State Level Pediatric Emergency Preparedness

Webinar Hosted by the Centers for Disease Control and Prevention

Host: Loretta Jackson Brown

Moderator: Dr. Georgina Peacock

Presenters: Dr. David Schonfeld, Dr. Joseph Wright, and Dr. Karen Remley

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Operator
Welcome. To ask your questions over the phone press star one. Today's conference call is being recorded, if you have any objections, you may disconnect your line at this time. I would now like to turn the conference over to your host, Miss Loretta Jackson Brown. Ma'am, you may begin.

Loretta Jackson-Brown
Thank you, Lori. Good afternoon, I'm Loretta Jackson Brown and I'm representing the clinician outreach and communication activity, COCA, with the emergency risk communications branch at the Centers of Disease Control and Prevention. I'm delighted to welcome you to today's COCA conference call, "State Level Pediatric Emergency Preparedness". We are pleased to have three subject matter experts here to discuss gaps in pediatric preparedness and review national recommendations aimed at improving pediatric emergency preparedness at the state level. During today's call, you may participate by audio only, via webinar, or you may download the slides if you're unable to access the webinar. The PowerPoint slide set and the webinar link can be found on our Web page at emergency.cdc.gov/COCA, click on "Conference Call." The webinar link and slide set can be found under the call-in number and the call passcode. Here to provide an end user introduction to navigating today's webinar is Miss Callie Campbell. (00:01:23)

Callie Campbell
Hi, my name is Callie, and I'm going to walk everyone through the procedures and tools available in this webinar. If you have a question for one of the presenters, you may use the Q&A button located at the top left portion of your screen. Type in your question and then hit enter to send the question to the presenters. If you're addressing a specific presenter, please state that in your question. Presenters will read selected questions out loud to the group. At the top right hand side of your screen, you'll see several tools available to you. The feedback tool has a colored square next to it. If you select the dropdown arrow next to the feedback, you can alert me if you are having trouble hearing or need help, you can also let the presenter know if you need them to slow down. This meeting is being recorded. If you have technical difficulties at any time during this presentation, you may call our technical support line at 1-877-283-7062. Thank you all for coming. Loretta Jackson-Brown is your host, and she will be taking over the presentation from here. (00:02:25)

Loretta Jackson-Brown
Thank you, Callie. At the conclusion of today's session, the participant will be able to identify gaps in pediatric emergency preparedness, describe the national recommendation to improve pediatric preparedness, discuss the importance of developing public health preparedness specific to improving pediatric emergency preparedness, and identify pediatric emergency preparedness strategies that can be implemented at the state level. Following the presentation, you will have an opportunity to ask our presenters questions on the phone by dialing star one to put you into the queue, and as Callie said, you may submit questions via the webinar. In compliance with continuing education requirements, all presenters must disclose any financial or other associations with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters, as well as any use of an unlabeled product or products under investigational use. CDC and planners and presenters for this presentation do not have financial or other association with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. This presentation does not involve the unlabeled use of a product or products under investigational use. There was no commercial support for this activity. Our moderator for this webinar is Dr. Georgina Peacock. Dr. Peacock is a developmental behavioral pediatrician and medical officer in the National Center on Birth Defects and Development Disabilities at Centers of Disease Control and

Prevention. Again, the PowerPoint slide set and the webinar links are available from our COCA website at emergency.cdc.gov/COCA. At this time, please welcome today's COCA call moderator, Dr. Peacock. (00:04:32)

Dr. Georgina Peacock
Hi, thank you, Loretta. As she said, I'm Dr. Georgina Peacock; I'm a developmental pediatrician in the CDC's National Center on Birth Defects and Development Disabilities and work on children's preparedness and response issues here at the CDC. In order to get us to our speakers, I'm going to give you some brief bios on all three of the speakers and then I will turn it over to our first speaker. Our first speaker is Dr. David Schonfeld; he's a developmental behavioral pediatrician and the Thelma and Jack Rubenstein Professor of Pediatrics and the director of the division of developmental behavioral pediatrics at Cincinnati Children's Hospital Medical Center. He's also the director of the National Center on School Crisis and Bereavement in Cincinnati. He is a member of the National Commission on Children and Disasters, the Disaster Mental Health Subcommittee of National Biodefense Science Board Federal Advisory Committee and the American Academy of Pediatrics Disaster Preparedness Advisory Council. Our second speaker is Dr. Joseph Wright; he is senior vice president and head of the Child Health Advocacy Institute, which is a newly established center of excellence at the Children's National Medical Center in Washington, D.C. In that capacity, Dr. Wright provides strategic leadership for the organization's advocacy mission, public policy positions, and community partnership initiatives. Dr. Wright also provides leadership regionally as EMS Medical Director for Pediatrics within the Maryland Institute for Emergency Medical Services Systems and nationally, he is the principal investigator of the federally-funded EMS for the Children's National Resource Center. Finally, our last speaker will be Dr. Karen Remley, who is the state health commissioner for the Virginia Department of Health. As state commissioner for health, Dr. Remley is responsible for managing the operations of the Virginia Department of Health, coordinating the department's emergency preparedness response efforts, and providing leadership for the commonwealth public health system in order to protect and promote the health for all Virginians. So at this time, I will turn the call over to Dr. Schonfeld. Thank you. (00:06:54)

Dr. David Schonfeld
Good afternoon, I'm here to talk about how we can best meet the unique needs of children in disasters. And I'm going to talk first about the national perspective and then turn to a state perspective with some specific guidelines of what you can each be doing in your own states. As we know, children are about 25 percent of the general population in our country. But, unfortunately, disaster training, exercises, medicines, and equipment are generally intended for able-bodied adults. This happened quite naturally, because they were first being studied as potential liabilities in times of war, so the initial research was done to protect the military. As a result, more study was done with adults and not with children. A typical example might be medical countermeasures for nerve agents. They were developed for adults, but are not yet approved in the appropriate formats for use with children, placing them at extreme risk if they were exposed to any nerve agents. What has happened in our country is that children have been placed into very broad categories of at risk, vulnerable, or special needs populations. And while that does underscore that they have special needs and they are at risk, they have tended to get lost within that large group, which has so many needs that seem very overwhelming and as a result, children's needs are often not addressed. And if they are addressed, they're in annexes or addendums to disaster plans. But, all too often, they're really not addressed at all. So it really isn't surprising there were shortfalls met in—noted—in meeting children's needs that were apparent in recent disaster, whether that be H1N1, American Samoa, and Haiti. So the commission was formed and its goal was to assess the needs of children related to preparedness, response and recovery from all hazards and all emergencies as it relates to disasters and then to report gaps and recommendations to the president and Congress. (00:09:02)

This slide outlines some of the milestones of the commission. It was the first public meeting was held on October 14th, 2008, and public meetings were then held on a quarterly basis from that point going forward. One year later, on October 14th, 2009, an interim report was delivered to President Obama and the Congress outlining some of the initial recommendations and then on October 14, 2010, the next report, the 2010 report, was delivered to the president and Congress. And then, just two weeks ago on April 4th, 2011, the authorization expired for the commission. In terms of additional background on the commission, what's important to know is it was an independent commission. It was authorized by Congress under federal law and not tied to any agency. This allowed the commission to look broadly throughout the federal and national response to come up with recommendations and not to be constrained by being associated with any one agency or organization. It is also bipartisan and the ten members were appointed by the president and the senate and the house leaders. And it's a diverse group. The expertise was drawn from several different disciplines, including pediatrics, state and local emergency management, non-governmental organizations, as well as state elected office. This slide shows you the cover of the 2010 report and there will be links at the end to give you information about how you can read the full report. I'm only going to be highlighting certain parts of it in this presentation. Let me start out with kind of the broad national strategy for children in disasters. And we felt that at all levels of

government, we really need to integrate children across all phases of disasters. In order to make sure the needs of children are well attended to, we recommended that you designate a permanent focal point for coordinating children's needs. So you might consider a children's working group at the state level, for example, to be able to replicate this focus. There now is a children's working group in FEMA, at HHS, and most recently one established at the White House. So having a children's working group around children and disasters at the state level would mirror that format. We want to make sure that we encourage relationship building and cooperation prior to disasters. (00:11:36) It's very hard to form that in the aftermath of a disaster. This should happen at all levels of the government, but including at the state level, and to build on existing capabilities and requirements. We also thought, within the commission, it's important to require accountability. We need to institute goals and progress monitoring measures so that we ensure that we don't continue with benign neglect, or what more often happens is the assumption that someone else is looking out for children's needs, and then we turn around and discover that actually no one has, and that's one of the findings of the commission that we really do need to attend to it. And there's been some progress at the federal level for doing that and that needs to be replicated at the state levels. We also want to stress that everyone has a role. That includes the federal government, state governments, local governments, and tribal governments. And I do want to say that we need to include coordination with tribal government to ensure integration with the tribal and Indian health system. Now, the focus of my presentation is really on the role of states. But throughout my presentation, please keep in mind that this requires integration and collaboration with the tribal and Indian health system. We also need to include nonprofits, the private sector, parents, and when possible as well, even children in their own response.

The first section I'm going to turn to has to do with the child's physical health and trauma. We want to ensure the availability and access to pediatric medical countermeasures at federal, state, and local level. One step is to provide—one recommendation— is to provide funding and guidance to the development, acquisition, and stockpiling of medical countermeasures for children and the strategic national stockpile. But there are examples that are also going to be relevant to state-level implementation. I already mentioned some of the issues around the strategic national stockpile and the need for drug development and approval when I talked about medical countermeasures and gave the example of nerve agents. But one that's particularly relevant to states, and may be of high interest right now, has to do with the availability of liquid potassium iodine in the event of a nuclear reactor disaster. And so we're seeing that kind of play out in Japan for example. One of the things that people may not realize is that it was only fairly recently that there was the availability of a liquid preparation of potassium iodine that would allow dosing for young children. That has been stockpiled in the strategic national stockpile. (00:14:09)

But to be quite honest, as of fairly recently, it was slated to expire within the next couple of years and the decision had been made not to replenish the liquid potassium iodine. And so many states do not have any liquid potassium iodine and that needs to be given within several hours of the disaster. So it really needs to be stockpiled and maintained in states and in local areas at highest risk. The second recommendation had to do with the need to amend the emergency use authorization to allow authorization of pediatric indications for medical countermeasures before an emergency occurs and even before it is felt to be imminent. The way it works with the current EUA process is there has to be a decision very high up that there is an imminent risk to allow medical countermeasures to be authorized, even if they have not yet been approved by the FDA for that purpose. But in many situations that will not give enough time for the medical countermeasures to be available for use with children if they have not been tested or evaluated fully or adequately in order to get FDA approval. So we really think there needs to be some process that allows us to use medical countermeasures for children before it goes through a formal approval process and before the EUA process can kick in. Because we know that many medications, if not most medications, in children are often— are currently—being used off label even outside of a disaster. So in a disaster situation we need to consider that for children. We also recommended that they create an advisory board to advise the HHS secretary on pediatric medical countermeasures, and increase pediatric representation within BARDA and establish a pediatric and a obstetric working group to conduct gap analyses and make research recommendations with the goal of making sure we have parity, at least parity, in the medical countermeasures so that children are well covered. We also talked about the need to expand the medical capabilities of all federally-funded response teams through the comprehensive integration of pediatric-specific training, guidance, exercises, supplies, and personnel. So that any team that responds to a disaster is prepared to meet the needs of children that they will encounter. We also need to ensure that all healthcare professionals who may treat children during an emergency have adequate pediatric disaster clinical training. (00:16:39)

I want to underscore that during a disaster, children and adults will be expected to present to both adult and pediatric facilities. Parents are not going to drop their children off at children's hospitals and then go to adult care facilities for their own care in the middle of a disaster, when they may need their care. They may present to a children's hospital or they may bring children with them to adult care facilities. Everyone at those two different sites needs to be prepared to meet

the needs of children. We also need to fund a formal, regionalized, pediatric system of care for disasters. We also recommended that we prioritize the recovery of pediatric health and mental healthcare delivery systems in disaster-affected areas. We need to make sure that the healthcare systems are able to get up online immediately after a disaster to meet the needs of the population. And Congress should establish sufficient funding mechanisms to support both restoration and continuity of these systems. This is a challenge, particularly for those healthcare systems which are for-profit and are not covered under the usual mechanisms for helping to rebuild after a disaster. We also felt that we should create Medicaid and children's health insurance program incentive payments for providers in disaster areas and the AMA should adopt a new code or modifier to the CPT for disaster medical care to enhance reimbursement of providers who are providing care. And we are—there's already been some effort to create the CPT modifier, and it's in the review process at this point. Let me turn now to emergency medical systems and pediatric transport. We need to improve the capability of emergency medical systems to transport pediatric patients and provide comprehensive pre-hospital pediatric care and feel that the states need to meet the performance targets of the emergency medical system for children program or EMSC program., Basic life support and advanced life support vehicles need to be equipped with recommended pediatric equipment and supplies. (00:18:51)

I'll also say that the pediatric transport capability at the federal level is limited when compared to the transport capability of adults. Because again, some of it uses military equipment to be able to transport adults after a disaster, but they are not necessarily staffed, or even built, to transport children, and that's an issue if we do need to transport large numbers. Okay, we turn now to mental and behavioral health, and felt we need to integrate mental and behavioral health for children into public health and medical emergency plans and activities. And also enhance the pediatric disaster mental and behavioral health training for a wide group of professionals and paraprofessionals. As a result of limited access to formal mental health services and treatment following a disaster, and the stigma associated with seeking mental health treatment even outside of a disaster, it's highly likely that communities are going to need to rely upon non-mental health professionals who, nonetheless, routinely interact with children and can provide support, such as teachers and other school staff, pediatric healthcare professionals, child care providers, child welfare and juvenile justice staff, and members of the faith-based community, just to name a few representative groups. And these professionals and paraprofessionals are in an excellent position to provide basic support services, brief interventions, and to conduct identification and referral of children in need of additional services. And the needs that the population has are often quite long term. One disaster generally initiates a cascade of losses and stressors that will require their own support. It may lead to a cumulative need for support far longer that federal support is made available. I think one only needs to look at the Gulf Coast to see that—whether it's one flood or another disaster—causes financial ramifications, leads to people losing their jobs and mental health problems increasing among members of the community. (00:20:58)

All of these cause additional mental and behavioral health risk factors for children. We also felt that it was important to enhance the research agenda for children's disaster, mental, and behavioral health and there's some effort moving forward to look at the current portfolio at the federal level. The last point on this slide was to establish a funding mechanism to support disaster-related mental health treatment for children. We need to modify the current crisis counseling assistance and training program model to provide greater utilization of mental health professionals with counseling skills after large scale disasters, and need to work out a system, a single flexible grant funding program, to support mental health treatment in the aftermath of disaster. Let me turn now to education recommendations, and this would be within schools. We need to improve the preparedness of schools and school districts by providing additional support to states, and unfortunately that is going to be difficult to do in the current financial environment at the federal level, which means, again, more will likely turn to the states to make sure that this happens. We have to enhance the ability of school personnel to support children recovering from disaster and ensure that recovering school systems are provided immediate resources so that they can reopen and restore the learning environments in a timely manner. Because it is unlikely parents will be able to get back to work and rebuild their homes and do that in a safe way if children are not back in schools and in child care. The next slide addresses some of the recommendations related to shelter operations. We need to be sure we can provide a safe and secure mass-care shelter environment for children, including access to essential services and supplies. There are some national standards and indicators for mass care emergency shelters, adopted by FEMA and the American Red Cross, and they need to be incorporated into shelter assessment tools. There are certain examples you'll see there of some of the recommendations, such as ensuring the children are sheltered together with their families or caregivers, but that there is a designated area for families away from the general population and there is temporary respite care for children so that parents can start to rebuild their homes and rebuild their careers as well. There's also some recommendations regarding having a shelter supply list for infants and toddlers that identifies such things as basic supplies necessary to sustain and support; we used ten infants and children less than four years of age for a 24-hour period. And this example are some of the things on the shelter supply list are formula, baby food,

diapers, feeding bottles, cribs, and portable playpens. So to make sure that when the shelters open, they are ready to receive and care for children. (00:23:49)

The next set of recommendations relate to evacuation and tracking. State and local emergency plans should include contracts with private entities to provide assistance in times of emergencies to ensure the evacuation and transport needs of children, including those with disabilities and special healthcare needs. There needs to also be an evacuee and patient tracking system that would include data relevant to identifying children, such as their name, name of parent or guardian, age, eye and hair color, medical needs, etc. And the last thing on this slide, in emergencies, Health and Human Services must have the legal and the technological capabilities to share information among themselves and with other agencies in a timely manner. We need to figure out how to balance privacy regulations with practical considerations regarding information sharing in the context of disaster. So often agencies are reluctant to share information because of privacy regulations and as a result they end up with very confidential information being shared outside of the system. One needs to only have walked through New York City in the first month after 9/11 and seen the posting of information and photos of very private information all over every surface that could be found. This was because there was the absence of a better system for sharing that information. So we have to figure out how it can be shared and get the regulations in place and the technology. We also need to figure out how to address the interfaces among child welfare education and juvenile justice. So information becomes really important after a disaster and we need to figure out how to share that and that will need to occur at a state level, is another area of concern. The next area had to do with childcare disaster preparedness and requiring disaster planning capabilities for childcare providers and the need to improve the capacity to provide child care service in the immediate aftermath of and recovery from a disaster. FEMA did, with some of our involvement, clarify that they will reimburse state and local governments and private nonprofit organizations for childcare provided in shelters and stand-alone facilities during the emergency sheltering period with eligible childcare sheltering costs including such things as labor, facility supplies, and commodities. HHS is collaborating with FEMA to provide guidance for developing comprehensive statewide childcare disaster plans and Save the Children and the National Association for Childcare Resource and Referral Agencies were developing guidance for childcare providers. The next slide talks about the need for disaster case management and states should develop a case management that's appropriately resourced to provide consistent holistic services that achieve tangible positive outcomes for children and families. (00:26:49)

We need to make sure that disaster case management is holistic. It is important that adults have money, a job, and a place to live; but children need more than that. They may need referral for mental health services, support to get back into school. And I think the current model that ACFS has developed does understand this, but, again, this was something the commission had worked on and ACFS recently implemented. (00:27:18)

Let me kind of end this by talking about some suggested child focus checklists for states on the next three and a half slides, I'll go over this quickly. The first is to make sure that we include the needs of children in disaster training exercises and in our after action reports. I won't mention which state it was in, but one of the states I was located in had been planning one of the national level exercises. When I asked about which—and this is some years ago—when I asked about the use of children within the exercise, I was told they were going to focus on adults because it was too difficult to plan for the needs of children. In this scenario they had actually planned on a mass casualty event involving a bus. This was at 9:00 in the morning and yet, there were no children in the bus. They had in the scenario only adults in the bus. And that is somewhat contrived because at 9:00 a.m. most buses are filled with school children. So we really need to push our states to make sure that they are looking at the needs of children and that they are testing that. As I mentioned, we recommend that you establish an advisory board such as a governor's cabinet on children and disasters or children's working groups, designate staff in the governor's office and state agencies to focus on children's needs. And then direct federal preparedness grants to support the needs of children. We also need to include child serving systems such has schools, child care, child welfare, juvenile justice, and mental health in state disaster planning. This is not simply that disaster planners need to inform these agencies, but they also need to think about them as a resource and it's bidirectional. These youth serving groups bring tremendous resources to meet the needs of children. For example, school systems may have the most buildings that can be used after a disaster. They often have the transportation system to move children around in school buses. They provide food service. I don't know if most people realize that at ground zero after 9/11, the food service prepared for the relief workers was from the New York City public school system cafeteria services. Schools also bring personnel, often with unique skills. In some school systems they are highly skilled in translation services for example and they bring a lot of expertise and knowledge about how to access and support children. (00:29:51)

I was working with one state, one city I should say, on disaster preparedness for children. We were doing a live exercise. It was quite involved and occurring on the campus of a school system, and in the scenario one of the staff, a custodial staff, becomes overwhelmed by some fumes, staggers out the door, and the building locks behind him. And we had, in the scenario, the children evacuated through the exit. The first responders arrived and started a decontamination procedure

and felt that they needed to get back into the billing to make sure no children were trapped but they did not know how to get back into the building because the door was locked. And it was a metal door and it was very secure. So, after a time period had passed I asked them what they were going to do and they said well we're going to the fire department and getting the Jaws of Life and cut open the door. And I actually – and I looked at them and I said well, won't that take a long time? Well, you know, we can cut through the metal doors; it cuts through everything. I said well, that's one approach. The other approach is if you saw the woman you just pushed out of the way, so that you could respond, that's actually the principal and she has a key to the door. You might want to ask her for it. And, you know they looked at me and kind of were surprised and said we hadn't thought of that. I think that's a very basic example of what they should be thinking about that, not just how to get into the building, how to access the children, how to provide the support to the children, how to know what the children need and how to meet it. So, schools and juvenile justice and child welfare and mental health, they have a lot of capacity and they need to be part of the planning process. (00:31:34)

We also need to establish disaster planning standards for child serving systems including evacuation, family reunification, accommodating the needs of children with special needs in collaboration with emergency management as I had alluded to. At the state level we also need to be sure that there's the capability of emergency personnel to transport children and provide effective prehospital pediatric care as well as ensuring the capability of hospital emergency departments whether those be in children's hospitals, or adult hospitals, to provide effective care for children. We also want to make sure that we provide basic psychological first aid training for emergency personnel to assist children, as well as training for professionals that work with children and can support their recovery such as school personnel. We also want to ensure there's access to medical counter measures for children as well as an effective plan to distribute these counter measures. Strategic national stockpile is important but it is a national asset and it cannot be accessed within minutes or within a couple hours of a disaster. So the first response is going to be at the local and the state level. (00:32:44)

We also need to make sure that there are disaster preparedness plans for state childcare administrators, including plans for standing up emergency childcare. And again that needs to be developed with emergency management office. We need to include child tracking and family reunification procedures in the emergency plan, and provide safe shelter environments for children and families including access to essential age-appropriate supplies. And identify resources within and outside the state to address the surge in the needs for children. And this will be especially, but not only, in health and mental health needs, to think through how we will meet the surge that we can anticipate after a disaster. And then, turning to long-term disaster recovery, the plan needs to involve children and families. It needs to include family appropriate housing, school, childcare, mental health, medical care, child welfare, juvenile justice and court facilities. The plan for long-term recovery is really much more than restoration of physical infrastructure and currently our long-term recovery planning is quite limited in the United States and at some state levels as well, but needs to be a priority. (00:33:59)

I'm going to end by saying there are some reference materials that you'll find in the 2010 report. There are several appendices that show model executive orders for how one could create some of this infrastructure at the state level and talks about the role of state and local governments as well as standards and indicators for disaster shelter care and for mass care sheltering. The last slide really just delivers some of the commission's overarching messages. I think those of us in pediatrics say often, and hear often, that children are not simply small adults. Although, I will say that adults, especially in disasters, often act more like big kids. So, if anything we should be planning for children and will meet the needs of more of the population. But clearly, if we just attend to the needs of adults we will overlook the needs of children. (00:34:56)

Children are, in our opinion, the center of family and community. It is what we should be working to preserve in a disaster. Disasters are especially disruptive to children and their families. Children need to be viewed as assets and not liabilities in disasters and we need to figure out, not just how we are going to deal with them but really how we protect them. Another take home message was that recovery is a lot more than rebuilding infrastructure. We need to place more attention in that area. And lastly, that disaster planning is shared responsibility. Planning and response requires substantial state and local involvement. It isn't solely or predominantly a federal effort. Those who wish more information on the report can contact either the commission's executive director at the address you'll see on the slide or at the commission website. And I'll just end by thanking you for your commitment to children. And turn this over to the next speaker. (00:35:54)

Dr. Joseph Wright

Okay, good afternoon everyone. Again, my name is Joseph Wright. I'm a pediatric emergency medicine physician at Children's National Medical Center in Washington, D.C. and, also I'm principal investigator of the emergency medical services for Children's National Resource Center. And what we—have nothing to disclose. And, what I intend to cover in the next 10 to 12 minutes, I'll pick up the pace a bit here, is to really describe the emergency medical services for children's program and the major programmatic accomplishments of this federal program and then also, talk specifically

about the EMSE performance measures against which states are benchmarked on their readiness to care for children in an emergency. (00:36:52)

We'll start with the programmatic overview. The EMSC program mission is fairly straightforward. It's really to ensure there are state of the art emergency care available for ill or injured children and adolescents and that those services are well integrated into the existing EMS system and backed up by optimal resources and then, more specifically, that the entire spectrum of emergency services as we see it through a pediatric lens, including prevention and return to community, are incorporated into the EMSC program. If I could just highlight the continuum of care model that is part and parcel of the care delivery through the EMSC program, where we focus on prevention, bystander care, prehospital care, transport, either 911 transport, transport or intra-facility transport, treatment at the definitive care level, rehabilitation and then return to community and secondary or postvention as we term it. (00:38:10)

Let's talk just a little bit about the history of the program. The program is now in its 27th year. Original sponsorship by Senator Daniel Inouye, there you see pictured, senior senator from Hawaii, who partnered with Dr. Calvin C. J. Sia, a pediatrician who was president of the Hawaiian Pediatric Society and they were the driving force behind the launch of the program. Its authorizing legislation was enacted in 1984. The program has been reauthorized six times, most recently as part of the Patient Protection and Affordable Care Act. And, if I can just share with you very quickly the language that is part of the healthcare reform act that speaks about the EMSC program. There you see bulleted that the authorization has been extended to four years with an optional fifth. There you see the funding recommendation. Remember, this is authorization and not appropriation. And, important in that quote in the third bullet, strive to enhance pediatric capability of emergency medical service systems originally designed for primarily for adults. This speaks to the point that Dr. Schonfeld made in his presentation, that many of the systems are, emergency care systems are primarily oriented towards adults and this reauthorizing language, the additional caveat that the systems originally designed for, primarily for adults need to be adapted for the need of children is an important addition. (00:39:53)

So, just a little more about the program background. The funding stream comes through the Department of Health and Human Services, the Health Resources and Services Administration and the Maternal and Child Health Bureau. The original appropriation, back in 1985 you see there, and in the FY11 president's budget. The program is held flat at $21.5 million dollars. There are 80 grantees funded across four categories of the EMSC program. There are two Technical Assistance Centers, one of which I lead here in Washington. And there is a research network, the Network Development and Demonstration Project, also known as the PECARN, Pediatric Emergency Care Applied Research Network, which funds five regional Note Centers expanding to seven with the next funding cycle, which conduct network, multi-center research across the country and has been a very successful network over the last decade in advancing some of the very vexing questions that we've had in pediatric emergency care over the years. There are 18 Targeted Issue Grants which are focused on special projects of regional and national importance. This is a feeding ground, if you will, for some of the pilot work that can feed into the PECARN network and there's a very important place for young investigators to get their feet wet with emergency care research. And what I'll be focusing on here today are the State Partnership Grants. Forty nine of the fifty states, the District of Columbia, and five U.S. territories hold state partnership grants from the EMSC program. These grants are largely held in Departments of Health or Departments of Public Health, to a lesser extent in EMS agencies at the state level and a very small number are managed out of academic medical centers in their respective states. (00:42:08)

Just a word, again, about the Targeted Issue Grants. Dr. Schonfeld mentioned the importance of prehospital readiness, and there are two currently funded projects in the targeted issues category that are focused on prehospital care. You see them here. The first one is Integrating Evidence Based Protocols into Practice in the prehospital arena. That is being led by a junior investigator out of Texas Children's Hospital, Dr. Manish Shah, and also focused on, another project focused on Refining Pediatric Triage Algorithms and education in the prehospital setting. That work is being led by Mark Cicero out of Yale. So, this is a quote here from the Future of Emergency Care in the United States health systems. The Institute of Medicine conducted this in 2006. You see here, this will be, not a surprise to, I think, most of the audience on the call, that if there is one word to describe pediatric emergency care, it is uneven. It depends on where you are and what services are available with regard to the care that is delivered. (00:43:28)

So let's talk a little bit about state performance measures, what is going on with the EMSC program at the state level. Well, the EMSC performance measures are no different than any of the federally supported programmatic and research programs that must comply with the Government Performance Results Act (GPRA), where the ability to measure the impact of these programs on the public must meet performance measures. So let me share with you a sample. Arkansas is a state that I most recently visited and I'll just share with you a bit of a report card of where they are in leading the state partnership performance measures as a way of demonstrating what we're trying to address. So, performance measure number 71 speaks to the ability for agencies in the state or territory to have online pediatric medical direction available, the ability for a provider in the prehospital region to reach a pediatric emergency specialist to provide online medical

direction. Performance measure number 72 speaks to offline medical direction activities. Those activities would include protocol development as a way to support the state or territory with regards to their readiness to care for children in the prehospital arena. Performance measure number 73 speaks to the availability of essential equipment and supplies on board ambulances; 74 speaks -- and 75 speaks to a regionalized or standardized system that allows for management of pediatric emergencies either in a medical context or in a trauma context. We'll speak a little bit more about performance measures 74 and 75 in a moment. So just to finish out the report card that all of the states are complying with, the performance measures 76 and 77 speak to the readiness for intrafacility transfer. I mentioned that part of the continuum of care and moving children around regionalized systems of care requires the ability to transport efficiently and effectively and the ability to do that is predicated on preexisting intrafacility transfer guidelines and preexisting intrafacility transfer agreements. (00:46:06)

The next performance measure speaks to education and requirements by the state or territory to have their personnel updated in pediatric emergency education for licensor purposes. And then the last two performance measures talk about the permanence of EMSC at a state or territory level and speaks about permanence from an organizational standpoint, meaning the existence of an EMSC advisory committee and incorporating pediatric issues into the existing EMS structure in the state and then lastly, permanence through regulatory or statutory mechanisms and this is where legislation and legislative advocacy becomes important. Just an additional word about performance number 80, again the degree to which the state has developed permanence through statute or regulation. This one gives me personally the most angst in terms of doing this because it requires having everybody onboard and everybody buying into the programmatic goals of the EMSC program, both at the national level and at the state level and building those into the policy makers and decision makers at the state level, in terms of building legislation or regulation. (00:47:35)

So let's talk a little bit about what the care system, emergency care system for children in our country looks like. This is information that has been codified by Maryann Gausche-Hill; you see the reference there, that the overwhelming majority of children in the United States are seen at non-children's hospitals. And, in terms of injured children only 2 to 3% are initially treated at a pediatric trauma center, again, speaking to the critical importance of intrafacility transport. Fully 75% of emergency departments in the United States see less than 20 children per day, and 50% see less than 10 kids per day. And when we talk about regionalization, I've used that term a couple of times, let me define it for you very quickly. A regionalized system is one that is geographically organized such that services are provided that ensure access to care at a level appropriate to the patient needs, while maintaining efficient use of the available resources. Now, why is this so important in terms of children? Well you see here in this graphic that is from the Institute of Medicine report that the children's hospital, the pediatric tertiary care especially center, down in the lower right hand corner of the graphic, is responsible for an area that comprises two different counties. This is not at all unusual with regard to our pediatric tertiary care centers, and may receive patients directly from the scene, may receive patients from, by secondary transport from a community hospital and all throughout this graphic is the ability to properly triage, properly recognize, what is going on with a child, that there seems that appropriate triage decisions can be made. And, some states have moved forward with trying to evaluate the impact of a statewide system of regionalization and categorization for readiness to provide pediatric care. Illinois is one such state. I'm showing here on this slide the recently published manuscript, from August 2009, in *Pediatrics*, that describes the Illinois model program which is a voluntary model for all the emergency departments in the state to categorize themselves with regard to readiness to care for children. I will share with you one slide here from the Illinois emergency medical services for children program which looked at the pre- and post- impact of the emergency department appropriate for pediatrics model. And, in this case looking at injury rates and in the bars to the right there, the purplish bars, you see a representation of a decline in injury mortality, post implementation of this system in Illinois. Also, we're very interested in the impact of the EDAP model, Emergency Department Approved for Pediatrics on medical emergencies. The data I showed you from the Illinois study looked at injury, traumatic, rates of traumatic injury. And one project that I'd like to share with you that also has been recently published in *Pediatrics*, was initially an EMSC Target Issue Grant. And, you see that represented here, on this slide, and the manuscript was also published last year in *Pediatrics*, speaks to the implementation of advanced life support interventions and how the ability for community hospitals to adequately provide these interventions is related to decreased morbidity and mortality when we're talking about non-traumatic shock. So, in other words, medically related shock as opposed to traumatic shock. And this is an important study, it is one of the first opportunities that we have had to look at a regionalized system of care, population based system of care, where attention to a model of categorization predicated on the ability of a hospital to provide interventions for children has been critically examined. So the hot topics in emergency medical services for children, I think you need to be aware of, is regionalization piece. We have evidence that injured children, performance of a regionalized system for injured children, exclusive system where children are triaged to specific centers, children do better, particularly for isolated head injury and for younger children in that kind of system. Also for categorization, specifically focused on state performance measure 74, the percent of hospitals that are recognized through a standardized system that stabilize and manage medical emergencies. I shared with you a couple of recent studies that

speak to this issue, and then finally readiness. I shared with you that the overwhelming majority of children are seen in non-children's hospitals in general emergency departments. And it speaks to the need for commitment to a floor of pediatric readiness upon which capability training and preparedness can be built. (00:53:28)

I want to show you this tool. This is a tool which has been derived from the American Academy of Pediatrics (AEP), the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) joint policy statement on Guidelines for Care of Children in the Emergency Department. This, you see the URL there at the bottom of the slide to access this tool. This is a tool that literally can be used as a checklist against which preparedness or readiness in a given emergency department can be ascertained. (00:54:05)

So with that, I'll be happy to answer questions at the end of the webinar. Appreciate your attention. Thank you. (00:54:13)

Dr. Karen Remley

Hi, this is Karen Remley. And as I'm going to get close to the end of the slide presentation time , wanted to first—let you all know that I'm been a pediatric emergency physician since 1983. And so, it's interesting for me to hear everything everybody said because I was part of the process of building this all up and being involved in some of the first issues that came forward, having worked in emergency medicinesince it's been in position. So that was a unique position to come into being the Commissioner of Health, which makes me a little different. And we were asked to speak specifically about what we do in the pediatric community around H1N1, which really was an incredibly collaborative effort. I'm going to scroll through these slides pretty darn quickly and hope that I don't give anybody a headache. I think everybody knows what the pillars were around H1N1. We added Direct Medical Care and Surge because we realized that was a very important component for us to focus on. Very specifically, we knew early on in April that this was going to be a pediatric disease and that we needed to really focus on exactly what people have been talking about, how would emergency departments, general hospitals handle an influx of kids. What age would they be able to handle, adult ventilators versus pediatric ventilators, and if we needed to triage from children to adult hospitals so that the children's facilities could have more room for those younger children. How would we do that? So early on, began a very aggressive dialogue with pediatricians specifically, family practitioners and school nurses. This is just kind of to give you guys an idea of, when you're in the middle, who all wants information from you on a daily basis so to think about how we got that out. One of the things that we did was we really built on our partnerships. We tried to set up communication with all physicians on a regular basis. They knew they would get the information. They anticipated it, they expected it, so there were less calls coming in. We set up and again it was great to hear you two speak about it. Commissioner's clinical advisory groups that included clinicians from around the state so that we could have continuous feedback and we could adjust our plans as needed. Because they were really our force multipliers on the ground and gave us an understanding of what was going on. We put them in two groups; one was infectious disease, which included both adult and pediatric infectious disease experts. We also put together a primary care group that included pediatricians, emergency physicians, pediatric critical care and also pediatric nursing care and our academic hospitals. With that group we put together we never had before in our state, we developed a regional approach to look at pediatric ICU beds from as far as North Carolina and Duke, up to D.C. and we were able to provide an up-to-date approach to be able to look at pediatric critical care beds. The example we talked about, the communication example, our "Dear Colleague" letters, we started sending them out every day. We then sent them out every week. We continued to send out "Dear Colleague" letters around any kind of urgent or critical issue in the state. The good news is they went out to 120,000 people that are in our Department of Health Professions database. We do know that they reached as far as Germany because we got questions from Germany, from clinicians there. And they were used by neighboring states as a way to communicate with their clinicians too. We tried to make them short, one page, actionable information that if you were a clinician you would need to know. (00:57:41)

And then, these are our guiding principles for vaccine allocation. I think the most important thing we did is we knew that we could not vaccinate everyone in the public sector. And we immediately partnered with our private sector, we used the judgment of the vaccine provider and the health care community. So we trusted our doctors and nurses who were out in the private community to give the vaccine to who it was most appropriate. We used our local health departments to really focus on school aged children in school so we could take away that hunk and we used our electronic record to have documentation. Here's our overarching principles. I think the one key thing I'd point out there is in talking with our pediatricians, they said if I have a child who comes in with special needs but I also have the sister who's healthy and mom and dad, can I vaccinate them all at once. And we said absolutely. If you've got them all together and you think that's the best way to vaccinate that family, do that. And so we clearly changed the way we provided information based on the feedback from our clinicians. (00:58:46)

I think these are the stories of success. These are all the different sites that got H1N1 vaccines and were giving it. So as you can tell that's a lot more than our health department. Here's the doses. The pink is what we gave in the public sector.

The teal is what was given in the private sector. And as you can tell we have 1.7 million doses and it was really fairly interesting, that the private sector really focused on those small children. We focused on the school aged kids. We worked together on the pregnant women and people with chronic disease. We had a media campaign. It's hard to read but this is the president of the Virginia AAP who was our star on our TV ads to show people real pediatricians offering real services. what we discovered, we found out in pediatric offices and primary care office that there was a real lack of education, understanding, and access to personal protective equipment. So we aggressively engaged in free clinics, doctors' offices, and community health centers to provide not just the equipment but the education that needed to go with it and the fit testing. And here's our results. In Virginia, in the first seven weeks, we ended up being 50% better than the national average in getting vaccines into noses and arms. And that was truly an incredible collaborative effort of the private and public sector. Because if you'd looked in the seven weeks, just as much was being given in the private sector as we were giving. So this was a true partnership from the very beginning. (01:00:13)

What did we learn? We learned that we really needed to communicate, between public health and clinicians at every level, federal, state, local. We need to get better at getting the federal AAP talking to HHS. It needs to happen at a state level, it needs to happen at a local level. We need to think about multi-lingual cross-cultural information for both our clinicians and for our communities, especially in those faith-based communities. And how do we better use social media to reach youth, those that are in the teen years. We were surprised when a lot of home schooled children kind of came forward and wanted to be vaccinated. So, coordination between public, private, home schooled kids are going to be really important and then the issues inherent with trying to vaccinate in higher education. A lot of cross-border coordination is necessary so that clinicians don't receive conflicting or different information from two different states. We really realize in vaccinations, as I think in any disaster, using the systems that are already in place and providing the structure and the support that they need to make their systems work better was very helpful. We provided money to our clinicians to be able to develop their electronic health record to have access to the immunization registry. Our clinicians in our state across the board, pediatricians, family practitioners, extended their office hours, opened up special vaccination clinics to try and get that vaccine into children as effectively as they could. We were one of the first states that partnered with the health plans to make sure they would reimburse appropriately for vaccinations so that there were no barriers. (01:01:52)

And I think I'm going to stop there. I know I talked very fast but I know that we're kind of having people fall off here, so I wanted to leave time for questions for any of us. Thank you. (01:02:03)

Loretta Jackson-Brown

Thank you Dr. Schonfeld, Dr. Wright, and Dr. Remley. We will now open up the lines for the question and answer session. Lori? (01:02:13)

Operator (Lori)

Yes ma'am. Thank you. At this time if you would like to ask a question, please press star one and record your name. (01:02:20)

Loretta Jackson-Brown

While we're waiting for questions from the phone, we do have questions on our webinar and this one seems to be directed to Dr. Schonfeld. And it comes from Diana. The question is, rather than having a lot of medication and stock piles, wouldn't it be better to advise sheltering in place to prevent radiation exposure. (01:02:41)

Dr. David Schonfeld

Well, the response to a radiation disaster is going to be, it's going to depend on a number of factors. Having a large, strategic national stockpile of potassium iodide is not going to be helpful because it has to be delivered very quickly. So one of the recommendations that we had considered was figuring out how to develop a local, regional, and state plan. So it might be in the school system that's right near a site, that they might use the school, they might stockpile some of the potassium iodide there and be able to distribute it quickly. In some situations what you do want to do is to shelter in place. But, if you need to distribute the medication, potassium iodide, to citizens and particularly to children, you need to have some means of distributing it. It's not an either or. I wasn't encouraging national stockpiles of potassium iodide. We do need to think about how to stockpile it near where it needs to be delivered. (01:03:39)

Dr. Karen Remley

This is Karen Remley; I can add on to that too. Here in Virginia our emergency planning, because we have nuclear reactors, then we have aircraft carriers with nuclear reactors, there's an immediate evacuation of 10 miles, similar to what happened to Japan. That then, based on how large the incident was and how far it would go, you would go farther. Around our nuclear reactors we do have our local health departments, all have potassium iodide stockpiled, and have

arrangements and have communicate with the community, both the clinicians and with the people who live in the community, so that they understand that, what their role would be, and where they would need to go to get their potassium iodide. We suffer from the same issues in terms of not having liquid potassium iodide. We're working with our pharmacists to understand how we can compound it while we wait to see, you know, what we could do, because if you need it, you need it immediately. (01:04:29)

Loretta Jackson-Brown

Lori, do we have any questions from the phone?

Operator (Lori)

We do. The first question comes from Sydney Renaldo. Your line is open.

Sydney Renaldo

Hi. This is Sydney Renaldo. I'm with Los Angeles County Department of Public Health. Back in 2009 we conducted a pediatric disaster preparedness workshop. And for this workshop we developed a supplemental handbook, a little pocket guide that provides really nice, simple summaries of a lot of the pediatric information that was suggested as being relevant in this call. And, this pocket guide, while we don't have any more hard copies available, it is available electronically on our web site. And I can give you our website. It is www.publichealth.LAcounty.gov\EPRP\plans. And I think it's something that a lot of your listeners might find useful. (01:05:26)

Loretta Jackson-Brown

Thank you. Lori, do we have any more questions from the phone.

Operator (Lori)

Yes we do. The next question comes from Paul Severin. Your line is open.

Paul Severin

Hi, it's Paul Severin from Chicago. I'm a Pediatric Critical Care Intensivist by trade. The question I had was that we've had barriers with our disaster preparedness planning over the years, trying to engage various entities within the city, an area, the most common of which is the public school system. Do you have any recommendations or ideas on how to kind of, break down the barriers so we can collaborate a little more effectively with our colleagues at the school level. Thanks. (01:06:13)

Dr. David Schonfeld

This is David Schonfeld, I will respond to that. There are a couple of things that can be done. There is a grant program that is available through the U.S. Department of Education, the REMS grant program, the Readiness for Emergency Management in Schools program. And I think partnering with that, that grant would need to be submitted through the school system, but it works on making sure that there's disaster preparedness within the locality, so it might be a town, a region, and it could even, I believe, be potentially a state. And by getting the funds together, it does encourage the school system to engage obviously as an active partner and to lead that effort. So one solution is to try to look for funding. Unfortunately, I'm not sure about the amount of funding in the REMS program in the future, given some of the cuts to the funding to the U.S. Department of Education. There is also funding that comes under Homeland Security and can be used for disaster preparedness in schools. A few of the schools actually do receive that money, so advocating to make sure that there is some funding that goes to the school system to support their efforts, I think would be particularly helpful in getting their more active engagement. And then, I think, otherwise, it's on how you network with really any group that you need to partner with, which is trying to provide something that they perceive of very high value, while assisting them in learning what they need to learn in this area that they may not yet see it as a high priority, given all of the other high priorities that they have and the limited resources. I'll let others see if they have anything to add to that. (01:08:08)

Dr. Karen Remley

This is Karen. And what I would tell you in Virginia, especially about H1N1, we had partnerships with the school nurses ahead of time, but really reaching out to them specifically, I make it a commitment that at least twice a year I meet with the group of school nurses for the state. They are our natural avenue into school districts. I also talk at the school— and I would highly recommend that at the state—there's always a state superintendent meeting in the summer, so if you meet

and talk with them and if they know who you are, they're much more willing to be engaged and involved. And then from the diocese and from the religious schools, reaching out and saying to the bishop, let's sit down and talk about how we can work on these things together. If you can either partner with your local health department or state health official or just you yourself, representing where you live, we have -- in Virginia they have been very open and excited to be engaged. And then the home school associations are the other group, to have them understand and start to think about what they would be doing, because their natural assumption is that they can go to the school the kids would have gone to get whatever it is that you're delivering. And sometimes those schools have policies that children who aren't part of the school can't come in, so we've done a lot of work, kind of ahead of time, trying to make sure we've broken down those barriers. (01:09:28)

Dr. Joseph Wright

Lastly, this is Joe Wright. Let me just also add that the state performance measure number 79, the one about permanence of the EMSC program, requires an EMSC advisory council in every state and one of the members of that council is recommended to be a representative from the school community and the state in which I live and participate on the EMSC advisory council we have sitting at the table with us, representation from—at the state level—from school health and they participate with us in planning activities, not just related to preparedness but all activities around emergency care, so that might be a, in Illinois, a place to look as well. (01:10:21)

Loretta Jackson-Brown

Hey Dr. Wright, perhaps you can take this question from the webinar. What type of research is going on related to emergency disasters in children with special needs healthcare and what are some examples of best practices relating to children with disabilities/special healthcare needs? (01:10:41)

Dr. Joseph Wright

Well, excellent question. As I mention, the PECARN Network, which is a network encompassing 25 hospitals and almost a million emergency department visits around the country is a very viable network for research around these issues. One of our targeted issue projects, one of the previous target issue projects that I didn't show speaks about reunification of children in a disaster circumstance and the PI on that one is Sarita Chung out of Boston Children's Hospital. And so, in terms of the EMSC research network, the network is an open network in that ideas and submissions for research, particularly around children with special healthcare needs, is something that can certainly be submitted to one of the principal investigators at one of the regional note centers and all of that information is Accessible at the Emergency Medical Center for Children's website. But I would encourage those who are interested in the research aspects of disaster preparedness to think about the EMSC program, and specifically the PECARN Network as a viable place to go. (01:12:12)

Loretta Jackson-Brown

Thank you. Lori, do we have any more questions on the phone? (01:12:17)

Operator

No ma'am, I'm showing nothing further.

Loretta Jackson-Brown

Okay, I have one additional webinar question. After a disaster, physicians report information overload and communication fatigue. What can states do to help with this? (Silence)

Does one of our presenters want to take that question? (01:12:45)

Dr. Karen Remley

In terms of—this is Karen from Virginia—the way we approach that was to try and provide, again, short, sweet, timely information and to essentially prepare people for the idea that we aren't going to bombard you with information. You can get it once a day, once a week, in this format. If the CDC already had it, and it was out there, we would link to that. We didn't try to change things around a little bit and put our own brand or name on it, because we realized there's just too many emails, too many sources of information. So, if you've got a reliable and trusted source, just refer to that reliable and trusted source. Don't feel the need to change it, modify it, put your own label on it and send it back out. (01:13:30)

Loretta Jackson-Brown

Thank you. Another question from the webinar and this one seems to be directed to Dr. Wright, What is EMSC doing to engage pediatric facilities in supporting pediatric and neonatal disaster preparedness. There seems to be a huge

disconnect between pediatric facilities and their communities when working on these efforts. And are you working with NACHRI and Children's Hospital Association on these issues to encourage these activities? (01:14:03)

Dr. Joseph Wright

Again, another excellent question. Let me take the back end of that first. NACHRI, the National Association of Children's Hospitals and Related Institutions, is one of the stakeholder organizations that advises and supports the Emerging Medical Services for Children's program and fits with us in working toward those readiness and preparedness for pediatric emergencies and certainly, disaster preparedness is a part of that bucket. The EMSC program, as you saw from my presentation of the state performance measures, does not yet have an explicit performance measure focused on disaster preparedness. But obviously, and one of the reasons that we wanted to share this information today is that those who are working at the state level with their EMSC programs really need to drive at a state-specific level what the needs are, given what their available resources or the state of development of readiness and specifically now that the NCCD and the information that Dr. Schonfeld presented is being disseminated to each and every state, and I think all the governors have received a letter from the NCCD about the recommendations that Dr. Schonfeld presented today. In short, the EMSC program is very interested in working closely at the state level with the needs of children, and part of the reason for, and I appreciate being included on this call today, to really integrate the infrastructure that EMSC has had for a number of years and really address some of the preparedness needs. So we do have—we all have work to do and life after the NCCD and I appreciate the question and the, specifically the reference to the potential for the EMSC program in this area. (01:16:28)

Loretta Jackson-Brown

This will be our last question for the webinar. For those who have submitted questions for the webinar, we will—because you have provided your email, we will be emailing you a response. But the final question is can you provide an update on progress regarding the lack of pediatric mask in the strategic national stockpile? This became apparent as an issue with H1N1, and Dr. Schonfeld or perhaps Dr. Remley, that question is fitting for either of you. (01:17:00)

Dr. David Schonfeld

I will say in terms of the progress that there has been a more careful review of the pediatric medical countermeasures that would be needed in the strategic national stockpile and also a commitment on the part of the Assistant Secretary for Preparedness and Response to ensure that future development of medical counter measures give careful consideration to the needs of children before they're developed and also a commitment to ensure that they increase the proportion of medical countermeasures that do have formulations and preparations that can be and indications for use with children. They don't -- I don't believe they release everything -- a listing of everything in the strategic national stockpile. So I can't—I'm not aware of the specifics to be able to comment. I don't know if someone else does. (01:17:58)

Dr. Karen Remley

I could tell you because the strategic national stockpile falls under our purview. This is Karen. Nicole Lori and her shop are making a big attempt to not only improve the proportion of pediatric equipment, supplies, and medications that are there, but to also develop specific pediatric focus modules so you could call for, specifically, a pediatric whether it be a DMAT hospital, a freestanding hospital you could set up quickly, or whether it just be medical countermeasures, but that we really have not done a—and this has been a discussion that has been ongoing and has really ramped up after what happened in the Gulf,—and H1N1—that we really have not focused on large scale pediatric emergencies, along with just meeting the needs of children during any disaster. So I think through ASPR and Nicole Lori's shop, the national leadership of the AAP has really helped; again, it needs to come from all sectors, focus on this. (01:19:00)

Dr. David Schonfeld

And can I add one other thing? This is David Schonfeld again. One of the challenges that was underscored for us was that the strategic national stockpile can only purchase and store those things that are FDA approved or approved for use in the group that it is intended for. So in a number of the medical countermeasures, there's not an approved use for children. While we do often treat off-label for children, we can't stockpile off-label in children. That's one of the challenges and why we need to really push more for evaluation and approval of medical countermeasures for children, so that we'll have it stockpiled and ready to be used. During a disaster, there isn't enough time obviously to evaluate, test, and develop, and distribute.

Dr. Joseph Wright

Dr. Peacock, this is Joe Wright, if I may just add one last thought here, particularly germane to the EMSC program and states. I think what is clear from all the presenters, is that everyday readiness is critical. That our states and region and local levels have to be prepared at a floor of readiness to care for children on an everyday basis to deal with surge, and in

order to be ready to take care of children in a disaster. So I encourage all of us to really think about this in the context of what we do every day and build upon that in terms of our disaster readiness. (01:20:39)

Loretta Jackson-Brown

On behalf of COCA, I would like to thank everyone for joining us today, with a special thank you to our presenters, Dr. Schonfeld, Dr. Wright, and Dr. Remley, and today's COCA call moderator, Dr. Peacock. If you have additional questions for today's presenters, please e-mail us at COCA@cdc.gov. Put Dr. Schonfeld, Dr. Wright, or Dr. Remley in the subject line of your email and we will ensure that your question is forwarded to them for a response. Again, that email address is COCA@cdc.gov. A recording of the call and the transcript will be posted to the COCA website at emergency.cdc.gov/COCA within the next few days. Free continuing education credits are available for this call. Those who participated in today's COCA conference call and would like to receive continuing education credits should complete the online evaluation by May 27, 2011 using course code EC1648. For those who will complete the online evaluation between May 28, 2011, and April 27, 2012, please use course code WD1648. All continuing education credits and contact hours for COCA conference calls are issued online through TCEOnline, the CDC's training and education online system at www2A.cdc.gov/TCEOnline. That's www2A.cdc.gov/TCEOnline. To receive information on upcoming COCA calls, subscribe to COCA by sending an email to COCA at CDC.gov and write subscribe in the subject line. Thank you again for being a part of today's COCA webinar. Have a great day. (01:22:43)

Operator

Thank you for participating in today's conference. You may disconnect at this time. (01:22:50)