Pediatric Emergency and All-Hazard Disaster Readiness

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AAP Ohio Chapter Annual Meeting
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Disclosures

- I have no relevant financial relationships with the manufacturers of any commercial products and/or providers of commercial services discussed in this CME activity.

- I do not intend to discuss an unapproved or investigative use of a commercial product or device in my presentation.
Objectives

- Describe the fundamental link between day-to-day emergency preparedness and disaster readiness for children

- Identify the unique vulnerabilities of children and the special needs of children and their families in mass casualty events

- Define the role for pediatricians as advocates for pediatric emergency and disaster readiness and as participants in disaster planning, response and recovery
‘Blueprint’ for Disaster Readiness

“All-hazard mass casualty event readiness”

“Day-to-day emergency readiness”

“The Elevated Hurricane Zone Housing Solution”
So, How’s The Foundation?

- Existing public safety systems (EMS, fire, etc) are frequently over-taxed by demand
- EMS and trauma systems are woefully under-funded
- Hospital-based emergency departments are increasingly and dangerously overcrowded
- Public health and disease surveillance systems are lacking
- Pediatric capabilities of our emergency (and disaster) care systems is uncertain
Emergency department visits grew by 26% between 1993 and 2003
- 90 → 114 million visits
- Number of EDs ↓ by 425, hospitals ↓ by 700
  - Inpatient beds ↓ by 198,000

Substantial ED overcrowding
- 91% of EDs now report this as a problem
  - 40% experience this DAILY

Ambulances are frequently diverted from overcrowded EDs
- ~ 500,000 diversions in 2003

Critical shortages of ED care providers
In addition to ED access concerns, overcrowding is associated with poor care quality & medical error
Overcrowding Crisis in Our Nation's Emergency Departments: Is Our Safety Net Unraveling?

Krug S, American Academy of Pediatrics Committee on Pediatric Emergency Medicine

POLICY STATEMENT

Pediatrics 2004; 114(3): 878-88

- Rapidly rising utilization has effectively saturated the capacity of emergency medical services in many communities
- ED overcrowding threatens access to emergency care for those who may need them the most
- Attributable to the lack of a coherent national health policy to create a comprehensive health care and social services delivery system for all Americans
  - Insufficient access to primary & specialty care services contributes to this problem
- The ‘canary in the coal mine’
  - ED overcrowding represents a warning sign of growing distress within hospital and primary care delivery systems and a fraying health care safety net
Pediatric Emergencies: The BIG Picture

- Nearly 25 million visits to US emergency departments each year

- Children account for 5 to 10% of EMS runs, 0.5% of which require true critical care
  - Limited experience for paramedics with sick kids

- Children compose 25-30% of ED visits, 5% of which require 3^0 care
  - > 90% of children are initially cared for in general hospital ED’s
  - Limited experience with sick kids for RNs and MDs in most EDs
How Big a Problem? *IOM Report*

- Although children make up at least 1/4 of all ED visits nationwide
  - Most general EDs and EMS agencies do not require specialized pediatric training for their clinical staff
  - Only 6% of all EDs have the full scope of pediatric equipment, medications, supplies
  - Paucity of research on best practices, clinical outcomes, & patient safety in pediatric emergency care

“If there is one word to describe the current state of pediatric emergency care in 2006, it is **UNEVEN**”

--- IOM Panel, 2006
Pediatric Preparedness of US Emergency Departments: A 2003 Survey

Marianne Gausche-Hill, Charles Schmitz, and Roger J. Lewis

Pediatrics 2007; 120(6): 1229-37

- Closed response survey of 5100 US emergency departments assessing their awareness & compliance with published AAP/ACEP pediatric readiness guidelines

- 89% of pediatric ED visits occur in a non-children’s hospital ED
  - 26% of these visits occur in remote or rural facilities < 1000 kids/yr
- 50% of respondents see less than 10 kids per day
- 75% of respondents see less than 7000 kids/year

- Only 6% had all of the equipment recommended by AAP/ACEP
  - Common shortfalls were neonatal & infant sized equipment (e.g. airways)

- Readiness scores were higher in larger volume EDs, and particularly in those with a physician and/or nurse leader for pediatric care
  - This could be an emergency medicine doc, or a pediatrician or family physician
Disasters: What Have We Learned?

“Disasters don’t happen to places, they happen to people”  L. Romig, MD
Andrew: **What Did We Learn?**

- **Second most destructive hurricane in US history – 8/92**
  - Category 5 storm → 65 deaths
  - Cost - 26.5 billion dollars

- **Delay in federal relief response**
  - Shortages of staff and supplies

- **41% increase in ED visits to Miami Children’s Hospital the weeks that followed**
  - > 30 miles N of the ‘eye’

- **Increased visits for:**
  - Gastroenteritis
  - Cellulitis
  - Minor trauma

Avianca Flt 52: What Did We Learn?

- Long Island, NY (Jan 1990)
  - 158 passengers, 73 deaths
  - 25 children → 22 survivors
- County disaster plan in place
- Only 2 of 7 critically injured children were transported to a pediatric tertiary center
  - Remaining 5 were treated at a level III trauma center with very limited pediatric capabilities
  - The closest pediatric Level I trauma center, which had a helipad, received no patients

State Disaster Planning

- 1997 FEMA survey of state disaster plans
  - Not one state plan had pediatric considerations
- All state plans must now contain considerations for “at risk populations”, including children*
  - The content, scope and efficacy of these pediatric elements vary greatly
  - Disaster drills may not include a significant number of child victims
  - Pediatric surge capacity may be lacking

*Pandemic All-Hazards Preparedness Act (2006)
September 11th: *What Did We Learn?*

- Occurrence of terrorism on US soil is a reality
- Focused the attention of the federal government on the threat of terrorism and the response to weapons of mass destruction
  - Under-resourced and poorly coordinated emergency and disaster response systems
  - Public health systems outdated
- Massive federal funding targeted to bioterrorism
  - EMS and trauma systems have received only 4-6% of these $$
Then Came Katrina
Pediatric Disaster Preparedness in the Wake of Katrina: *Lessons to be Learned*

- Support for intact hospitals and other care facilities with power, water, food, supplies and security
- Planning for the care and evacuation of hospitalized children, infants and premature newborns
- Strategies for the evacuation of children with their parents, families and caretakers
- Strategies for reunification of children with parents or families – especially infants and pre-verbal toddlers
- Appropriate sheltering for children and families
- Preparations for culturally and developmentally appropriate mental health interventions for children
- Disruption of the medical home, impeded access to care, and increased risk for morbidity for CSHCN

Disaster Medicine 101:  
*One Plan for All Hazards & All Victims*

- Can we manage acutely ill or injured children like small adults?  
  - Neither singly nor in multiples

- Why not….  
  - Unique vulnerabilities  
  - Assessment/triage  
  - Specialized care resource needs  
  - Development/mental health  
  - Family issues

- So, does your local disaster plan have a pediatric component?
Enhanced Vulnerability of Children: Anatomic & Physiologic Issues

- **Thinner and less keratinized dermis**
  - Increased susceptibility to chemical agents
    - Vesicating agents (nitrogen or sulfur mustard, Lewisite)
    - Nerve agents (Sarin, VX, Tabun, Soman)
    - Irritants & corrosives (chlorine, ammonia, phosgene)

- **Increased body surface area/mass ratio**
  - Increased susceptibility to chemical agents and radiation
  - Increased risk for hypothermia during field decontamination and treatment
Enhanced Vulnerability of Children: Anatomic & Physiologic Issues

- **Smaller relative blood volume**
  - Increased susceptibility to dehydration secondary to vomiting and diarrhea
    - Cholera, Salmonella, E. coli, SEB, Ricin

- **Higher minute ventilation rates**
  - Increased susceptibility to aerosolized agents
    - Biologics, chemicals, radiation

- **Higher basal metabolic and cellular growth rates**
  - Increased susceptibility to radiation, chemical agents
Enhanced Vulnerability of Children: Anatomic & Physiologic Issues

- Live closer to the ground
  - Increased susceptibility to biological and chemical aerosols that are denser than air
    - Nerve gases, vesicants, irritants/corrosives
      - e.g. Sarin, sulfur mustard, chlorine
  - Increased exposure to radiation

- Increased susceptibility to infections
  - Newborns
  - Children with chronic illnesses
Enhanced Vulnerability of Children: *Developmental Considerations*

- Inability to anticipate, recognize or flee from dangerous situations
- Fear of strangers – inability to cooperate or communicate with officials/providers
- Family separation – unaccompanied minors – highly vulnerable
- Increased risk for acute and post-traumatic stress disorders and behavioral/psychological dysfunction
Psychological Responses to Disaster

- Incidence of PTSD in grade school children in the aftermath of Hurricane Floyd (1999)
  - 4th grade students, six months after hurricane
    ➢ 95% experienced at least mild symptoms
    ➢ 71% with moderate to severe symptoms

- Incidence of PTSD in school-aged children in high impact area of Hurricane Andrew (1992)
  - 51% experienced moderate levels of symptoms
  - 38% had severe to very severe symptoms

- Stress and anxiety levels likely greater after an act of terror vs. natural disaster
  - 11% of all NYC public school 4th-12th grade students self-reported PTSD 6 months after 9/11

- Katrina

Pediatric Disaster Preparedness: A Five Step Program

- **Step One:** Preparedness for pediatric emergencies – at all levels
  - Consider the needs of special populations

- **Step Two:** Consideration of and preparation for ‘natural’ MCI’s

- **Step Three:** Development of mass casualty plan for WMD’s

- **Step Four:** Development of pediatric plan within the WMD/MCI plan

- **Step Five:** Education and practice
Step One – Preparedness for Pediatric Emergencies

Preparation for pediatric victims of disasters starts with a basic preparation for pediatric emergencies

- This should occur at all levels of care
  - Office
  - Pre-hospital
  - Hospital
- This should anticipate the needs of CSHCN
Closing the Gap: Emergency Medical Services for Children {EMSC}

- Federal program first funded in 1985
  - 4M 1985 → → → 19.8 M 2007
- Developed in recognition that EMS systems have not met the emergency care needs of children
- Goal to improve capabilities of existing EMS systems through education, training and research
- Largest single source of support for research, and education/training initiatives in PEM

EMSC Program Accomplishments

- Education/training programs
  - EMTs and paramedics
  - ED nurses and doctors
  - School nurses

- Protocols for pediatric trauma and emergency care, disasters

- Equipment, medication and staffing guidelines
  - Ambulances
  - Emergency departments - EDAP

- Research & resource centers
  - PECARN, NEDARC, EMSC-NRC

http://www.ems.ohio.gov/EMSC%20web%20site_11_04/emschome.htm
Preparation for Emergencies in the Offices of Pediatricians and Pediatric Primary Care Providers
Frush K, and the Committee on Pediatric Emergency Medicine

POLICY STATEMENT
Pediatrics 2007; 120(1): 200-12

- Perform a self-assessment of office readiness for emergencies
- Develop an organizational plan for emergency response in the office
- Maintain recommended office equipment, medications, supplies and tools to guide resuscitation interventions (e.g. protocols, pre-calculated drug doses)
- Develop a plan to provide education and training for all office staff
- Practice mock codes in the office on a regular basis
- Educate families about what to do in an emergency
- Partner with EMS and hospital-based emergency care providers to ensure optimal emergency care and disaster readiness for children
Emergency/Disaster Readiness: 
*EMS and Public Safety Systems*

- Are your EMS/public safety systems ready?
  - Protocols for pediatric care
  - Pediatric training for EMS
  - Pediatric sized equipment

- Important considerations
  - Training for fire, police and other first responders
  - Disaster drills with child victims
Care of Children in the Emergency Department: Guidelines for Preparedness

American Academy of Pediatrics, Committee on Pediatric Emergency Medicine and American College of Emergency Physicians, Pediatric Committee

POLICY STATEMENT

Pediatrics 2001; 107(4): 777-781

- Joint AAP and ACEP policy statement
  - Endorsed by 17 professional organizations
  - Reaffirmed in 2004 – currently being revised

- Guidelines for pediatric emergency readiness in hospital EDs
  - ED administration and clinical leadership
  - Physicians, nurses and other practitioners staffing the ED
  - Pediatric quality improvement guidelines
  - Key policies, procedures, and protocols
  - Support services (lab, radiology)
  - Equipment, medications and supplies
Mortality Rates per 1,000 Injury-Related Inpatient Admissions From the ED Pre- and Post EDAP: 1994-2005

- Age group: 0-15 years
- Data is only from those hospitals participating in IL EDAP program
- Reductions in mortality exceed national trends for ISS ≥ 17

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Sources: Illinois EMSC & Illinois Hospital Assn.
Step II: Prepare for Natural Disasters

- Consider likely natural disaster scenarios
  - Tornado, hurricane, flood, earthquake
  - Pandemic flu

- Consider likely man-made disaster scenarios
  - School bus, train or plane crash
  - HAZMAT
  - Act of violence

- Consider disaster events in child/family locations
  - School, church, shopping mall, stadium

- How would you handle the pediatric victims?
Emergency/Disaster Readiness: The School System

- Are your school systems prepared
  - External review of their disaster plan
  - Coordinated with EMS and public safety
  - Shared with community physicians, parents
  - Performance of regular drills

- Important considerations
  - Parents unable to pick up kids
  - Children with special needs
  - Mental health resources
  - Children in route
  - Day care facilities
  - Places of worship

*Pediatricians can play a key role in school readiness*
Disaster Evacuation and Shelters

- Whenever possible, children should be evacuated with family
- Shelters should be resourced to meet the needs of children/families
  - Basic necessities – food, diapers, toys, etc
  - Medical care – including mental health
  - Social services and child identification
  - Safety
    - Physical, infection control, violence
- Are there existing facilities in your community that are designed and staffed with children in mind
  - Yes – schools, places of worship
- Question: In response to a disaster should we
  - Evacuate children away from schools – or –
  - Should we keep them at schools
Disaster Preparedness: What Should We Tell Families?

- Establish a family disaster plan
  - Include escape plans and meeting locations
  - Out of state contact person
- Become familiar with EMS system
  - Know how and when to use 911
- Take first aid/CPR classes
- Stock emergency supplies
- Special considerations for CSHCN
  - Emergency power, medications, supplies
- Family readiness kit

Kit available at: http://www.aap.org/family/frk/frkit.htm
Step Three: Development of a Plan for Bioterrorism and WMDs

- Who is involved in your state, community, or hospital WMD planning?
  - Is there pediatric input?

- If you’re not already involved, get involved!

WMD – Weapon of Mass Destruction
‘Man-Made’ Disaster Planning vs. Natural Disaster Planning

- Timing of acts of terror can be erratic or unpredictable
  - No season (e.g. tropical storms, influenza)

- Attacks can be of any size and may occur in multiple areas simultaneously or sequentially
  - This can severely tax resources

- Substantial psychological trauma, fear
  - Psych casualties: actual victims > 5:1
  - This may affect victims, responders, and care providers
Chemical Weapon Attack vs. HAZMAT Incident Planning

- Intent to cause mass casualties
- More toxic substances
- Initial substance identity unknown
- Greater risk to EMS & first responders
- Many worried well
- Mass hysteria, panic
- Pediatric considerations
  - Increased exposure & toxicity risks
  - Antidote dosing (eg. nerve agents)

Biological Weapon Attack vs. ‘Natural’ Infectious Disease Epidemic

- Intent to cause mass casualties
- More virulent agents (Category A & B)
  - High infection rates & morbidity and mortality
- Delayed diagnosis – rare diseases
- Compressed time frame with multiple disease outbreaks
- Greater risk to care providers
- Many worried well, mass hysteria
- Pediatric considerations
  - Increased exposure & morbidity risks
  - Antimicrobial dosing and treatment

Pandemic flu planning provides an excellent model for many bioweapons
Radiation Disasters

- Hospital and community disaster planning for radiation events may be poorly developed
  - Care provider training/knowledge base
  - Large scale and long-term evacuation

- High prevalence of distress and behavioral disorders for exposed populations

- Special implications for children
  - Children are much more sensitive to the ionizing effects of radiation
    - Transmission to human and cow’s milk
    - Congenital anomalies (in utero) and cancer
  - Antidotes - KI administration (radioiodine)
    - Efficacy diminishes rapidly post-exposure
    - 80% - 2 hours $\rightarrow$ 7% - 24 hours

Step IV: Insert Pediatric Care Issues Into All Aspects of Disaster Planning

- Disaster plan components that should consider children
  - Surveillance
  - Triage
  - Decontamination
  - Treatment
  - Evacuation/shelters
  - Recovery

- Are there unique populations of children with special health care needs that must be met
Disease Surveillance: A Key Role for Primary and Emergency Care Providers

- Cluster of unusual or unexplained illnesses
- Unexplained critical illness in a healthy host
- Symptom or syndrome driven rather than disease-recognition specific
  - Acute respiratory distress and fever
  - Influenza-like illness
  - Acute rash with fever
  - Neurologic syndromes

- Key epidemiologic principles
  - An epidemic number of patients
  - Common exposure history
  - Exotic disease presentations

Early recognition may be our best weapon to effectively reduce WMD related death/disability
Disaster Victim Triage: *Pediatric Assessment Issues*

- Basic triage principles should apply
  - Sickest or most severely ill/injured should come first
    - Immediate → delayed → minimal → expectant
  - Focus precious resources only on salvageable victims

- Children possess different physiologic and developmental characteristics
  - Young children not ambulatory
  - Age specific RR normally > 30/minute
  - Capillary refill subject to external influences
  - Mental status may be difficult to judge
  - Apneic children may still have pulse and may be salvageable

- Tendency for over- or under-triage of children with adult triage tools
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<td>Alert, responds to verbal stimuli or appropriate response to pain</td>
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*Immediate Treatment Life-threatening*

*Delayed Treatment Serious Injury*

*Minor Injury Ambulatory*

*Not Expected to Survive*

*Komig LE. Journal of Emergency Medical Services 2002; 27:52*
Decontamination Goals

- Reduce further harm to the victim from a chemical, radiologic, or biological exposure
- Maintain viability of the ED and hospital as a treatment center
- Reduce further spread to other members of the population
- Protection of ED staff and other healthcare providers
- Cannot assume that EMS will be able to decontaminate victims prior to their arrival to the ED
  - Tokyo Sarin event
- Are you prepared to do this at your facility?
Decontamination Pearls

- Remove, collect, control & dispose of all clothing
  - 80-90% of exposed surface
    - Make them naked!
- Wash head to toe with water
  - Have patients do this, if possible
  - Need process for the incapacitated
  - Copious irrigation of open wounds
  - Soap
  - Collect effluent if possible
- Delivery of acute care by staff in PPE will be difficult
  - Will need multiple PPE teams
- Will be very time consuming
  - 2 to 3 minutes per patient

Not all exposures warrant decontamination!
Decontamination: *Pediatric Issues*

- Children may experience disproportionate exposure to certain toxins
- Young children unlikely to cooperate with mass casualty decontamination systems
  - Infants not ambulatory
  - Children may not self-decontaminate
  - Children will be frightened by staff in PPG
- Ideally should try to keep families together
  - Parents can assist decontamination team
    - What about unaccompanied children?
- Hypothermia concerns in children
  - Warm vs. cold water
  - Indoor vs. outdoor facility
Post-Decontamination Care: *Pediatric Issues*

- **What would you do with a large number of children after decontamination?**
  - Identification and tracking of children should begin upon completion of decontamination

- **Consider a separate zone for triage, reassessment and observation of children**
  - Allows for the concentration of specialized pediatric care resources

- **Consider medical and non-medical needs**
  - Child supervision, psychosocial needs, feeding, hygiene
  - Temporary or custodial care, child and parent identification, uniting with family
  - Unaccompanied children
Disaster Victim Treatment:

*Pediatric Surge Capacity Issues*

- With rare exceptions, most facilities and health care delivery systems are primarily designed, staffed and/or equipped for adults
  - HRSA – 500 adult & pediatric victims per 1 M population
  - Surge capacity, if plausible, will be adult oriented

- Question: How can you create **surge capacity** to provide care for large numbers of children?
  - Emergency care
  - Ambulatory care
  - In-hospital care
  - Tertiary or critical care
  - Post-recovery care
    - Solutions can be local and/or regional
The Harsh Reality of Terrorism:  
*Children As Unintended Victims*

- **Oklahoma City (1995)**
  - Bombing of Murrah Federal Building
    - 186 deaths (10% children), 900 injured
    - 31% of children vs. 21% of adults died

- **Tokyo (1995)**
  - Sarin gas release in subway
    - 12 deaths, 6000 injured
    - 16 pediatric victims

- **Bhopal (1984)**
  - Methyl isocyanate gas release
    - 3-5,000 deaths - 20% children
    - Injury estimates: 500,000?

- **Oregon (1984)**
  - Contamination of salad bar (salmonella)
    - 700 injured
    - > 20% pediatric victims
Harsher Reality: *Children As Targets*

Beslan massacre
September 2004
334 deaths
186 children

**Terrorism**: Violence, the threat of violence, or other harmful acts committed for political or ideological goals with a primary purpose of inducing fear
Disaster Recovery: Pediatric Issues

- Loss of loved ones
- Disruption of family
- Displacement from home
- Living with distressed adults
- Lack of educational structure
  - Loss of schools, teachers
- Poor physical environment
- Changes in the community
- Socialization to violence
  - Superdome experience, media
- Disruption of the medical home
Disaster Recovery: Family Care

- Families may be in ongoing physical danger, both from natural and/or human sources.
- Families may be evacuated either together or separately from different locations.
- Families may suffer psychological as well as physical stresses.

How Can We Help Children to Cope: Strategies to Promote Resiliency

- Maintain normalcy in family unit and the environment
  - Keep family/community together
  - Consider use of familiar shelter locales
    - School, daycare, worship settings
  - Maintain ‘normal’ activities if possible

- Avoidance of painful reminders
  - The media – limit exposure to graphic details

- Reassurance of safety

- Encourage them to express their feelings
  - Answer their questions – explain!

- Encourage families to seek help
  - Focus will be towards medical concerns
  - Many will fail to seek help for mental health issues
  - Role for primary and mental health care providers
  - Anticipate delayed and anniversary reactions
Step V: Educate, Practice, & Participate
Advocate for children and families in disaster planning at all levels

Become knowledgeable about issues related to pediatric disaster management

Participate in disaster planning:

- Office emergency readiness and an office disaster plan – develop & practice
- Take part in local community and hospital disaster planning, exercises, drills
- Work with local schools and child care facilities in developing their plans
- Provide anticipatory guidance to families on preparedness – esp. CSHCN
- Participate in disease surveillance and reporting activities
- Participate/provide guidance to local volunteer disaster response groups
Disaster Medical Assistance Teams

- Deployed by NDMS, FEMA & DHHS
- 50 teams nationally – locally sponsored
  - 35 care professionals (MDs, RNs, EMTs, etc.)
  - Ohio has 3 DMAT’s – someday a 4th??

- DMAT’s may have limited pediatric capabilities*
  - Volunteer experience/training
  - Equipment, medications & supplies
    - Teams respond with 72 hour supply
  - Training/drills
    - 1/3 did not include kids in drills
  - Two pediatric resource focused DMATs
    - Boston & Atlanta

Medical Reserve Corps

- Community-based units, a means to locally organize & utilize volunteers who want to donate their time and expertise to prepare for and respond to emergencies.

- MRC volunteers supplement existing emergency and public health resources.
  - Volunteers include medical and public health professionals: physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists.
  - Many community members—interpreters, chaplains, office workers, legal advisors, and others—can fill key support positions.
  - MRC volunteers can also choose to support communities in need nationwide.
  - **Ohio has 82 registered MRCs**

  Mr. David O'Reilly  
  Ohio MRC Co-Coordinator, Database Administrator  
  Ohio Community Service Council  
  E-mail: david.oreilly@ocsc.state.oh.us

http://www.medicalreservecorps.gov/HomePage
AAP Disaster Preparedness Advisory Council

- Gary Peck, MD, FAAP, Chairperson
- Steven Krug, MD, FAAP
- Scott Needle, MD, FAAP
- Michael Shannon, MD, MPH, FAAP
- David Schonfeld, MD, FAAP
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    Office of Health Affairs
  - Richard E. Besser, MD, FAAP
    Centers for Disease Control and Prevention
    Coordinating Office for Terrorism Preparedness and Emergency Response
  - David Marcozzi, MD, FACEP
    US Department of Health and Human Services
    Office of the Assistant Secretary for Preparedness and Response

- Laura Aird – AAP Staff
AAP DPAC Objectives

- Pediatricians and pediatric office practices are prepared to assist children and families, and communities with disaster planning.

- Children’s needs are fully integrated and exercised in Federal, State and local plans for all hazards/emergencies having public health impact.

- The AAP has an on-going mechanism to implement disaster preparedness initiatives, respond to requests for pediatric expertise on disaster readiness, and integrate these resources with relevant internal and external activities.
AAP DPAC Activities

- Development of AAP strategic plan
- AAP Children and Disasters website
- Interface with elected officials & federal agencies
  - FEMA, HHS ASPR, DHS, CDC, others
  - Congressional testimony
- Review & comment on federal proposals (e.g. NRF)
- Interface with professional and lay organizations
- Appointments/representation at meetings
- Publications, presentations & related resources
- Advocacy!
Disaster Planning Resources for Pediatricians
  • S. Needle: A Disaster Preparedness Plan for Pediatricians

Information on Biological, Chemical, Nuclear & Thermo/Mechanical Agents

Psychosocial Aspects/Mental Health

Public Policy

Resources for Families

Numerous Links
  • Pediatric Terrorism and Disaster Preparedness: A Resource for Pediatricians  http://www.ahrq.gov/research/pedprep/resource.htm
A disaster preparedness plan for pediatricians

By
Scott Needle, MD, FAAP
Pediatric Private Practice After Hurricane Katrina: Proposal for Recovery

Scott Needle, MD, FAAP

Special Article
Pediatrics 2008; 122(4):836-42

- Explores the factors that threatened the survival of pediatric practices in the aftermath of Hurricane Katrina and offers a series of proposals intended to provide stability and foster recovery to health care in the region affected by a disaster.

  • Recognize the importance of the primary care physician and the medical home in the delivery of post-disaster care

  • Funding, funding funding………..
National Commission on Children and Disasters

Created by the Kids in Disasters Well-being, Safety and Health (WISH) Act of 2007, authorized under the Consolidated Appropriations Act of 2008

- Conduct a comprehensive study that examines and assesses children's needs as they relate to preparation for, response to, and recovery from all hazards, including major disasters and emergencies.
- Identify, review and evaluate existing laws, regulations, policies and programs relevant to such needs.
- Identify, review and evaluate the lessons learned from past disasters relative to addressing such needs.
- Report to the President and Congress on its findings & recommendations to address such needs, including the need for a national resource center on children and disasters, coordination of resources and services, administrative actions, policies, regulations and legislative changes.

The Commission is compromised of 10 members

- Michael Anderson – Cleveland, OH
- Irwin Redliner – New York, NY
- David Schoenfeld – Cincinnati, OH
Ohio EMSC Products & Resources

- Emergency Guidelines for Schools
- Office Preparedness for Primary Care Physicians Course
- First Aid for Child Day Care Personnel Course
- Ohio Emergency Medical Services Pediatric Care Guidelines and Procedures Manual
- SCOPE – Special Children Outreach and Prehospital Education
- EMT’s and Injury Prevention: Advocates for Children
- Pediatric Disaster Preparedness Links

Ohio EMSC Program – Ohio Department of Public Safety/Division of EMS
Available at: http://www.ems.ohio.gov/EMSC%20web%20site_11_04/emschome.htm