

ASPR Region IX Regional Emergency Coordination: A declaration may be the solution.

Facilitator: Arizona State University had EMT students help with vaccinations during COVID through an authorization by the Arizona Governor.

ASPR Region IX Regional Emergency Coordination: During the pandemic, the State Health Officer issued an order that allowed the state to move patients in an effort to load-level once that particular region reached specific criteria, particularly ICU bed capacity.

California EMSA: Approximately 75,000 out-of-state professionals were approved to be sent to California during COVID. For a large-scale event, we could do this again.

Facilitator: The military may not be available for 72 hours. It may take this long to secure out-of-state workers through EMAC.

Los Angeles County EMS Agency: The Mercy ship wouldn't take COVID patients. Thus, medical staff were assigned from the ship to hospitals. Alternate care sites don't work so well.

Military: Military hospital ships need time to get ready. Also, military staff for the hospitals are "pulled" from civilian hospitals/other jobs. It would be better to have military medical professionals sent to the hospitals as long as the hospitals are safe and stable. Generators, potable water, and other resources may be sent to hospitals to keep them operational.

National Center for School Crisis and Bereavement: Given the scenario, flight resources may be needed for other reasons. Furthermore, bringing in too many volunteers could cause problems. Maybe it's better to take the time needed to determine exactly what resources are needed.

Facilitator: Keep in mind that the scenario is focused upon the first 24 hours following an earthquake. Hence, we're mainly looking at response. Planning should be occurring simultaneously to response.

Dr. Rick Johnson (Contractor for the California Pediatric Surge Annex): We're talking about life-saving care that may be provided by non-medical individuals. Perhaps we need to begin training the communities in advance on such strategies as Stop the Bleed.

Facilitator: Let's transition into a discussion about mental health, focusing upon we're doing as organizations to help our own people. How do we support first responders/recipients and their families so they are able to work effectively? How do we keep the work force healthy during an incident?

David Geffen School of Medicine at UCLA: It is timely to mention impacts on the work force with the NDMS teams deployed to Florida; there are a lot of ASPR resources on the ground.

There have previously been efforts to explore the impacts of significant distress to staff, which caused impairments on their abilities to perform needed functions. We need to plan in advance to support immediate as well as long-term mental health needs. WRAP-EM is working on a plan – "Anticipate, Plan, and Deter" – to do this.

The first responders and hospitals in the scenario will need to be assessed regarding mental health.

Also, the level of traumatic injury of each child may cause mental health needs. Yet, the mental health system for kids in the nation is already in crisis. We will need to focus on population-based care. Perhaps the optimal strategy is to use a "neighbor-to-neighbor: model for checking mental health needs in such an incident. FEMA offers a model: "Listen, Protect, and Reflect."

We need to get people to understand the level of impact regarding food supply, water, access to acute healthcare, hazardous materials, as well as mental health. Training on Stop the Bleed and immediate psychological needs is a start.

National Center for School Crisis and Bereavement: The same basic needs must be provided to the families of healthcare workers and first responders.

Facilitator: It is crucial we take the same basic needs for hospital workers and their families while waiting for other resources to arrive.

We will have a reduction in the work force due to personnel being incident victims. How do we build plans to keep our working staff healthy? How do we manage shift rotations and so forth without running staff into the ground?

Dr. Rick Johnson (Contractor for the California Pediatric Surge Annex): What is the first thing that a worker will need? Food, water, restrooms, shelter, a hug, a pat on the back. The worker needs during the first 24 hours are very basic. The neighbor-to-neighbor concept works; that's where mental health starts.

PPN: We need to ensure that someone is there to tell staff to stop and take a break.

Facilitator: Whose responsibility is safety? It is everyone's responsibility to ensure that the team is safe and to tell staff to stop and go home, as necessary, so they aren't worked into the ground.

WRAP-EM: Within the plan that is developed, human resources and occupational health should be considered.

National Center for School Crisis and Bereavement: With communications being problematic, it will be important to assign staff to check on families.

Facilitator: There may need to be runners who check addresses to assure staff their families are okay. Another option may be the satellite phones, which would need to be distributed. We may need to go "horse and buggy."

NPDC: The neighbor-to-neighbor approach is a great idea. It is good to keep as many children as possible close to their homes. The hospitals in the scenario could evacuate to parking lots, but then what?

Ambulances don't have universal adaptors for equipment to accommodate pediatrics.

Often, where pediatrics are transported is determined by informal relationships already present among hospitals.

How do we get together after this conference to develop plans to support what we've talked about (interoperable functions, resources, legal protections, and more)? How can we glean from other disaster findings to create models?

Facilitator: We can strategize about low-hanging fruit and then explore needed legislation. We need to strategize about supporting the type of scenario offered for the conference and similar types of events requiring interstate transport/evacuation as well as engagement of political partners and local agencies. Who will drive this initiative?

Tempe Emergency Management: Tempe is working on a new bystander engagement training curriculum. This training will help civilians understand what to expect when talking with first responders as well as training the civilians on basics in tourniquet and gauze use and first aid. We need to work with the businesses in the community; what can they bring to the table?

Facilitator: Businesses will need to be brought in right away to assist with the response as they have the food, water and other resources needed. The food must be managed so that only what is needed is requested. Similarly, there will be many resources sent that will need to be managed. Compensation of businesses for resources offered in a catastrophic event should be considered now as planning occurs.

Regarding systems and data, how do we protect people's privacy and information, but also conduct patient tracking?

PPN: PULSE (Patient Unified Lookup System for Emergencies) may be most applicable (web-based program). If electronics are out, the Electronic Medical Record-keeping can't be used. But web-based information can be accessed rapidly.

California EMSA: California has some experience with PULSE. The California Emergency Assistance Teams used the system at shelter sites. They didn't really use PULSE as effectively as they could have, but it's likely a different strategy will be examined for use.

Tempe Assistant Fire Chief: Tempe is creating a comprehensive plan to respond to disasters. During the Las Vegas shooting, approximately 50 percent of the victims self-transported or went to hospitals in vehicles other than ambulances.

Alarm rooms must alert hospitals, emergency managers (EMs), and medical examiners (MEs) early through text and other systems rapidly during a Mass Casualty Incident (MCI). The alert should denote the nature of the event, the population impacted, and location of the incident. A second alert will be sent to the hospitals, EMs, and MEs office when victim number estimates are known. Then the hospitals can stand up their Emergency Operations Centers and prepare their emergency rooms for the surge. EMs can stand up the EOC and activate appropriate resources.

The Tempe plan will evolve Emergency Call Centers and Family Reunification Centers to help in large disasters. In addition, two fire department companies and battalion chiefs will be sent to hospitals to help with triage and stabilization of patients. The Battalion Chief will serve as liaison to Command.

Photo identification coordinators ("PICs") will be sent to the hospitals as well to take photos of victims as they arrive. Unique identifiers assigned will be taken with the images of the victims. The information will be uploaded to encrypted SharePoint sites that will include spreadsheets with other reunification information. A public facing site would be activated for family and friends to upload photos of those they are looking for with name, age, identifying markers, and emergency contact information. A number to call and location for the family reunification center will be provided for reunification purposes. The photos will be matched by a reunification team to identify which hospital victims are located at.

Deployable reunification teams (humane society, Red Cross, and others) will be established and will need to be tapped to set up reunification sites across the Valley. These entities will be responsible for set-up and maintenance of the reunification site in coordination with a local reunification coordinator.

All of the planning occurring among Tempe, other communities in the Valley, Maricopa County, and the state relies on the concept of "simple, realistic, feasible, interoperable, and cost effective".

Facilitator: With communications' technology out, ham operators may be needed.

National Center for School Crisis and Bereavement: Kids will be wandering around on the streets unaccompanied.

Tempe Assistant Fire Chief: Family Reunification Centers (temporary operations until Family Assistance Centers are activated) must be able to accommodate the unaccompanied minors.

Facilitator: Consider working with schools and universities to identify individuals who can assist with taking care of the unaccompanied minors in the Family Reunification Centers.

Tempe Emergency Management: The Tempe planning team is looking at sending law enforcement or contracted security to hospitals for the purpose of assisting with the perimeter protection and to alert families about where to go to find Family Reunification Centers.

WRAP-EM: Hospital Reception Sites must be integrated into community planning. The resources sent to hospitals may not be what they need. Many hospitals do not have reunification plans; we need to help them.

Tempe Assistant Fire Chief: The Tempe planning teams include hospitals and many other partners. There are childcare providers within cities who have already had background checks.

WRAP-EM: Families should also be included in these discussions. Representatives from Family Networks should participate in planning discussions. Public perception about the role of hospitals in disaster is discrepant with what the hospitals can and should actually provide. Resetting these expectations must include community partners. Community partners can help reset messaging.

Tempe Assistant Fire Chief: We will garner input from the community. We can always strive to do better. It is important to understand emerging technologies.

Arizona Coalition for Healthcare Emergency Response (AzCHER): During such an incident, AzCHER would provide situational awareness and could help with the early alert process to hospitals from the alarm rooms. AzCHER can also help with resource sharing through their MOU (some resources can be deployed within the first 24 hours). AzCHER would develop an Incident Action Plan (IAP) to identify priorities for Arizona healthcare facilities and hospitals to focus on activating their surge response plans and assessing pediatric capacity. This helps create a common operating picture and ensure federal ASPR Region IX and ADHS information is shared at the local level.

Dr. Rick Johnson (Contractor for the California Pediatric Surge Annex): We have been focusing on moving patients across state lines. We need to move staff and resources into California.

Also, the people who make transport decisions every day should be making the decisions about transport in the scenario offered.

American Medical Response: Non-critical patients can be moved out of state.

Tempe Emergency Management: We need to be conscientious about what we're doing by moving patients out of state. There are mental health considerations.

WRAP-EM: A child was sent out of state from the Stanford Center. During a recent hospital decompression effort, we had to send multiple patients across state lines and, at times, outside of the region. An evacuation of a single pediatric center will require patient movement across state lines and potentially out of a federal region. In this scenario, we are evacuating more than one children's hospital, and this will require a national movement plan for pediatric patients.

Considerations for Improvements: The discussion noted above contains many insights. Some overall considerations listed below pertain to the information shared.

1. Develop and test plans for interoperable interstate communications, coordination, and response during the onset of a catastrophic incident. **State and regional Emergency Management, military partners, first responders, and private sector (airports, mass transit, Department of Defense contractors, and others, as applicable).** This should include identification of:

    a. A pre-identified radio frequency for use by the military and first responders.
    b. Aircraft pediatric transport management:
        - Coordination responsibilities,
        - Viable aircraft,
        - Needed equipment and supplies, and
        - Staffing (is it better to use military nurses on military aircraft or is it better to send a nurse who is familiar with the patient?).
    c. Chain-of-custody ambulance transport to airports determined to be safe for operations.
    d. Mid-way and/or border triage, stabilization, and transport staging sites as well as field hospitals. Identify who will staff these as well.
    e. Integration of National Guard, Active Duty, and Reserve representatives in the state emergency operations centers.
    f. Medical asset de-confliction strategies (e.g., will anyone really benefit if doctors and nurses are deployed away from hospitals to serve in military responses?).
    g. Interaction with incident management teams to deter deployment of unnecessary assets; and
    h. Lessons learned from the Israeli response to the Haiti disaster.

2. Clarify liability coverage for volunteers crossing state boundaries for response. Also, distribute the legal document created by Prof. James Hodge to all hospitals (currently found at: https://wrap-em.org/). Develop a strategy of incentives for hospitals to sign off integrating findings. **ASPR.**

3. Create an environment to support military training and response for pediatric injuries and transport. This will require legislative involvement and funding, but it is a gap that has not been successfully addressed. **NACCD.**

4. Determine a funding source for pediatric patients to return from hospital destinations (repatriation) once the patients are stabilized and able to return home (applies to non-federally transported cases; NDMS does not transport pediatrics at this time). This cost should not be borne by hospitals (deters reception of patients and was counterproductive during Katrina; this is a lesson learned that has not been addressed). **ASPR (to FEMA), NACCD, and the centers for pediatric excellence.**

5. Identify pediatric equipment funding for EMS and distribute funding (for equipment and supplies), potentially using caches sited in hubs across a state. For example, universal adaptors for pediatric patients may be needed. Ensure there is accountability in spending. **NACCD.**

6. Create a strategy to ensure the assets needed are available and operational. For example, the SNS resources must be resupplied**. ASPR.**

7. Identify a national standardized system of determining the pediatric patients who can be moved versus those who should not be moved (in-hospital triage). **EMSC.**

8. Ensure all facets of reunification are planned, able to be staffed, and tested. These must be able to accommodate the unaccompanied minors. **NACCD**. Elements should include:

    a. Hospital Reception Sites,
    b. Family Reunification Sites,
    c. Family Assistance Centers, and
    d. Emergency Call Centers.

    As a resource, consider contacting the Tempe Emergency Manager for reunification models. Also, go to the WRAP-EM site for the Hospital Reception Site model. **PPN**.

9. Create an incentive for hospitals to work together pertaining to resource sharing, patient transport among different hospital systems, and more. The financial incentives – such as hospital support for emergency management, training, and exercises – were lost in parts of the country when ASPR discontinued full funding to the state health departments (coordination) and hospitals and instead opted to launch health care coalitions, which often have no operational role in disaster response. **NACCD.**

10. Re-examine the role of health care coalitions and whether the funding is sufficient to for operational roles and recruitment of first responder participation. ASPR has embarked on a new operational mission; perhaps there is merit to reconfiguring the roles of the health care coalitions and others at this time as well. **NACCD and ASPR.**

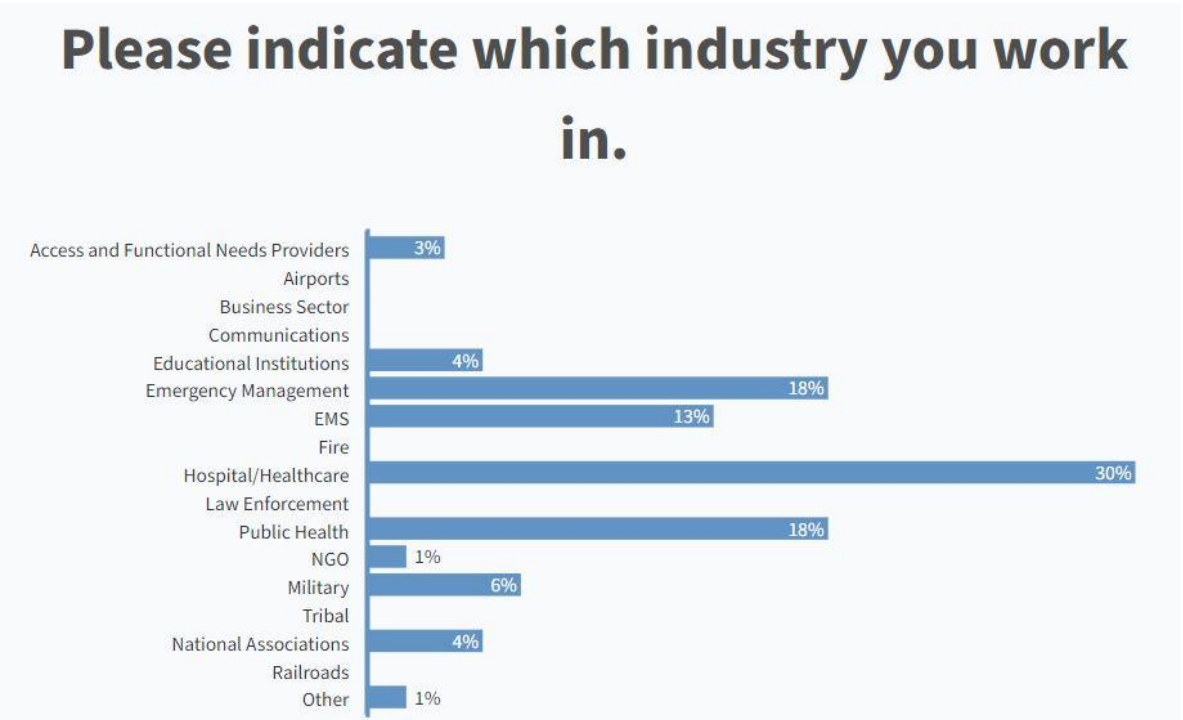
11. Amplify and distribute the WRAP-EM "Anticipate, Plan, and Deter" project (building responder resilience). **WRAP-EM.**

12. Publish with fire, EMS, and others the best practices on mental health and other types of support for hospital workers, first responders, and their families. **NACCD.**

13. Evolve a standardized web-based health information exchange project for use with diverse hospitals to use during disasters. As patient tracking platforms across the country have demonstrated, challenges arise when the federal government permits unique systems to develop that won't "talk" to each other. There is an opportunity to shift the vision. **NACCD.**

Evaluation: The Day 1 evaluation results are displayed on pages 26 and 27. The Day 2 evaluation results are depicted on pages 28 through 35.

Day 1 Composition of Evaluation Respondents (251 Respondents)



Do you have a better understanding of: California's local and state command structure(s), situational awareness, resources, limitations, and resource distribution during a catastrophic incident?

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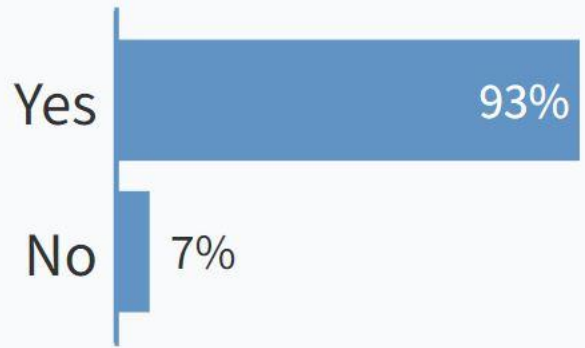
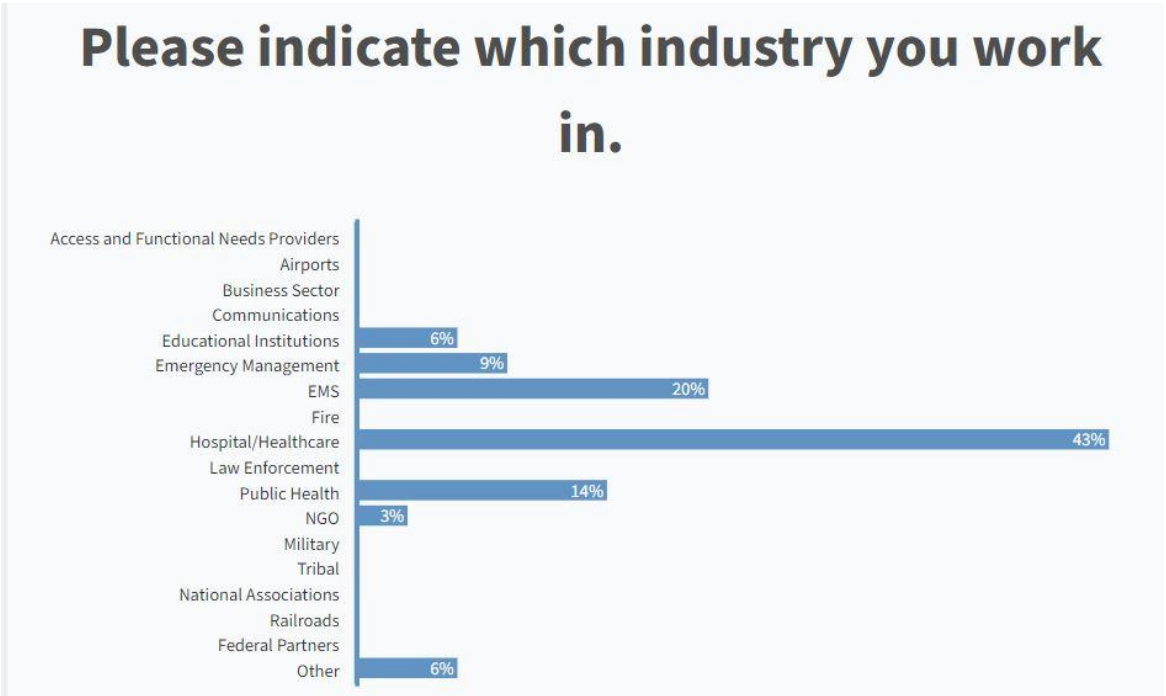
OF EMERGENCY SERVICES

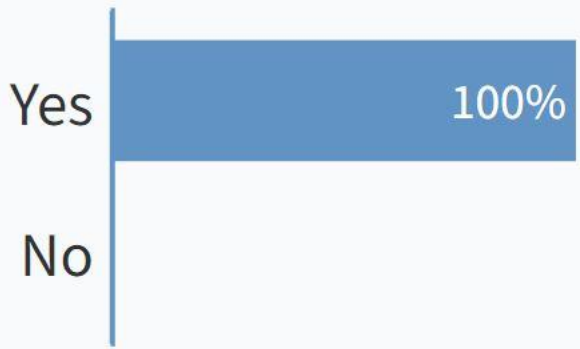
Do you have a better understanding of: First responder, military, and private sector staging, triage, and ground and air transport during a catastrophic incident?



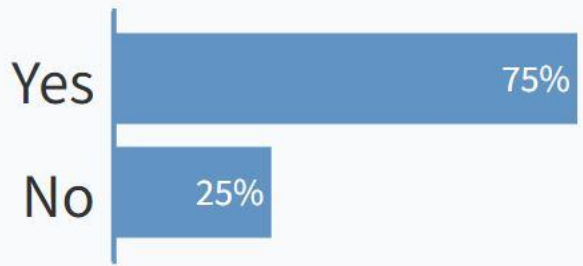
Day 2 Composition of Evaluation Respondents (250 Respondents)



Do you have a better understanding of: Legal complexities of hospital interstate evacuations during a catastrophic incident?

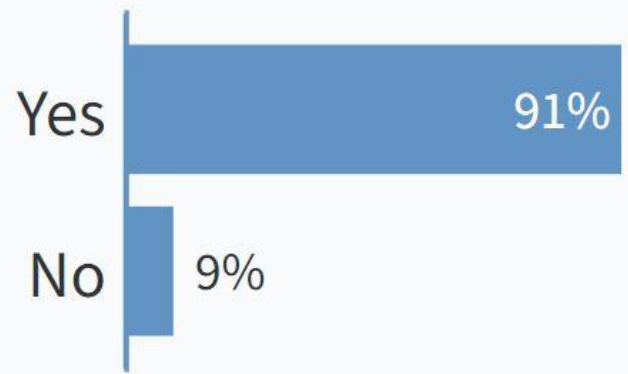


Do you have a better understanding of: Mental health complexities pertaining to the interstate evacuation, transport, and reception of pediatric patients during a catastrophic incident?

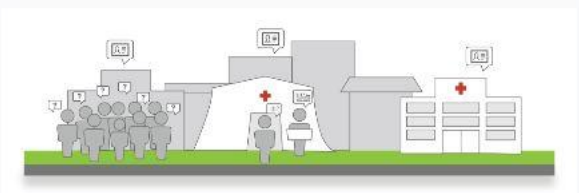


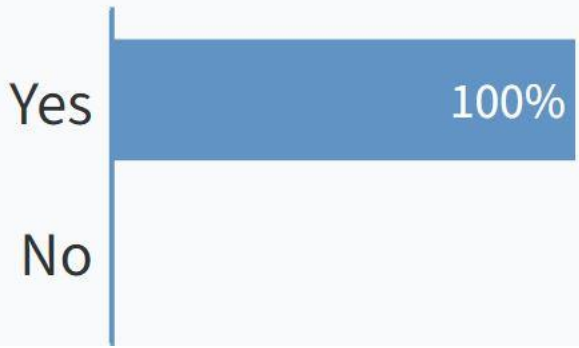
Do you have a better understanding of: Healthcare capacity status identification, hospital needs assessments, communication strategies, and essential elements of information collection during a catastrophic incident?

Do you have a better understanding of: Transfer of patient information amongst healthcare systems during a catastrophic incident?



Do you have a better understanding of: Patient tracking in healthcare systems and agencies supporting family reunification during a catastrophic incident?





Do you have a better understanding of: Hospital pediatric patient reception best practices and challenges during a catastrophic incident?

Appendix A

National Pediatric Disaster Conference Oversight Committee

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Heather L. Beal, PhD, CEM, President & CEO, BLOCKS

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Nichole Fortson, State Exercise Branch Manager, Emergency Management/Exercise Branch, Arizona Department of Emergency and Military Affairs.

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Christopher Newton, Trauma director, UCSF Benioff Children's Hospital in Oakland; Principal Investigator, Western Regional Alliance for Pediatric Emergency Management (WRAPEM); and Co-Principal Investigator of the Pediatric Pandemic Network.

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John Wogec, DO, MPH, Senior Emergency Services Coordinator, California Department of Public Health, Emergency Preparedness Office.

Mark Young, Regional Administrator, Administration for Strategic Preparedness and Response (ASPR for AZ, CA, HI, NV, AM. Samoa, Guam, CNMI, RMI, FSM, Palau).

Appendix B

Glossary of Acronyms

(Some Common Acronyms are not Included)

AzCHER – Arizona Coalition for Healthcare Emergency Response

ADEM – Arizona Department of Emergency Management

ADHS – Arizona Department of Health Services

AMR – American Medical Response

ASPR – Administration for Strategic Preparedness and Response

CAL-MAT – California Medical Assistance Team

EMAC – Emergency Management Assistance Compact

ESFs – Emergency Support Functions

EMSA -- Emergency Medical Services Authority (California)

EMSC – Emergency Medical System for Children

ESAR-HVP – Emergency System for Advance Registration of Volunteer Health Professionals

MHCC – Medical Health Command Center (California)

PULSE – Patient Unified Lookup System for Emergencies

NACCD – National Advisory Committee on Children and Disasters

NDMS – National Disaster Medical System

NGO – Nongovernmental Organization

NPDC – National Pediatric Disaster Coalition

PICs – Photo Identification Coordinators (pertains to victim tracking)

PPN – Pediatric Pandemic Network

SEOC – State Emergency Operations Center (Arizona)

SERFs – Significant Event Readiness Event Forums

SNS – Strategic National Stockpile

SOC – State Operations Center (California)

USARNORTH – United States Army Northern Command

USNORTHCOM – United States Northern Command

WRAP-EM – Western Regional Alliance for Pediatric Emergency Management